

East Sussex Healthcare NHS Trust

Eastbourne District General Hospital

Quality Report

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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



Accident and emergency

Requires improvement



Medical care

Requires improvement



Surgery

Inadequate



Intensive/critical care

Good



Services for children & young people

Requires improvement



End of life care

Requires improvement



Outpatients

Inadequate



Summary of findings

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Summary of findings

Overall summary

We inspected Eastbourne Hospital as part of the East Sussex Healthcare NHS Trust inspection on 10,11 and 12 September 2014. The trust was placed in band 1 in our Intelligent Monitoring latest data, and therefore recognised as a high priority for inspection (band 1 being highest and band 6 lowest).

The trust serves a population of around 525,000 patients from across the East Sussex area. There are approximately 700 beds and 7,200 staff. The trust provides a full range of DGH services, although not all services are available at both acute hospital sites. The trust has links to Brighton, Tunbridge Wells and London for some tertiary services.

We found that services provided at the hospital were inadequate, with particular concerns about the provision of services in Outpatients and Surgery .

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 of many areas required improvement.

We found that caring was largely good across the trust. However, the NHS Staff Survey 2013 demonstrated very low staff morale and we found high staff sickness levels at the trust

We saw challenges with staffing in some areas. We saw poor management of medicines in a number of areas and practices that our clinical experts deemed unsafe.

We found concerns relating to the under-reporting of clinical incidents. We found discrepancies in the approach to speciality-specific mortality and morbidity reviews. In some cases, these meetings were firmly embedded, but in others they had not taken place for at least six months. We identified concerns with medication management within the department and subsequently undertook a specialist pharmacy inspection as part our unannounced visits.

The quality of the medical notes we viewed were unsatisfactory. Many clinics were running without patient health records and using temporary sets of notes. Health records were in a poor state of repair

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..

Staff had been unsettled by the changes brought about by the reconfiguration of service provision and were stressed, unhappy and keen to discuss their experiences of this change throughout our visit. Staff mostly acknowledged the reasons for the changes but felt that they had occurred with little consultation, without a good knowledge of their job roles, and without adequate support. There were examples of poor patient experiences as a result of the changes.

At Eastbourne Hospital; the maternity services are provided as a midwife led unit through the consultant led maternity unit at Conquest Hospital in Hastings. All maternity services are reported in one report which can be found in the Conquest Hospital report.

We saw several areas of outstanding practice including:

- Clinical leadership across the intensive therapy unit (ITU) is strong with a culture that includes staff and service development, with a focus on improving services for patients and providing safe care..
- There is a strong safety and governance culture with evidence of learning from incidents, feedback and complaints, good infection control procedures with low levels of MRSA and Clostridium difficile (C.difficile) and good performance against safety measures.
- The nurse-led discharges and the introduction of advanced practitioners on wards and in theatres with a very specific skill set which supported the service.
- The introduction of VitalPAC electronic monitoring and recording system, which is a valuable tool to monitor deteriorating patients

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

Importantly, the trust must:

- Make sure the management of medicines, including storage and recording of temperatures, is done in accordance with national guidelines.

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- Make sure the privacy and dignity of patients is upheld by avoiding same-sex breaches in the clinical decision unit (CDU).
 - Improve bed management processes to ensure that patients do not remain in ITU longer than required, which can impact on their privacy and dignity.
 - Conduct a trust-wide review of venous thromboembolism (VTE or blood clot) prevention compliance as a matter of urgency.
 - Address our concerns regarding the checking of emergency equipment.
 - Conduct a trust-wide review of medication compliance.
 - Review and improve the complaints-handling process to ensure that the services learn and improve as a result.
 - Review occupational health and human resources support and resources in place for staff who are on long-term sick leave or who need support, to ensure the trust can meet its duty of care to its workforce.
 - Conduct a trust-wide review of staffing levels to ensure that patient acuity and turnover is taken into consideration.
 - Address the long waiting times for oral and maxillofacial surgery for adults with learning disabilities.
 - Review medical cover at Eastbourne District General Hospital.
 - Repair or replace the emergency bell in the Day Surgery Unit.
 - Identify and address inappropriate staff behaviour toward patients, relatives and staff.
- Ensure that staff fully and accurately complete documentation.
- Ensure that staff receive feedback from managers and supervisors on good and poor practice.
- Make sure that executive level staff integrate with the workforce at local level, observing practice and assessing the impact of changes on individuals and departments., increasing staff inclusion, confidence and empowerment.
- Review some areas of the environment in accident and emergency (A&E) with regard to the lack of visibility of patients in the waiting area, arrangements for supporting patient privacy and the overall security of the department.
- Make sure any assessment of patients' capacity or best interest decisions are accurately recorded in patient records.
- Take action to ensure that staff receive mandatory training in line with trust policy.
- Ensure that patient information is available in languages other than English and in other formats so that it is accessible to people with disabilities.
- Take action to ensure that staff receive an annual appraisal in line with trust policy.
- Review the methods of sharing information with the local population to improve public engagement.
 - Develop a vision for critical care services across both hospital sites to address nurse staffing uncertainties.
 - Provide facilities for translation of written information to other languages to enable all patients and relatives to have information supporting care and procedures in critical care.
 - Embed end of life care in the trust-wide training strategy and include end of life champions on every ward, with regular training for staff to develop and maintain knowledge and skills.
 - Consider the implementation of McKinley T34 syringe pumps across the trust with mitigation plans to support the transition from previous syringe drivers (the subject of a national safety alert) that should now be withdrawn.
 - Include discussion of incidents at the end of life steering group and cascade learning across the trust.
 - Regularly review the quality of MCA (mental capacity act) assessments and ensure that they are clearly documented.

In addition the trust should:

- Review the out-of-hours medical cover available on the site to ensure there sufficient staff to meet the needs of all patients without undue delay during busy periods.
- Include oversight from doctors in the system for reviewing serious medical incidents. Staff completing the reviews should have appropriate training to ensure a full in-depth analysis and clear learning streams.
- Review how medical incidents are managed and escalated to ensure that appropriate management personnel are involved at an early stage to oversee actions and escalate and disseminate information appropriately.

Summary of findings

- Review the quality of nursing documentation to ensure it accurately reflects the care delivered with individualised care plans for end of life patients.
- Collect and consider the opinions of carers of patients receiving end of life care to support a continual cycle of improvement.
- Review the support provided to the SPC team to ensure the resources enable them to achieve their ambitions for the trust. Improved leadership and administrative support is required.
- Consider expansion of the SPC team to enable face-to-face working seven days per week.
- Consider the introduction of an end of life care electronic alert system (to easily identify patients who attend hospital already on an end of life care pathway) across trust.
- Improve the profile of end of life care across the trust by introducing a standing trust board agenda item on end of life care and have a designate a clinician as trust-wide lead for end of life care who understands what is needed and is empowered to implement policy.
- Implement an integrated strategy for end of life care.
- Audit the effectiveness of nurse-led discharges (trust wide) and the admissions.
- Improve staff morale and seek ways of improving communication effectiveness.
- Review the quality of nursing documentation to ensure it accurately reflects the care delivered.
- Ensure all agency and transient staff have a full induction in clinical areas which is formally recorded.
- Address theatre efficiency across both hospital sites and in all theatres.
- Review the operating lights in main theatres.
- Engage in effective listening with staff to improve efficiency.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive to people's needs?	
Are services well-led?	

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

The A&E department requires improvement to ensure that patients are protected from avoidable harm.

Medicines were not always stored securely or checked regularly which increases the risk of medicine misuse.

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

Nurse staffing levels did not consistently meet the Royal College of Nursing Baseline Emergency Staffing Tool (BEST) recommendations.

Tools for monitoring patient's condition were not consistently used, which increases the risk of an oversight of patient deterioration.

Compliance with mandatory training requires improvement to achieve a safe workforce.

Staff in the A&E department showed good clinical practice following accepted national and local guidelines. 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.

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

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

Overall, the A&E provided a caring and compassionate service. We observed staff treating 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. We saw that staff respected patients' choices and preferences and were supportive of their cultures, faiths and backgrounds.

The A&E department requires improvement to ensure that people's needs are taken into account and met. Recent reconfiguration of services has meant that some patients need to be transferred to Conquest hospital. Treating patients, especially children, further

Requires improvement



Summary of findings

away from their homes makes visiting more difficult and costly. The facilities and premises do not always meet patients' needs. The layout of the department does not support patients' privacy, dignity and confidentiality.

Poor out of hours access to mental health liaison team meant the needs of patients presenting with ill health were not met in a timely way. If patients were experiencing a mental health crisis, their behaviour in the department could be very disruptive.

Once patients were within the treatment areas of the A&E their initial needs were responded to quickly and effectively. In the year leading up to our inspection, the trust consistently met the national target of admitting or discharging 95% of patients within four hours. However, the total time in A&E was consistently higher than the national average.

The leadership and culture require improvement so that the delivery of high quality, person centred care is supported.

Leadership roles had recently been restructured in the urgent care directorate. We found a lack of defined leadership "on the floor" of the departments.

We found that staff were not actively engaged and staff satisfaction was not seen as a high priority. Staff were concerned about the level and speed of change implemented in the urgent care directorate within the trust.

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.

Medical care (including older people's care)

Whilst we saw areas of good practice during the inspection we identified concerns requiring improvement.

We were concerned about the level of medical cover during out-of-hours periods.

The review and analysis of serious incidents to ensure appropriate managerial oversight and dissemination of learning as not sufficient.

There was failure to prevent repeated outbreaks of infection, including a case of MRSA where a patient was infected by a member of staff.

There was inconsistent completion of Situation, Background, Assessment, Recommendation (SBAR) for patients requiring transfer or those whose condition was deteriorating.

Requires improvement



Summary of findings

Care and treatment were delivered in line with nationally recognised pathways of care and followed National Institute for Health and Care Excellence (NICE) guidance.

Staff were seen to be caring and compassionate. Patients and their carers or family members could not speak highly enough of the staff who cared for them.

Staff were knowledgeable, well-trained and skilled in their roles.

We saw areas of good practice – such as the use of a computer-based monitoring and recording system (VitalPAC) to provide real-time information across multidisciplinary teams and alert staff if patients deteriorated. The integrated patient care document provided a comprehensive overview of the patient and their needs.

Services had been reviewed at trust level and, following independent scrutiny, several services had been centralised to provide a more specialised and focused response to patients.

At ward level every patient was treated as an individual, integrated patient care documents enabled assessments to be completed and care and treatment tailored to the individual. The document also provided staff with a comprehensive picture of the patient, their needs and their acuity.

We found that leadership at local level was very strong. Matron-led wards and close liaison between department heads meant that in most instances learning was shared between teams.

The transformation process the trust had undergone had left many junior staff feeling disenfranchised, if not by the changes themselves then by the pace of change. They did not feel that their views were listened to outside their own department. Senior managers at board level were, in the main, not visible enough to staff.

At ward level every patient was treated as an individual, integrated patient care documents enabled assessments to be completed and care and treatment tailored to the individual. The document also provided staff with a comprehensive picture of the patient, their needs and their acuity.

Surgery

Overall, we found that surgical services were inadequate.

Our inspection identified concerns relating to the under reporting of clinical incidents within the surgical department.

Inadequate



Summary of findings

We identified a disparity in staff competence relating to the emergency equipment checks and a lack of consistency and continuity which demonstrated that best practice guidance was not being followed. In particular, we found discrepancies in the approach to speciality-specific mortality and morbidity reviews.

We saw problems with medication management within the department and subsequently undertook a specialist pharmacy inspection as part of our unannounced visits. Our observations and subsequent conversations with staff revealed that the trust infection control policy was not being adhered to.

The quality of the medical notes we viewed were unsatisfactory.

We were also made aware of ongoing issues relating to the frequency of medical notes not being available.

We identified concerns with the staffing levels in most surgical areas. We found a lack of evidence to demonstrate that temporary staff had undergone an induction to their particular clinical area, or that the trust's policies and procedures were adequately explained to temporary staff. In areas where long-term agency employment was the norm, there was no oversight of their mandatory training records or annual appraisals or monitoring of their learning needs.

We saw a very dedicated, committed workforce whose main focus was delivering quality care to patients. However, we also noted an exhausted staff group, who were under enormous pressure to deliver safe care due to staffing shortages. Staff appeared to be under so much pressure to maintain patient safety and deliver care that there was little time to adhere to hospital policy and procedures, for example, incident reporting, mandatory drug checks and emergency checks.

We observed task-orientated nursing care which was not individualised or holistic in its approach because of the unrealistic demands placed on staff to manage with low staffing levels, poor skills mix and an unpredictable transient workforce. The NHS Staff Survey 2013 demonstrated very low staff morale and we found high staff sickness levels at the trust.

The trust had initiated some incentives which had the potential to make services more effective and responsive to patients' needs. An example of this was the nurse-led discharges and the introduction of advanced practitioners on wards and in theatres with a very specific skill set which supported the service. But we noted a lack of quality assurance measures to monitor the quality of service delivered. We saw the introduction of the VitalPAC computer-based monitoring

Summary of findings

system, which is a valuable tool to monitor deteriorating patients. However, the trust relied on agency and bank (overtime) staff who reported not having access to the system when they needed it because they did not always have a log in password.

There was a lack of consultant input and support for junior doctors and the telephone support system provided by the Conquest Hospital was insufficient to ensure that the medical staff were supported, with prompt access to the specialist knowledge they need.

We found all the clinical areas we visited to be clean and tidy and clearing records were available to view. There was an ample supply of personal protective equipment available.

We found the department supported advance practitioners in some areas to bridge the gap between healthcare assistants and nurses.

Overall we found that staff at the trust were caring and delivered care which promoted patients' dignity and respect. Staff on the surgical ward phoned patients who were discharged to review their progress.

Intensive/critical care

The intensive care service used procedures to ensure that patients received safe and effective care. Clinical outcomes were monitored and were similar to units of similar size. Practice changed where required improvements were identified. Staff were caring and compassionate, working to maintain privacy and dignity of their patients. However, some improvements were needed in bed management processes to ensure that patients did not remain in the intensive therapy unit (ITU) longer than required and patients requiring critical care were managed in an appropriate setting. Clinical leadership on the unit was strong and supported staff development. However, changes to the clinical unit management team led to a lack of engagement with ITU staff, making it difficult for clinical staff to develop plans for the future.

Good



Services for children & young people

Services for children and young people at Eastbourne District General Hospital were caring and well led, however improvements are required to be safe, effective and responsive.

The Trust does not have a non-executive director who could champion children's rights at Trust board level and currently there is no children's services strategy.

Effective working partnerships did not exist between all consultants and the children's services management team. There were mixed views communicated from consultant paediatricians regarding the

Requires improvement



Summary of findings

merger and whether it had improved care and support within children's services. Staff raised concerns about the lack of support and involvement during and post reconfiguration of children's services.

We found shortfalls in nursing staff attendance in mandatory training which meant that staff skills and knowledge had not been regularly updated. This meant that nursing staff may not have the necessary skills to care for the critically sick child.

We did not see a consistent picture of how risks had been identified and monitored which could impact on children's care.

Staff spoke about clinical decisions being delayed on Friston ward which meant that children had been transferred late in the evening to Kipling ward at Conquest Hospital in Hastings. We were also told of ambulance delays on two occasions in the last six months which had resulted in nursing staff staying overnight on Friston ward to wait for the ambulances.

Concerns had been raised about access and flow because children's outpatients' clinics had been cancelled due to the lack of registrar cover. This meant children had long waits to see the paediatric specialist doctor. Difficulties had been experienced arranging appointments for children through the child and adolescent mental health service.

Parents said they were fully informed and involved in decisions relating to their treatment and care.

End of life care

Services for end of life care at Eastbourne District General Hospital were caring; however, improvements were required to be safe, effective and responsive. Improvements were also required in leadership.

The SPC team were available five days a week, with St Wilfrid's Hospice providing out-of-hours and weekend cover. A telephone and bleep system is in place for referrals to the SPC team which ensures patients are seen and assessed in a timely way. We saw data that confirmed that high percentage of patients referred were seen within 24 hours. Medicines were provided in line with guidelines for end of life care.

The trust had a Resuscitation Policy that was available to all staff, setting out the use of 'Do Not Attempt Cardio – Pulmonary Resuscitation' (DNACPR) orders. The quality of the hospital's DNACPR orders varied and there were no standardised processes for completing mental capacity assessments.

Requires improvement



Summary of findings

Training relating to end of life care was provided at study days however it was not mandatory across the Trust. End of life champions were being introduced across the trust's wards, however, uptake into these positions was patchy. Leadership of the SPC team was good and the quality of the patient experience was seen as a priority.

All patients requiring end of life care could access the SPC team. ESHT formulated a document highlighting the 'Key Elements of Good Care in the Last Hours to Days of Life' that would support the removal of the LCP after the 14th July 2014. Staff were asked to follow these steps and complete this document for all patients approaching the end of their life.

On reviewing medical records of four end of life patients across the wards we visited, we did not find individualised care plans. We saw evidence that care was delivered and recorded but we did not see any information on how individualised care would be delivered around patients' needs and preferences. There was a multidisciplinary team approach to facilitate the rapid discharge of patients to their preferred place of care.

Relatives of patients receiving end of life care were provided with free car parking. Patients were cared for with dignity and respect and received compassionate care.

Outpatients

The central booking service was not always able to give patients appointments within the NHS England and Clinical Commissioning Groups (CCGs) regulations 2012 18 week targets.

The Trust was falling below national averages with the two week wait timescale for patients with urgent conditions such as cancer and heart disease. Despite the Trust consistently falling below the national average we were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the Trust improved on their waiting times.

The Trust had recently undergone a service redesign of OPD. They had changed processes and job roles in order to centralise the administration teams, and to create a new operating system for OPD both in The Conquest and Eastbourne Hospitals. The Trust told us that they had done this to improve the quality and safety of the services they provided. The changes to the service and ways that patients were managed throughout the department were still imbedding at the time of our inspection.

Staff had been unsettled by the changes and were stressed, unhappy and keen to discuss their experiences of this change throughout our visit. Staff mostly acknowledged the reasons for the

Inadequate



Summary of findings

changes but felt that they had occurred with little consultation, without a good knowledge of their job roles, and without adequate support. Occupational Health told us that they were concerned about the sharp rise in the numbers of staff needing their assistance with work related stress.

There were examples of poor patient experiences as a result of the changes. This was partly due to patients checking in at a central desk and being sent to the wrong areas of the hospital. The computerised system being used in the department did not allow staff working in each area of OPD to check to see whether patients had arrived at the hospital. As a consequence patients who had been sent to the incorrect areas went unnoticed, and staff were recording them as not having attended clinic. On the week of our inspection fewer patients than usual were booked to attend OPD and yet the problems caused by the new systems was evident. We saw patients who were lost and in the wrong areas, and we saw staff spending a great deal of time redirecting or searching for patients.

The Trust had issues with the storage and accessibility of patient health records. Many clinics were running without patient health records and using temporary sets of notes. Health records were in a poor state of repair. Staff were not reporting the incidents with medical records consistently through their online reporting systems in accordance with Trust Policy. This was because staff did not have the time due to an already large workload, because there were such a large number of incidents and because staff were unsure of what incidents required reporting.

We found that the OPD was not protecting patient's confidential data as they are required to by law (Data Protection Act 1998). We found patient records in public accessible areas without staff present.

We found that the OPD was not accurately monitoring patient pathways at the time of our inspection. This was due to the redesign of the service which meant that documentation was not being collected and recorded by staff consistently.

We found that staff in OPD were not tracking patient health records because this job had not been considered during the redesigning of the service.

Summary of findings

Areas for improvement

Action the hospital **MUST** take to improve

Importantly, the trust must:

- Make sure the management of medicines, including storage and recording of temperatures, is done in accordance with national guidelines.
- Make sure the privacy and dignity of patients is upheld by avoiding same-sex breaches in the clinical decision unit (CDU).
 - Improve bed management processes to ensure that patients do not remain in ITU longer than required, which can impact on their privacy and dignity.
 - Conduct a trust-wide review of venous thromboembolism (VTE or blood clot) prevention compliance as a matter of urgency.
 - Address our concerns regarding the checking of emergency equipment.
 - Conduct a trust-wide review of medication compliance.
 - Review and improve the complaints-handling process to ensure that the services learn and improve as a result.
 - Review occupational health and human resources support and resources in place for staff who are on long-term sick leave or who need support, to ensure the trust can meet its duty of care to its workforce.
 - Conduct a trust-wide review of staffing levels to ensure that patient acuity and turnover is taken into consideration.
 - Address the long waiting times for oral and maxillofacial surgery for adults with learning disabilities.
 - Repair or replace the emergency bell in the Day Surgery Unit.
 - Identify and address inappropriate staff behaviour toward patients, relatives and staff.
- Include oversight from doctors in the system for reviewing serious medical incidents. Staff completing the reviews should have appropriate training to ensure a full in-depth analysis and clear learning streams.
- Review how medical incidents are managed and escalated to ensure that appropriate management personnel are involved at an early stage to oversee actions and escalate and disseminate information appropriately.
- Ensure that staff fully and accurately complete documentation.
- Ensure that staff receive feedback from managers and supervisors on good and poor practice.
- Make sure that executive level staff integrate with the workforce at local level, observing practice and assessing the impact of changes on individuals and departments., increasing staff inclusion, confidence and empowerment.
- Review some areas of the environment in accident and emergency (A&E) with regard to the lack of visibility of patients in the waiting area, arrangements for supporting patient privacy and the overall security of the department.
- Make sure any assessment of patients' capacity or best interest decisions are accurately recorded in patient records.
- Take action to ensure that staff receive mandatory training in line with trust policy.
- Ensure that patient information is available in languages other than English and in other formats so that it is accessible to people with disabilities.
- Take action to ensure that staff receive an annual appraisal in line with trust policy.
- Review the methods of sharing information with the local population to improve public engagement.
 - Improve communication and engagement between the clinical unit management team and the clinical leads in critical care to develop a plan to address the environmental issues on the Conquest site.
 - Develop a vision for critical care services across both hospital sites to address nurse staffing uncertainties.

Action the hospital **SHOULD** take to improve

In addition the trust should:

- Review the out-of-hours medical cover available on the site to ensure there sufficient staff to meet the needs of all patients without undue delay during busy periods.

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- Provide facilities for translation of written information to other languages to enable all patients and relatives to have information supporting care and procedures in critical care.
- Embed end of life care in the trust-wide training strategy and include end of life champions on every ward, with regular training for staff to develop and maintain knowledge and skills.
- Consider the implementation of McKinley T34 syringe pumps across the trust with mitigation plans to support the transition from previous syringe drivers (the subject of a national safety alert) that should now be withdrawn.
- Include discussion of incidents at the end of life steering group and cascade learning across the trust.
- Develop a system for checking do not attempt cardio-pulmonary resuscitation (DNACPR) orders on a regular basis to ensure compliance with best practice.
- Regularly review the quality of MCA (mental capacity act) assessments and ensure that they are clearly documented.
- Review the quality of nursing documentation to ensure it accurately reflects the care delivered with individualised care plans for end of life patients.
- Collect and consider the opinions of carers of patients receiving end of life care to support a continual cycle of improvement.
- Review the support provided to the SPC team to ensure the resources enable them to achieve their ambitions for the trust. Improved leadership and administrative support is required.
- Consider expansion of the SPC team to enable face-to-face working seven days per week.
- Consider the introduction of an end of life care electronic alert system (to easily identify patients who attend hospital already on an end of life care pathway) across trust.
- Improve the profile of end of life care across the trust by introducing a standing Trust Board agenda item on end of life care and have a designate a clinician as trust-wide lead for end of life care who understands what is needed and is empowered to implement policy.
- Implement an integrated strategy for end of life care.
- Audit the effectiveness of nurse-led discharges (trust wide) and the admissions.
- Improve staff morale and seek ways of improving communication effectiveness.
- Review the quality of nursing documentation to ensure it accurately reflects the care delivered.
- Ensure all agency and transient staff have a full induction in clinical areas which is formally recorded.
- Review medical cover at the Conquest Hospital to ensure there are sufficient staff to care for patients.
- Address theatre efficiency across both hospital sites and in all theatres.
- Review the operating lights in main theatres.
- Engage in effective listening with staff to improve efficiency.

Good practice

We saw several areas of outstanding practice including:

- Clinical leadership across the intensive therapy unit (ITU) is strong with a culture that includes staff and service development, with a focus on improving services for patients and providing safe care.
- The clinical team are innovative and have introduced a number of systems which are having a positive impact on patient care such as the electronic patient record and the electronic early warning system, which has been rolled out across the trust.
- There is a strong safety and governance culture with evidence of learning from incidents, feedback and complaints, good infection control procedures with low levels of MRSA and Clostridium difficile (C.difficile) and good performance against safety measures.
- the nurse-led discharges and the introduction of advanced practitioners on wards and in theatres with a very specific skill set which supported the service. The service also followed up discharged patients with their 50:50 nurse

Summary of findings

- the introduction of VitalPAC electronic monitoring and recording system, which is a valuable tool to monitor deteriorating patients

Eastbourne District General Hospital

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Chair: Dr Mike Anderson, Chelsea and Westminster NHS Foundation Trust.

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

The team included CQC inspectors and a variety of specialists: The team of 52 that visited across the Trust on 10, 11, 12 September and the team of five who visited the two district general hospitals on 23 September 2014 included senior CQC managers, inspectors, data analysts, inspection planners registered and student general nurses and a learning disability nurse, a consultant midwife, theatre specialist, consultants and junior doctors, a pharmacist, a dietician, therapists, community and district nursing specialists, experts by experience and senior NHS managers.

Background to Eastbourne District General Hospital

Eastbourne District General Hospital is located in the town of Eastbourne and geographically serves the population of Eastbourne, Polegate and Hailsham. Merged with Conquest Hospital and the Community locations to form East Sussex Healthcare Trust, healthcare is provided to the whole population from this and other trust locations.

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,

Detailed findings

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 data we already held about the Trust to inform our inspection planning. Teams, which included CQC inspectors and 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

Why we carried out this inspection

Data from our July 2014 Intelligent Monitoring show the trust as a band one risk (where band one is the highest risk and band six is the lowest risk). This position had become worse over the past 12 months. More recent data has been made available subsequent to the inspection and they are no longer a mortality risk. The case was closed post inspection

Key Intelligence Indicators

The trust flagged on our monitoring as an outlier for Summary Hospital Level Mortality Indicator (SHMI); although since our visit, these data have improved to within acceptable levels.

Additionally, the trust was highlighted as an outlier for times for Referral to Treatment (RTT).

The NHS Staff Survey showed three areas where the trust was rated worse than expected:

- Proportion of staff receiving support from their line manager.
- Staff who thought the incident reporting procedure was fair and effective.

- Proportion of staff reporting good communication between staff and senior management.

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 eight core services across East Sussex Healthcare NHS Trust –

- Accident and emergency services including the Minor Injuries Units
- Medical care including care of older people in both acute hospitals and community settings
- Surgery
- Critical care
- Maternity services
- Services for Children and Young People
- End of Life Care
- Outpatient services

Before the announced inspection we reviewed the information we held about the Trust and asked other organisations to share what they knew about the services being provided. These included the local Clinical Commissioning Groups, Trust Development Agency (TDA), NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Royal Colleges and the local Healthwatch. We also approached local voluntary organisations and other NHS trusts for comments and information.

Detailed findings

We held two public listening events in the week preceding the inspection. One in Hastings and one in Eastbourne, both on 4 September 2014. The one in Eastbourne was particularly well attended.






We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

We met with members of local voluntary and campaign groups to listen to their concerns and comments about services being provided by the Trust.

We made an announced inspection of the Trust services on 10, 11, 12 September 2014 and an additional unannounced inspection visit to both acute hospitals on 23 September 2014. We interviewed clinical and non-clinical staff of all grades, talked with patients and staff across all areas of the hospitals and in the community. 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 focus groups to listen to staff working in different areas of the Trust.

On 23 September we looked in depth at how medicines were being managed and operating theatre practice.

Accident and emergency

Safe	Requires improvement 
Effective	Not sufficient evidence to rate 
Caring	Good 
Responsive	Requires improvement 
Well-led	Requires improvement 

Information about the service

East Sussex Healthcare NHS Trust provides emergency and minor injury unit services across five sites.

Following a reconfiguration of some services across the trust between December 2013 and May 2014, general surgery emergency and high-risk services, along with orthopaedic emergency and high-risk services were centralised at Conquest Hospital in Hastings. The Conquest Hospital in Hastings is a Major Trauma Unit and therefore receives only those trauma patients deemed suitable for this level of provision. Eastbourne DGH does not receive patients who have experienced a major trauma.

The trust also operates three minor injury units (MIU) at Crowborough War Memorial Hospital, Lewes Victoria Hospital and Uckfield Community Hospital.

The emergency department at the Eastbourne District General Hospital is also known as the accident and emergency (A&E) department. The A&E saw 41,921 adult patients and 8,406 children between 1 April 2013 and 31 March 2014.

The department is divided into areas depending on the acuity of patients. The resuscitation area has four adult bays, one paediatric bay and one neonate bay for newborn babies. There are eight spaces for treating major cases (Majors) and six spaces, including two rooms for isolation or privacy, for treating minor cases (Minors). In addition, there is a 10-bed clinical decision unit (CDU) which has two bays of five beds each. There is a room near the reception for the assessment and triage of non-ambulance patients.

Eastbourne Hospital has a short stay paediatric assessment unit but paediatric inpatient services were centralised at Conquest Hospital in Hastings in May 2013. Paediatric patients presenting at Eastbourne who require admission and overnight stay are transferred to Conquest.

General surgery emergency and high-risk services, along with orthopaedic emergency and high-risk services were centralised at Conquest Hospital in Hastings in December 2013 and May 2014 respectively. Patients presenting at Eastbourne who require these services are transferred to Conquest.

Information provided by the trust showed that 680 patients were transferred from Eastbourne A&E to Conquest Hospital between 1 April and 24 September 2014. These included 297 patient transfers to the surgical assessment unit, 127 transfers to Kipling Children's Unit and 92 transfers to Benson and Egerton trauma wards.

We visited the A&E over two weekdays during our announced inspection. We observed care and treatment and looked at the records of five patients. During our inspection, we spoke with 23 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We spoke with nine patients and their relatives. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

Accident and emergency

Summary of findings

The A&E department requires improvement to ensure that patients are protected from avoidable harm.

Medicines were not always stored securely or checked regularly which increases the risk of medicine misuse.

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

Nurse staffing levels did not consistently meet the Royal College of Nursing Baseline Emergency Staffing Tool (BEST) recommendations.

Tools for monitoring patient's condition were not consistently used, which increases the risk of an oversight of patient deterioration.

Compliance with mandatory training requires improvement to achieve a safe workforce.

Staff in the A&E department showed good clinical practice and followed accepted national and local guidelines. 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.

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

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

Overall, the A&E provided a caring and compassionate service. We observed staff treating 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. We saw that staff respected patients' choices and preferences and were supportive of their cultures, faiths and backgrounds.

The A&E department requires improvement to ensure that people's needs are taken into account and met. Recent reconfiguration of services has meant that some

patients need to be transferred to Conquest hospital. Treating patients, especially children, further away from their homes makes visiting more difficult and costly. The facilities and premises do not always meet patients' needs. The layout of the department does not support patients' privacy, dignity and confidentiality.

Poor out of hours access to mental health liaison team meant the needs of patients presenting with ill health were not met in a timely way. If patients were experiencing a mental health crisis, their behaviour in the department could be very disruptive.

Once patients were within the treatment areas of the A&E their initial needs were responded to quickly and effectively. In the year leading up to our inspection, the trust consistently met the national target of admitting or discharging 95% of patients within four hours. However, the total time in A&E was consistently higher than the national average.

The leadership and culture require improvement so that the delivery of high quality, person centred care is supported.

Leadership roles had recently been restructured in the urgent care directorate. We found a lack of defined leadership "on the floor" of the departments.

We found that staff were not actively engaged and staff satisfaction was not seen as a high priority. Staff were concerned about the level and speed of change implemented in the urgent care directorate within the trust.

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.

Accident and emergency

Are accident and emergency services safe?

Requires improvement 

The layout of the A&E made observation of patients difficult at times and privacy and dignity was not always maintained. The triage room was in a busy corridor and throughout our visit we observed the door was left open when patients were being assessed. The department was not secure and all areas were accessible to the public. Medicines were not always stored securely or checked regularly.

The service had a separate, small waiting room for children. However, it did not allow staff a direct line of sight to waiting patients. This meant that the condition of patients waiting to see a doctor could deteriorate without staff being aware. The children's waiting room was not always used and we saw several children waiting in the main area.

The department did not have a room specifically identified for accommodating patients presenting with mental health needs. Staff told us they would use the relatives' room.

The department was not secure. All areas of the department were accessible by the public and there was no facility to 'lock down' the department to isolate it in the event of an untoward incident.

The medicines fridge containing controlled drugs and insulin in the Majors treatment area was unlocked on both days of our inspection as the lock was broken. The medicine fridge in the resuscitation area was unlocked on the second day of our inspection. Daily checks of controlled drugs between shift handovers were not consistent. Audits showed this had been identified as an issue but there continued to be a significant shortfall in compliance.

Overall, compliance with mandatory training required improvement.

Staff made decisions in the best interests of patients who lacked capacity, but assessment of capacity and best interest decisions were not consistently recorded in the patient records we looked at.

Workforce Scorecard for the acute and emergency medicine directorate showed that only 55% staff had attended manual handling training and 46% had attended health and safety training

National early warning score (NEWS) and paediatric warning score (PEWS) tools were available for use in the department, but staff did not always use them.

It was common practice for one nurse to cover the resuscitation area and during our inspection there were four patients present, which we considered a risk because of the acuity of the patients.

Consultant and middle grade vacancies in A&E were identified as risks on the urgent care directorate's risk register. 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. Middle and junior grade doctors were on duty 24 hours a day in the department.

Incidents

- There were no Never Events in the A&E at this hospital between April 2013 and March 2014. (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). The trust reported one serious incident to the Strategic Executive Information System (STEIS) relating to the A&E at this hospital between April 2013 and March 2014.
- Staff working in A&E told us they felt confident to complete incident reports and raise any concerns they had, but they did not always receive feedback about the incidents they reported.
- The number, category and severity of incidents were reviewed at the directorate's monthly acute clinical governance meetings. The trust's own analysis showed the 'top five' incidents in acute and emergency medicine were: health records and other documentation; slips, trips and falls; patient discharge and transfer; resources/staffing and medication errors.

Cleanliness, infection control and hygiene

- The department was clean and tidy. We saw support staff cleaning the department throughout the day and doing this in a methodical and unobtrusive way.

Accident and emergency

- The department had a range of equipment that was seen to be clean, and there was a system of labels to indicate that an item had been cleaned and was ready for use.
- 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 seen to be observed by all staff.
- The trust's infection control team completed validation hand hygiene audits in October 2013. The A&E department at Eastbourne achieved 60% compliance.
- 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 'Workforce Scorecard' for the acute and emergency medicine directorate in July 2014 showed that 72% of staff had attended infection control training in the previous 12 months.
- Eastbourne hospital scored 96.69% for patient satisfaction with cleanliness in the patient-led assessment of the care environment (known as PLACE) 2014 surveys, which is around the national average.

Environment and equipment

- The design of the waiting area did not allow the triage nurse or receptionist direct line of sight to waiting patients. There was also a separate, small waiting room without direct line of sight to waiting patients. This meant that the condition of patients waiting to see a doctor could deteriorate without staff being aware. The children's waiting room was not always used and we saw several children waiting in the main area.
- The department did not have a room specifically identified for accommodating patients presenting with mental health needs. Staff told us they would use the relatives' room and that these patients would not be left alone in the room. The relatives' room was not an appropriate area for interviewing patients with mental ill health as it presented several risks such as ligature points and potential missiles and weapons.
- The triage room was in a busy corridor and throughout our visit we observed the door was left open when patients were being assessed.

- The department was not secure. All areas of the department were accessible by the public. There was no facility to 'lock down' the department to isolate it in the event of an untoward incident. Hospital security staff were based in a small room near the reception area.
- There was adequate resuscitation and medical equipment. This was clean, regularly checked and ready for use.
- Each bed space within the resuscitation area was designed and configured in the same way, which allowed staff working within that area to be familiar with the bed space, which contributed to improved efficiency during trauma and resuscitation events.
- There was a specific area for the resuscitation of children. This contained a wide range of equipment so that children of all ages could be immediately resuscitated.
- X-ray and scanning facilities were adjacent to the A&E.

Medicines

- We found the medicines fridge containing controlled drugs and insulin in the Majors treatment area unlocked on both days of our announced inspection visit. We were told the lock on the fridge was broken. We found the medicine fridge in the resuscitation area unlocked on the second day of our inspection visit. This increases the risk of unauthorised access to medicines.
- Daily checks of controlled drugs between shift handovers were not consistently done. We saw audits that showed this had been identified as an issue but there continued to be a significant shortfall in compliance. This means potential medicine misuse might go undetected
- Medicine administration records were complete in the patient records we looked at.

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

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document was clear and easy to follow. There was space to record appropriate an assessment, including an assessment of risks, investigations, observations, advice and treatment and a discharge plan. We looked at the integrated patient care documents for four patients in the CDU and found they were completed.

- The trust's NHS workforce scorecard, for the acute and emergency medicine directorate in July 2014, showed that 46% staff had attended information governance training in the previous 12 months.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that verbal consent was obtained for any procedures undertaken by the staff.
- The trust's Workforce Scorecard for July 2014 showed that 83% A&E staff who required training on Mental Capacity Act 2005 and 80% A&E staff who required training on Deprivation of Liberty Safeguards had done so.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Where people lacked the capacity to make decisions for themselves, such as those patients who had arrived into the department unconscious or under the influence of a substance, we observed staff following the principles of the Mental Capacity Act. However, patients' capacity and any best interest decisions were not consistently recorded in the patient records we looked at.
- We saw appropriate mental health referral practices.

Safeguarding

- Staff spoken with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. We observed staff making a referral for a child identified at risk.
- Staff had access to patients' previous attendance history and to the child risk register. All children who attended were immediately checked to identify if they were 'at risk' within their home environment.
- The Workforce Scorecard for the acute and emergency medicine directorate in July 2014 showed that, of staff who were required to undertake training:
 - 76% had attended level 2 safeguarding,
 - 51% had undertaken level 2 safeguarding children,
 - 90% had undertaken level 3 in safeguarding children.

Mandatory training

- Overall, compliance with mandatory training required improvement. For example, the trust's Workforce Scorecard for the acute and emergency medicine directorate in July 2014 showed that, in the previous 12 months, 55% staff had attended manual handling training, 46% had attended health and safety training and 74% had attended fire safety training.

Initial assessment and management of patients

- 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. We observed this was effective in practice during our inspection as a team was called together in readiness for the arrival of a child in respiratory arrest.
- Patients arriving by an ambulance were assessed by the Shift Co-ordinator. The nurse was given patient handover information by the ambulance crew in the corridor outside the Majors area. 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.
- The trust consistently met the target to receive and assess ambulance patients within 15 minutes of arrival in the 12 months up to January 2014.
- Patients who walked into the department, or who were brought in by friends or family were directed to a receptionist. Once initial details had been recorded, the patient was asked to sit in the waiting room. These non-ambulance patients were assessed by a triage nurse in order of arrival unless the receptionist thought that a patient needed to be seen urgently. If so, the patient was transferred to the resuscitation or a more appropriate area.

Management of deteriorating patients

- The A&E used the Manchester triage guidelines. This helped to determine the severity of the patient's injury or illness.
- The trust issued Standards for Monitoring and Recording Vital Signs (Recognising the Deteriorating Patient) in November 2013. These standards stated that all patients admitted into the trust, (including patients in A&E and Outpatients when a decision has been made

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to admit) must have a trust observation chart commenced and physiological observations recorded at the time of their admission. The records we reviewed showed that vital signs were recorded for patients attending the department.

- We observed that the national early warning score (NEWS) and paediatric warning score (PEWS) tools were available for use in the department, but staff did not always use them. We found that NEWS was not recorded for every patient presenting in the department. Staff told us they made individual judgements about when it was necessary to implement the tool.

Nursing staffing

- The trust reviewed nurse staffing levels in March 2014 in line with the guidance How to ensure the right people, with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability by the National Quality Board. The trust's review adopted an approach where an evidence-based model (The Hurst Model) was used alongside professional judgement, to form a basis for skills mix and numbers, involving the ward matrons and heads of nursing.
- The skills 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. There were also student nurses on placement in the department.
- During each day shift, the department was supported by nine registered nurses and four healthcare assistants. At night, this was reduced to six registered nurses and three healthcare assistants. These staff covered the main A&E (resuscitation, Majors and Minors), triage and the CDU. In addition, an emergency nurse practitioner was on duty on each day shift and a 'twilight' shift until midnight.
- Staff were allocated to specific areas of the department for their shift, but could be moved around if one area became busier than another. On one day of our inspection, we observed that one nurse was covering the resuscitation area with four patients present, which we considered a risk because of the acuity of the patients. We were told this was not uncommon. This does not meet the Royal College of Nursing Baseline Emergency Staffing Tool (BEST) recommendation of a nurse patient ratio of one to one.

- Handovers between staff were effective. Delegation was clear, and communication skills were good.
- The department had low reliance on bank (overtime) and agency personnel to ensure that the unit was safely staffed.
- The community MIU at Crowborough War Memorial Hospital, Lewes Victoria Hospital and Uckfield Community Hospital, were each staffed with one emergency nurse practitioner and one healthcare assistant. We found that staff shortages sometimes resulted in closure of a Minors unit. Information provided by the trust showed it had been necessary to close one of the three units (for some or all of the planned opening times) on 25 occasions since 1 April 2014.

Medical staffing

- Four whole time equivalent (WTE) consultants were employed against an establishment of five WTE. Consultant cover was provided daily from 8am until 5pm on weekdays and for six hours on Saturday and Sunday with an on-call rota for outside of these hours. The trust did not meet The College of Emergency Medicine (CEM) recommendation that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week. The clinical duty rota showed middle and junior grade doctors were on duty 24 hours a day in the department.
- The trust reported a clinical vacancy rate of 8%. Consultant and middle grade vacancies in A&E were identified as risks on the urgent care directorate's risk register. Vacancies were covered by the hospital's own staff and moderate use of locums.
- There is a surgical registrar on call 24/7 at EDGH. Staff also told us they could obtain a surgical opinion by telephone from staff at Conquest Hospital if necessary. Patients presenting at EDGH who required surgical assessment or admission were transferred to the Conquest hospital.
- EDGH did not provide overnight care for sick children, but during the day children were cared for in the short stay paediatric assessment unit (SSPAU). Children requiring overnight care were transferred from EDGH to Conquest. A&E staff could access a paediatric consultant, who was available between 9am and 9pm in the SSPAU. A senior paediatric registrar was available until midnight in A&E. There was a paediatric registrar

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on call 24/7 However, urgent care clinical leads told us they were concerned about paediatric medical cover out of hours in the event of a very sick child presenting in the department.

Major incident awareness and training

- The hospital had a major incident plan (MIP), which had last been reviewed in August 2014. Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (HazMat).
- We observed members of the security team regularly present in the ED. Staff working in the department told us they felt safe and supported and reported that the relationship between the ED and security team was good

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate 

Staff in the A&E department showed good clinical practice following accepted national and local guidelines. 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.

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

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

Evidence-based care and treatment

- The A&E department used a combination of the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided and a range of clinical care pathways had been developed in accordance with this guidance. For example, we saw protocols available for fractured neck of femur, sepsis, stroke and haemorrhage.

- We were told trust/departmental guidelines were produced and revised by an ED consultant every year. We saw a copy of the printed 14th edition produced in August 2014.
- Comprehensive antimicrobial were available online with specific alerts of when to discuss with the microbiology department to protect against antibiotic resistance. We saw current ALS guidelines clearly displayed in resus along with criteria for a trauma call.

Pain relief

- We were informed that an assessment of pain was undertaken on a patient's arrival in the hospital as part of the admission process. This was supported by the care we observed. Staff consistently asked patients if they required pain relief and analgesia was prescribed and administered appropriately. We did not observe patients left in pain. Age-specific pain scoring tools were used for children. However, pain scoring tools were not consistently used.
- The A&E participated in two CEM audits, which included: the management of moderate or severe pain; the management of patients presenting in moderate or severe pain caused by renal colic and the CEM clinical audit into the management of fractured neck of femur.
- 70% of patients who presented to the Eastbourne A&E during 2011/12 complaining of pain as a result of renal colic, had a pain scored recorded. This placed the A&E between the upper and lower quartiles when compared nationally. The CEM standard was 100%.
- 40% of patients who presented in severe pain with renal colic were provided with analgesia within 20 minutes of arrival. This placed the A&E in the upper quartile when compared nationally. The CEM standards recommend that 50% of patients presenting in severe pain with symptoms of renal colic, should receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes upon arrival to the A&E. The department was also placed in the upper quartile for patients receiving analgesia within 30 minutes (60%) and 60 minutes (85%).
- 11% of patients who presented to the Eastbourne A&E during 2011/12 in severe pain with fractured neck of femur were provided with analgesia within 20 minutes of arrival. This placed the A&E between the upper and lower quartiles when compared nationally. The CEM standards recommend that 50% of patients presenting in severe pain with fractured neck of femur, should

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receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes upon arrival to the A&E. The department was also placed between the upper and lower quartiles for patients receiving analgesia within 30 minutes (22%) and 60 minutes (56%).

Nutrition and hydration

- Patients told us that they were offered food and drink. We saw this recorded in their records. We observed people in the CDU having meals.
- The integrated patient care documentation booklet prompted staff to carry out a nutritional risk assessment using the malnutrition universal screening tool (MUST). We saw these completed for patients in the CDU.
- Following the assessment of patients, intravenous fluids were prescribed and recorded, as appropriate.

Patient outcomes

- The department participated in national CEM audits to benchmark their practice and performance against best practice and other A&E departments. Audits included vital signs in majors, renal colic, fractured neck of femur, severe sepsis and septic shock.
- We noted that in 2013/14 the attendances resulting in admission were lower (better) than the national average and the unplanned re-attendance rate to A&E within seven days was consistently between the England average (7–7.5%) and the CEM standard (5%).
- The number of ambulance handovers delayed over 30 minutes during the winter period of November 2013 to March 2014, compared to all trusts in England, was better than the expected standard.

Competent staff

- Nursing staff were supported by a quality and practice development facilitator, a band 7 nurse who also worked clinically.
- 25% of nursing staff had undertaken a level 6 A&E module at Brighton University.
- One paediatric nurse was employed in the department and a further seven members of the nursing staff had undertaken a level 6 course in acute assessment of paediatrics.
- 75% of nursing staff had undertaken paediatric immediate life support and 25% of the nursing staff had undertaken the advanced paediatric life support training.

- We saw evidence that staff were supported in maintaining their competence. The quality and practice development facilitator maintained a local record of training undertaken by staff and the trust held individual electronic records for each staff member.
- The trust's Workforce Scorecard for the acute and emergency medicine directorate in July 2014 showed that 47% of staff had received an appraisal. This was the lowest performance for appraisal among directorates within the trust.
- The trust's quality and performance report for June 2014 showed the medical appraisal status for clinical staff in the trust was 100%.
- We spoke with junior doctors who told us that they received regular supervision from the A&E consultants, as well as weekly teaching.

Multidisciplinary working

- There was effective multidisciplinary working within the A&E. This included effective working relations with speciality doctors and nurses, social workers and GPs.
- We saw good examples of multidisciplinary working with the hospital's team of allied healthcare professionals whose role was to facilitate the early discharge of patients who may have otherwise been admitted to a ward while waiting for an appropriate care package to be organised prior to their discharge.
- There was evidence of good partnership working with the local ambulance service and regular meetings took place. These ensured that the two services worked cooperatively to minimise delays and patient safety risks. A service-level agreement had been developed to mitigate the risks associated with ambulance queues.
- The department had access to radiology support 24 hours each day, with full access to computerised tomography (CT) and MRI scanning.

Are accident and emergency services caring?

Good 

Overall, the A&E provided a caring and compassionate service.

We observed staff treating patients with respect. Patients and their relatives and carers told us that they felt

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well-informed and involved in the decisions and plans of care. We saw that staff respected patients' choices and preferences and were supportive of their cultures, faiths and backgrounds.

Compassionate care

- Throughout our two-day inspection of A&E, we saw patients being treated with compassion, dignity and respect.
- Staff used patients' preferred names and spoke in an appropriate tone of voice when supporting people.
- At our listening events people told us they were satisfied with the care they received at A&E but they were unhappy about a lack of privacy at the receptions window on arrival in the department where confidential conversations could be overheard
- Two questions in the CQC's Adult Inpatient Survey, 2013 related to people's experience in A&E ('While you were in the department, how much information about your condition did you receive?', and 'Were you given enough privacy when you were being examined or treated in the department?'). The trust scored about the same as other trusts in response to both of these questions.
- The NHS Friends and Family Test is a single-question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Eastbourne District General Hospital performed about the same or below the average for England. In March 2014 it scored 52 compared with the average for England of 54, and in June 2014 it scored 42 compared with the average for England of 53. The response rate was 19.5% in March 2014 compared with the England average of 18.5%. The response rate was 43.2% in June 2014 compared with the England average of 20.8%.
- Between 1 April 2013 and 31 March 2014, the A&E at Eastbourne District General Hospital recorded five complaints which specifically included concerns about poor staff attitudes.

Patient understanding and involvement

- Staff had an understanding of the Mental Capacity Act and how assessments of a person's capacity were needed if there were reasons to doubt their level of understanding.
- During our visit to the A&E department, patients and relatives told us that they had been consulted about their treatment and felt involved in their care. One

patient said, "I've been looked after very well and they've kept me informed." A relative of a patient told us, "They've had a nurse with her all the time and they've told me what's happening".

- However, between 1 April 2013 and 31 March 2014, the A&E at Eastbourne District General Hospital recorded nine complaints which specifically included concerns about poor communication.

Emotional support

- 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.

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

Requires improvement 

We found this service to require improvement before it would be responsive to people's needs.

Poor out of hours access to mental health liaison team meant the needs of patients presenting with ill health were not met in a timely way.

The behaviour of patients experiencing a mental health crisis could be very disruptive. The department had no suitable accommodation for these patients and security staff were sometimes given the task of supervising these patients.

Computer screens could be seen by patients and phones were near patients so conversations could not take place privately. This issue was included in the department's risk register.

Male and female patients were accommodated in the CDU overnight. This compromises the privacy and dignity of patients and does not meet the standard for mixed sex accommodation. Staff did not complete the trust incident reporting system patient safety incident report or keep a local record of these breaches. The trust was therefore

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taking inaccurate assurance on mixed sex accommodation breaches. The trust's quality and performance report records nil breaches of single-sex accommodation in the last quarter.

The total time for in A&E (average per patient) was consistently higher than the national average.

Once patients were within the treatment areas of the A&E their initial needs were responded to quickly and effectively. In the year leading up to our inspection, the trust consistently met the national target of admitting or discharging 95% of patients within four hours. However, the total time in A&E (average per patient) was consistently higher than the national average (month by month for the year ending February 2014).

Service planning and delivery to meet the needs of local people

- General surgery emergency and high-risk services, along with orthopaedic emergency and high-risk services were centralised at Conquest Hospital in Hastings in December 2013 and May 2014 respectively. Patients presenting at Eastbourne who require these services are transferred to Conquest. Eastbourne Hospital has a short stay paediatric assessment unit but paediatric inpatient services were centralised at Conquest Hospital in Hastings in May 2013. Paediatric patients presenting at Eastbourne who require admission and overnight stay are transferred to Conquest.
- A high number of local people contacted us before and during our inspection to share their concerns about the reconfiguration of services in the trust. People raised concerns in particular about children being transferred in the late evenings which caused distress and confusion. Reception staff told us it was not uncommon for visitors to arrive at EDGH to find their friend or relative had been transferred to Conquest.
- People were concerned about the distance they had to travel to accompany or visit relatives in Conquest Hospital, Hastings because services had been moved from EDGH. There was limited public transport between the two sites and taxi fares were around £30 one way.
- People also shared concerns about transfers between EDGH and Conquest Hospital. Information provided by the trust showed that 680 patients were transferred from Eastbourne A&E to Conquest Hospital between 1 April and 24 September 2014. These included 297 patient transfers to the surgical assessment unit, 127 transfers to Kipling Children's Unit and 92 transfers to Benson and Egerton trauma wards.
- The waiting area had adequate seating. There was a consulting area for triage and a separate room where patients could be seen by an Emergency Nurse Practitioner (ENP). The department had a small, separate children's waiting room just off 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 that several children waited in the main waiting area. One cubicle in the minors area of the department was allocated for paediatric use but there was no evidence of child friendly design or décor.
- The privacy and dignity of patients in the A&E was compromised by poor departmental design. Computer screens could be seen by patients and phones are all near patients so conversations could not take place privately. This issue was included in the department's risk register.
- We observed that the door to the triage room was left open during the majority of patient consultations. The triage room was in a busy thorough fare corridor of the department so consultations could be seen and overheard. This does not support patients' privacy or confidentiality.
- The CDU comprised two five-bed bays. Patients could be accommodated on more than one or two days in this area, with overnight stays. Staff told us they "do their best" to avoid mixed-sex accommodation and maintain single-sex bays, but said it was "sometimes necessary" to place men and women in the same bay. During our inspection we saw male and female patients accommodated in the same bay; staff confirmed this occurred overnight. This arrangement did not comply with standards set out by the Department of Health's Chief Nursing Officer in 2009. There was no action taken to mitigate this. Although staff did their best to avoid mixed sex accommodation by moving patients around, the practice was accepted as inevitable. Staff told us they did not complete a patient safety incident report or keep a local record of these breaches. The trust's quality and performance report records nil breaches of single-sex accommodation in the last quarter.

Accident and emergency

- There were sometimes delays for patients attending A&E who required specialist input from the mental health team. Patients were often very anxious or agitated and could wait a long time before being seen by the team. This issue was included in the department's risk register. The department had no suitable accommodation for these patients other than the standard bays or the relatives' room. There was no appropriate interview room for patients presenting with mental ill health. Security staff were sometimes given the task of supervising these patients.

Access and flow

- An electronic system was in place for tracking how long patients had been in the department, to ensure they were treated in a timely way. The flow of patients from the department into other parts of the hospital was generally good.
- The government target is for 95% of patients in A&E to wait less than four hours to be admitted, transferred or discharged. NHS England A&E activity statistics for this trust showed the target was met for 95.2% of attendances in the quarter ending December 2013, 95.6% for March 2014 and 94.5% for June 2014. Underperformance against targets by the Conquest and Eastbourne A&E departments were offset by consistent 100% performance by the three Minor Injury units (MIU) operated by the trust.
- We found that the average length of stay for a patient in A&E (average per patient) was between 135 and 170 minutes. This was consistently higher than the national average of between 125 and 140 minutes (month by month for the year ending February 2014).
- The percentage of emergency patients via A&E waiting between four and 12 hours from the decision to admit until being admitted was about the same as the national average (month by month for the year ending June 2014).
- The percentage of patients leaving the department before being seen (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) was about the same as the national average (month by month for the year ending February 2014).
- NHS England winter pressures daily situation reports (SitRep) data between 4 November 2013 and 30 March 2014 showed the trust had nil occurrences when ambulances waited more than 30 minutes to hand over.

Meeting people's individual needs

- There were two 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.
- 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. We observed an incident when an agitated patient who did not speak English as a first language was helped by the support of a bilingual staff member from another area of the department. Patient information and advice leaflets were available in English, but were not available in any other language or format.

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.
- We looked at the trust's complaints report for 2013/14 and were provided with detailed information about each of the complaints received by the urgent care directorate. We noted that, overall, the trust responded to complaints in a timely manner, with 86% responded to in time. The trust identified the top five areas of complaint relating to the urgent care directorate were care, communication, pathways, attitude and discharge.
- 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.

Accident and emergency

Are accident and emergency services well-led?

Requires improvement 

We found that this area required improvement.

The management structure for nurses was new and was not embedded; this meant nursing staff felt unsupported.

The ED had no clinical representation at directorate level as the senior triumvirate posts were held by job sharing acute medical physicians and there was no identified clinical lead in the ED. This meant clinical staff felt unsupported.

Morale was generally low among nursing staff. They felt disengaged with changes implemented in the urgent care directorate and were suspicious of the trust's plans for the future. This adversely impacts on the trust's vision and strategy.

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, but expressed concern about the security of their posts following the changes implemented in the urgent care directorate within the trust. Staff morale in the department was variable. The nurse management structure of the department was new at the time of our inspection and had not been embedded.

There was no evidence displayed in the department of changes made as a result of patient feedback and staff we spoke with were not aware of any public engagement groups or other initiatives where input from patients was sought to help improve the overall A&E experience.

Vision and strategy for this service

- The trust defined their mission is to: "Deliver better health outcomes and an excellent experience for everyone we provider with healthcare services." The trust's defined their 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.
- 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. A&E medical staff expressed concern that the directorate's clinical leads did not have sufficient insight Emergency Care medicine as the directorate leads were acute physicians.
- At service level, staff expressed concern about the level and speed of change implemented in the urgent care directorate within the trust. Staff did not feel engaged with the changes made.
- Some staff we spoke with felt suspicious about the long-term plans for the emergency department, worrying about possible plans to further scale down the services offered at Eastbourne Hospital since some specialities were recently centralised at Conquest Hospital in Hastings.

Governance, risk management and quality measurement

- Monthly departmental governance meetings were held, during which complaints, incidents, audits and quality improvement projects were discussed. Invitation to the meeting extended to band 7 nursing staff who each had an area of responsibility for leadership. We looked at the department's risk register, which fed into the divisional risk register and, ultimately, the trust-wide risk register.
- There was consistency between what frontline staff and senior directorate 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.






Leadership and culture within the service

- A general manager had oversight for management of acute and emergency medicine for Eastbourne District General Hospital and Conquest Hospital, which included ED, medical assessment units and three minor injury units in the trust's community hospitals.

Accident and emergency

- Cross-site nursing leadership in the ED was provided by a senior (band 8b) Head Nurse. Two nurse service managers (with service-specific rather than site-specific responsibilities) were accountable to the head of nursing. Band 7 nurses coordinated the shifts in the department and had specific management responsibilities. This management restructuring had taken place a matter of weeks ago and had not been embedded. Service managers had been in post for two weeks at the time of our inspection. Many nursing staff we spoke with were aware of the recent changes, but had yet to meet their new service manager. Senior nursing staff told us it was a challenge to devolve responsibilities to band 7 nursing staff since the restructure. Staff working in the departments felt they lacked a nursing lead on the floor as there was no longer an identified nursing lead in the departments because service managers were service rather than site specific. This was also expressed by senior doctors who said, “It’s difficult to know who’s responsible for what, so we don’t always know which nurse to go to.”
 - 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. Consequently, Emergency Care Consultants felt the ED “had no voice” at leadership level.
 - Staff told us that they felt valued by leaders “on the floor”, but not by the organisation. Staff did not feel involved with the recent changes made to services. All the staff that 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, but expressed concern about the security of their posts following the changes implemented in the urgent care directorate within the trust. Staff morale in the department was variable and staff felt suspicious about the trust’s future plans. The majority of staff we spoke with did not believe trust leaders were open and transparent. We spoke with several staff who felt cautious about speaking openly with us for fear of reprisal.
 - The trust’s quality and performance report for June 2014 showed high staff sickness levels in the acute and emergency medicine directorate at 5.3% for the month and 6.2% annually.
- ## Public and staff engagement
- 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).
 - Staff and patients we spoke with were not aware of any public engagement groups or other initiatives whereby input from patients was sought to help improve the overall A&E experience.
 - A higher than expected number of the public contacted us before, during and after the inspection to raise concerns about the trust’s reconfiguration. Some of their concerns related to the distance between the trust’s sites which meant people had to travel long distances with a reliance on an inadequate infrastructure. We met with public action groups, who voiced their concerns, which included the welfare of staff as well as patients.
- ## 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 in patient paediatric ward is also at Conquest Hospital so ambulances conveying sick children are received at Conquest. A capital bid was being considered by the trust development authority for expansion by December 2014. The general manager told us the improvements were scheduled to be completed within the financial year.
 - Junior doctors we spoke with told us they were not currently involved in any ongoing audit.

Medical care (including older people's care)

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

Information about the service

Eastbourne District General Hospital is part of the East Sussex Healthcare NHS Trust.

The hospital provides acute medical services in partnership with the trust's other district general hospital, Conquest Hospital, based in Hastings.

Over the last 18 months the trust has undertaken a transformation process with services being centralised at one or other hospital, rather than providing smaller units at each site. Centralisation of services has seen Eastbourne District General Hospital become the centre for diabetic services and a centralised stroke unit.

The trust provides a range of inpatient services, including acute stroke, respiratory medicine and medical day care services. At Eastbourne District General Hospital we visited, Berwick, Cuckmere, Seaford 1, Folkington, Pevensey, Wilmington, and Jevington wards, the endoscopy unit and stroke unit.

We spoke with 21 patients and relatives, 44 members of trust staff, including domestic staff, porters, nursing and medical staff. We observed the delivery of care and assessed the division's quality assurance processes as well as its local leadership, staffing and performance against both national and internal measures.

Summary of findings

Whilst we saw areas of good practice during the inspection we identified concerns requiring improvement.

We were concerned about the level of medical cover during out-of-hours periods. We had concerns regarding numbers and seniority of doctors on duty at night.

The review and analysis of serious incidents to ensure appropriate managerial oversight and dissemination of learning as not sufficient.

Failure to prevent repeated outbreaks of infection, including a case of MRSA where a patient was infected by a member of staff.

There was inconsistent completion of Situation, Background, Assessment, Recommendation (SBAR) for patients requiring transfer or those whose condition was deteriorating.

Care and treatment were delivered in line with nationally recognised pathways of care and followed National Institute for Health and Care Excellence (NICE) guidance.

Staff were seen to be caring and compassionate. Patients and their carers or family members could not speak highly enough of the staff who cared for them.

Staff were knowledgeable, well-trained and skilled in their roles.

We saw areas of good practice – such as the use of a computer-based monitoring and recording system (VitalPAC) to provide real-time information across

Medical care (including older people's care)

multidisciplinary teams and alert staff if patients deteriorated. The integrated patient care document provided a comprehensive overview of the patient and their needs.

Services had been reviewed at trust level and, following independent scrutiny, several services had been centralised to provide a more specialised and focused response to patients.

At ward level every patient was treated as an individual, integrated patient care documents enabled assessments to be completed and care and treatment tailored to the individual. The document also provided staff with a comprehensive picture of the patient, their needs and their acuity.

We found that leadership at local level was very strong. Matron-led wards and close liaison between department heads meant that in most instances learning was shared between teams.

The transformation process the trust had undergone had left many junior staff feeling disenfranchised, if not by the changes themselves then by the pace of change. They did not feel that their views were listened to outside their own department. Senior managers at board level were, in the main, not visible enough to staff.

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Are medical care services safe?

Requires improvement 

Medical services at Eastbourne District General Hospital required improvement.

We had concerns regarding numbers and seniority of doctors on duty at night. We were shown evidence that only two junior doctors were available to cover the whole site. This included all the medical wards and the A&E department.

Serious incident reviews were being completed by inexperienced staff with no oversight from clinicians. We could see no in-depth analysis in the reports, which meant no meaningful learning could take place.

The review and analysis of serious incidents to ensure appropriate managerial oversight and dissemination of learning as not sufficient.

Failure to prevent repeated outbreaks of infection, including a case of MRSA where a patient was infected by a member of staff.

Management systems to ensure cross-trust issues were properly escalated were not always present. We saw that one serious incident relating to infection control had not been effectively communicated from the infection control team to the infection control lead at Eastbourne District General Hospital which meant learning and analysis could not take place and be effectively shared across the trust.

Situation, Background, Assessment, Recommendation (SBAR) records were not always being completed consistently or fully, which could impact on the safe transfer of patients.

Incidents

- Eastbourne District General Hospital had not recorded any Never Events – incidents which, if proper care is taken, should never happen.
- Between April 2013 and May 2014 the trust submitted 8756 incidents to the National Reporting and Learning System (NRLS). Medical specialities accounted for around 30% of the total number reported. The trust in the top 25% of reporting organisations reporting 8.8 incidents per hundred patients, the national average being 6.79 per hundred. NRLS reports include the

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qualifying statement, "Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problem is".

- Incidents including serious incidents were recorded on the trust's computer based reporting system. We were told that these formed the basis of local management meetings and learning was shared across departments and cascaded to staff during team meetings.
- During the period April 2013 to May 2014 the trust reported a total of 96 serious incidents to the NHS National Reporting and Learning System (NRLS). Medicine had accounted for 47 of these serious incidents during the last 12 months, of which 19 related to falls or trips.

Safety Thermometer

- We saw that information about the NHS national Safety Thermometer was displayed on noticeboards on the wards for the information of staff, patients and visitors. The safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care.
- Information relating to falls, pressure ulcers, and infection outbreaks was displayed for the information of staff, patients and visitors.
- The figures illustrate that during the period the trust had performed better than the national average in terms of harm free care. During this period East Sussex Healthcare NHS Trust averaged 94.15% of harm free care against a national figure of 93.4%
- 'All Harm' refers to all types of harm reported in the period including new cases. 'New harm' refers to incidents since the last report was submitted. During the period the trust reported an average of 2.99% of new harm against a national average of 2.76%; however for the same period the trust reported all harm at an average 5.85% against the national average of 6.6%. This suggests that the trust identify and report high numbers of new issues (New Harm), but deal with them effectively reducing the numbers overall (All Harm).

Cleanliness, infection control and hygiene

- The trust had a dedicated infection control lead based at Eastbourne. Each hospital had its own infection control team.
- The Eastbourne gastroenterology department had suffered three outbreaks of infection during the last 12

months. Two of *Clostridium difficile* (C.difficile) and one of MRSA. We learned that subsequent tests revealed that the MRSA infection had been transferred from a member of staff to the patient. When we spoke with the trust infection control lead, they told us that they had not been made aware of the incident by the local team. This meant that the trust could not be satisfied that proper escalation and analysis of the issues had been completed and therefore effective learning could not be shared across the trust.

- We observed staff using aprons and gloves when assisting patients or providing care. We saw that fresh aprons and gloves were used for each patient. The trust had a policy of using differently coloured disposable aprons for patients in isolation. Staff explained that, while all aprons and gloves were disposed of after each use, the different coloured apron was a constant reminder that infection was a higher priority.
- Some side wards had been identified as isolation rooms; there was information on the doors of these rooms to remind staff and visitors about the additional precautions they needed to take.
- Hand cleansing gels were available at entrances and inside all clinical areas. Signs were positioned to remind staff and visitors to use the gel. Hand-washing instructions were displayed at wash basins.
- Patients told us that cleaning staff regularly visited wards and that they found the wards were kept clean and tidy. Patients also confirmed that they had witnessed staff wash their hands and use aprons and gloves when appropriate.
- All staff we spoke with were able to describe the issues, benefits and methods of preventing and controlling infection.

Environment and equipment

- All the areas we visited during the inspection were clean and tidy. Some wards had limited storage space but managed to reduce clutter and avoid trip hazards so that people were kept safe.
- It was noted by the inspection team that the medical wards and hospital in general had a very calm atmosphere. Staff were attentive but unrushed, which put patients at ease.
- We saw that in most areas resuscitation trolleys were well-maintained. Logs were kept with each trolley which showed they had been checked by staff. However when we inspected the two trolleys in the stroke unit we

Medical care (including older people's care)

found that they had not been checked that day. There were gaps in the checking schedule on other dates too. Best practice dictates that resuscitation trolleys be checked daily to ensure they were ready for use. When we checked the trolleys we saw that the contents were intact and ready for use.

- In the hospital medical equipment maintenance department, staff told us that the hospital technician responded quickly to any requests for repairs or replacements. Equipment such as specialist beds was also available for loan from the hospital library store.

Medicines

- During the course of the inspection we observed medicines being administered on one ward and we checked the storage, facilities and record keeping on two other wards. We found that correct procedures were followed and records were maintained in accordance with regulations.
- We found that procedures were completed in line with best practice. Medicine trolleys were not left unattended. Medicines which were temperature sensitive were stored appropriately and regular checks were made of refrigeration and ambient temperatures. Records were updated as staff completed each patient's medication and staff ensured that people had taken their medication before moving on to the next patient.
- Controlled drugs, which are generally more dangerous than others, were stored in their own secure cabinets and were signed for when used.

Records

- The service used a combination of paper and electronic records systems.
- We saw that the trust had introduced an integrated patient care document consisting of a 36-page booklet which led staff through all the key information and considerations which they needed to complete with every patient, and covered all aspects of the patient's mental and physical health, their ability to understand and communicate both their current and underlying health issues. Sections on the front cover related to the Mental Capacity Act 2005 and resuscitation status of the patient. This meant that all clinicians could see quickly and clearly what issues the patient might have which may complicate their treatment or affect their care.

- Consultants' notes were produced on coloured forms which were attached to the booklets. This enabled staff to locate any specific instructions about patients' care quickly and easily.
- The integrated care documents contained risk assessments which we saw had been completed when patients were admitted to the ward. Staff we spoke with described how risk assessments were updated if circumstances changed and reviews were conducted if patients remained in the hospital for long periods. This was evidenced in what we saw in the notes.
- Some patients had forms attached to their records which identified that they did not wish to be resuscitated if this treatment became necessary. These are 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms. We saw that the forms were completed correctly and there was evidence of involvement of family, patient and clinicians in the decision-making process. The forms were either completed by or countersigned by consultants.
- We saw that a nationally recognised quality tool for the recording of information known as Situation, Background, Assessment, Recommendation (SBAR) was being used. The information is used to assist in the safe transfer of patients, ensuring specific information is available in a set format. When we checked records we saw that SBARs had been fully completed for only six out of 16 patients, in a second area, we found only one out of ten records checked contained all the required information. This meant that staff receiving the patient might have to make additional enquiries about the patient in order to ensure appropriate care was given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 provides safeguards for people who are not able to make important decisions for themselves. Where there is doubt about a person's capacity to make such decisions, the Act requires that an assessment is completed. If a person is found not to have capacity then other safeguards come into play which ensures that any decision made on their behalf has the person's best interest at heart.
- We saw that, prompted by a section on the integrated patient care document, staff had to consider the need for a mental capacity assessment for every patient.
- Where assessments were required, this was clearly marked and the assessments were attached.

Medical care (including older people's care)

Safeguarding

- All staff at the trust were required to undertake safeguarding training. Those who worked on elderly or vulnerable patient areas had a higher level of training known as level 3 training. Staff we spoke with had a good knowledge of safeguarding issues, they were able to describe the different types of abuse and how they would be dealt with. The trust had a safeguarding lead who was available to provide advice if staff required it.
- We saw that safeguarding training and updates had been completed by all staff on the wards with exception of those on long-term leave.

Mandatory training

- We checked the training matrix for staff on two wards we visited. We saw that 92% and 95% of staff had completed all areas of training.
- Mandatory and specialist training for nurses and healthcare assistants was monitored and arranged by the matrons. As renewal dates approached, the number of staff requiring the particular course would be provided and training dates would be cascaded back to the wards.
- We saw that health and safety training had not been completed by staff on one ward. The matron told us that e-learning was now used and that it was difficult for staff to complete as the computers in the department were in constant use. The only computer which could be used was in the matron's office which was impractical because the room was never free. Staff had been offered facilities in the trust's education centre but this meant having to leave the ward which was not ideal. An additional computer terminal had been requested but this had not been logistically possible.

Assessing and responding to patient risk

- We saw how the integrated patient care documents were used by staff to identify risks to individual patients. Where identified, interventions were put in place to mitigate or remove any risks. We saw how patients who had been identified as at risk of falls had use of specialist beds which could be lowered so that the patient lay very close to floor and if they tried to get out of bed unassisted they would not fall great distances and injure themselves.
- Patients who needed a higher degree of attention and monitoring were, where possible, grouped into the same bays or areas so that staff had a clear view of them

and could respond more quickly if required. One member of staff said, "I can't say we have less falls by grouping people together, but we have less unwitnessed falls".

- Staff on all the wards we visited had either undertaken or were due to complete dementia awareness training and there were dementia champions throughout the trust who had undergone additional training and supported their colleagues.
- The hospital had a dedicated discharge lounge; however, staff in some areas explained that, where discharge patients had dementia, or might be adversely affected by being moved from the ward before going home because of the change in environment and unfamiliar staff, they would be discharged direct from the ward.
- The VitalPAC system acted as an early warning, alerting clinicians and nursing staff to any unexpected changes.

Nursing staffing

- We found that the numbers and skills mix of staff on the wards was very good, meeting and, in most cases, exceeding national guidelines.
- Staff absences were covered by a combination of ward staff working additional hours, or bank (overtime) staff being brought in. Bank staff are trained staff who are employed by the trust to provide cover in these circumstances. Using bank staff provides a degree of continuity for patients and for regular staff. If neither ward nor bank staff are available, the trust will use agency staff.
- We were told that, if additional staff were required above the planned establishment, (for instance to provide one-to-one care), this was usually authorised and arranged quickly. Some out-of-hours cover could be difficult to arrange due to availability of people willing to attend. In such cases we were told that one-to-one cover was provided, but at the expense of the rest of the ward.
- Staff used a number of methods to assess and monitor patients in their care. Nationally recognised pathways of care were followed.
- Nursing staff and healthcare workers had access to the trust's VitalPAC system. The NHS Technology Adoption Centre who recommend the system describe VitalPAC as a clinical software system which allows clinicians to use handheld mobile devices to record inpatient observations (such as pulse, blood pressure and

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temperature) at the bedside. The system uses the data input to calculate an early warning score (EWS), a measure of risk, for each patient. The system uses these scores to alert relevant staff to patients who may be deteriorating, as well as recording when the next set of observations should be taken, according to the patient's individual level of risk.

- Clinical staff could access patient observations from any computer, tablet PC or mobile device with access to the hospital network.
- We did not witness a staff handover during our inspection; however, staff we spoke with described the process and had a clear understanding of the system. We saw patient boards on all the wards we visited. The boards were set out to show each bed and were colour-coded to identify which consultant was assigned to each patient. Other information was also displayed on the boards about individual risks as a reminder to staff.

Medical staffing

- Some services, because of their nature and frequent use, had remained as cross-trust services. Out-of-hours consultant cover was provided through a system of 'consultant of the week'. However, not all consultants in all disciplines had agreed to provide cover other than at their own site. Nursing staff told us that some consultants who provided cover appeared to prioritise their own patients, spending more time with them than others, although this had not been documented and could not be evidenced.
- We had concerns regarding numbers and seniority of doctors on duty throughout the night. We were shown evidence that only two junior doctors were available to cover the whole site. This included all the medical wards and the A&E department. This could potentially leave patients at risk if both doctors were busy. This situation was emulated at the trust's other acute site at Hastings. Not all junior doctors saw this as a concern but some felt more senior doctors with more experience on hand for advice would speed up diagnosis and improve patient flow and safety.
- We found that the skills mix of medical staff was good. The trust had slightly less consultant cover than the England average, at 36% compared to 38%, and a higher proportion of middle grade doctors, at 19% compared to 9% England average. This meant that, overall, the

trust had a larger number of less-experienced doctors being supervised and mentored by fewer senior doctors. However, the level of competence, knowledge and understanding of doctors did not give cause for concern.

Major incident awareness and training

- Most staff had a good understanding of the trust's major incident plans. They were aware of how to access the plans and what their role would be or who would be responsible for directing them.

Are medical care services effective? (for example, treatment is effective)

Good 

Medical services were effective.

Patients were cared for by qualified and skilled staff who used and understood nationally recognised pathways of care and followed NICE guidance.

Multidisciplinary teams worked to ensure patients received appropriate interventions when they were required.

Patients and their families or carers were involved in planning care. Their opinions were listened to and patients felt empowered and involved.

Staff numbers and skills mix were regularly reviewed to ensure patients' needs could be met.

People's health was continually monitored using a combination of conventional and technologically advanced equipment.

Evidence-based care and treatment

- Care and treatment were based on nationally recognised evidence based pathways and in accordance with NICE guidance.
- Audits were completed of procedures in all areas of the service. Not all audits were completed with or reviewed by doctors. We saw that an endoscopy 30-day mortality rate review had been completed by a staff nurse. Some of the information in the review did not appear to have been subject to in-depth analysis.
- Further enquiries revealed that nurses on the unit complete a total of 38 individual reviews throughout the year. However, they were not given any formal training in how to complete them.

Medical care (including older people's care)

- Staff used a combination of conventional monitoring and recording of patients' condition using the East Sussex Healthcare NHS Trust integrated patient care document, combined with a state-of-the-art monitoring and recording system, which enabled trust-wide access to real-time information across multidisciplinary teams.

Pain relief

- Both the VitalPAC and integrated patient care documents were used to help monitor patients who required pain relief during their stay at hospital.
- Multidisciplinary teams, including physiotherapists and occupational therapists, visited people on the wards, complementing and supporting any drug therapies which people needed.
- The hospital had a pain management team.

Nutrition and hydration

- Patients told us they enjoyed the food. They said they had plenty of choice and could change their mind if they wanted to. One patient said, "I can't get enough of it, I don't know what they put in it but I love it". One of the matrons told us that the provision of meals had changed. Previously they had had individual dishes and were able to serve people exactly what they wanted, whereas now the meals were already plated and just needed heating on the ward. They told us that some patients were unable to remember what they had asked for and, when their chosen meal was provided, they would reject it. They said they could always find an alternative but it had been easier to please people prior to the new system. They told us that, from a ward perspective, the new system was no faster or easier than the previous system.
- Some people needed to have their food mashed or pureed. The matron explained how these foods were presented on the plate to resemble their original form and colour, for instance carrots were pureed and piped on to the plate in the shape of a carrot, to make the food appetising and familiar, which encouraged patients to eat.
- We saw that patients who needed help to eat were highlighted on the ward boards as a reminder to staff.
- People were encouraged to drink fluids and we saw juice and water at most of the beds. Hot drinks were available on request. Patients told us that the nurses and healthcare workers were always encouraging them to drink.

- We observed people being helped to drink where they were unable to manage for themselves.

Patient outcomes

- The Summary Hospital-level Mortality Indicator (SHMI) provides details of patient mortality at trust level across the NHS in England. The SHMI gives an indication of whether the mortality ratio of a trust is as expected, higher than expected or lower than expected when compared to the national baseline (England). The number of deaths includes both patients who died whilst in hospital and those who died within 30 days of being discharged.
- The most recent SHMI statistics prior to our inspection were released in July and represent the twelve months January to December 2013. East Sussex Healthcare Trust during that period had a higher than expected ratio of patient deaths. Of 57786 patients a total of 2749 died in or within 30 days of being discharged from the trust. This produced a SHMI value of 1.127, where a figure of 1 would represent expected mortality rates. However, it is acknowledged that the data collection methodology is not inclusive of integrated trusts and that this may impact negatively on ESHT results.
- We reviewed three serious incident reports relating to unexpected deaths. We found that, in one endoscopy case, the death had been incorrectly recorded as unexpected when it was clear from the notes that the death had been expected. When we spoke with the endoscopy consultant it became apparent that the papers had been filed without any referral to the consultant who would have been able to identify the discrepancy.
- Prior to our inspection we had looked at information which the trust provided as part of national monitoring of standards. It had been identified that the trust had a higher-than-average number of dermatology deaths. During our inspection we looked at the records regarding these deaths; we found that inaccurate clinical coding had resulted in the apparent high figures. Elderly patients with multiple problems were recoded as having died from cellulitis and coded as dermatology. We were told that, when patients were admitted to the hospital, an initial diagnosis was entered into their record. If a patient passed away at the hospital, the initial diagnosis was used to code the death against that department.

Medical care (including older people's care)

- National audit in relation to stroke patients – the Sentinel Stroke National Audit Programme (SSNAP) – aims to improve the quality of care for stroke patients. Stroke services had been centralised at Eastbourne District General but the statistics for stroke services were compiled while both Eastbourne and Conquest locations were providing the service. SSNAP data showed a national average of 58.1% of stroke patients being admitted to a stroke unit within four hours of arrival at the hospital or onset of symptoms (for existing patients) during the period October to December 2013. The trust rate of admissions within four hours for the same period was 77.7%.
- For the period January to March 2014, the national average for stroke admissions had fallen to 57.8% while the trust figure had improved further to 80%.
- Similar above-average figures were achieved for the proportion of patients who spent the majority of their stay on a stroke unit, and the proportion of patients scanned within an hour.
- The Myocardial Ischaemia National Audit Project (MINAP) collects performance data from hospitals for heart attack patients. We were shown data from the audits for Eastbourne District General Conquest hospitals.. We needed to consider the figures at trust level to see the impact that centralising services had provided. We saw that by 2013/14 trust level performance had improved. For example, in 2011/12 the England average for patients receiving treatment within 90 minutes of arrival was 92%; Conquest Hospital was below average at 89.7% and Eastbourne below average at 89.4. By 2013/14 the combined trust performance was 91.1%, against a national average of 89.85%.
- The England average for treatment within 150 minutes in 2011/12 was 82.4%. Conquest Hospital was better than average at 85.7% and Eastbourne higher at 86.4%. By 2013/14 the England average had fallen to 82.3% while the trust average was 84.7%.
- The British Cardiovascular Intervention Society list Eastbourne District General Hospital in their 'excellent' category for completeness of data.
- Performance data also shows how improvements had been made at discharge, with an appropriate care score of 93.8% against a sector average of 72%. One area where significant improvement had been measured was in discharge instructions. In 2010 the trust scored only 14.3% whereas the figure at the time of the inspection was 93.8%. This had been achieved by the introduction of a transfer of care document which was used to provide all discharge information for the patient and for other healthcare professionals. The service also followed up discharged patients with their 50:50 nurse. These are nurses who spend 50% of their time in the hospital and 50% visiting patients in the community providing educational and psychological support to patients and their relatives.
- The National Diabetes Inpatient Audit for 2013 showed that Eastbourne District General Hospital performed better than national average in most of the audited areas. The trust had a higher-than-average instance of diabetic foot problems leading to amputations. The lead consultant diabetologist explained that the high levels of poor foot care had been investigated and the leading factors related to the lack of understanding and willingness of some groups of patients to engage with services. The trust served a large ageing population, but also had a large population of younger patients from very deprived areas and some would not seek help until their illness had progressed and even then were often reluctant to follow advice.
- We found that patients were assessed on admission and an estimated discharge date was determined in relation to their condition and personal needs. The demographics for East Sussex show that the population had a higher-than-average number of elderly residents. The region also had five of the top 20 deprived areas in the country. These factors have an impact on the recovery of patients following injury or illness which is reflected in the length of stay which some patients face. Despite the difficulties with the demographics of the area, the overall length of stay was in line with the national average.
- Staff explained that the initial estimate of discharge could change depending on a patients recovery rate. Where changes were made, these were fully discussed with patients and relatives so that they understood the reasons. This was confirmed by people we spoke with. We observed staff on one ward liaising with social services regarding the discharge of a patient and arranging for an assessment to be completed for home care on their discharge. On another ward we were present when a care home manager attended to complete an assessment of the needs of a potential resident to ensure the home care could meet the person's needs.

Medical care (including older people's care)

- Standardised relative risk of readmission to Eastbourne District General Hospital was below average in most target areas, gastroenterology and cardiology being the exceptions.

Competent staff

- The majority of staff reported having regular supervision by their managers or supervisors. Staff felt supported and motivated. All staff we spoke with were knowledgeable and enthusiastic about the service they provided.
- Mandatory and specialist training were monitored well and courses were arranged in good time to prevent staff falling behind.
- Some doctors, including senior consultants, complained they did not receive sufficient protected time to complete their personal development; as a consequence, they needed to study in their own time to ensure they met revalidation standards set by their respective registrations.
- We saw evidence of nursing numbers and skills mix being reviewed regularly. The 'HURST' model of staffing and establishment was used to assess staffing levels against acuity. Wards had strong leadership from matrons and the director of nursing was well-known to staff and seen in clinical areas.
- We were told that induction processes were inadequate for core medical trainees. Trainees did not have sufficient knowledge of how to use systems and what processes were in place before starting, and this was a distraction for regular staff who had to support them.

Multidisciplinary working

- We saw evidence of multidisciplinary working throughout our inspection.
- Ward meetings were held each day to discuss any new patients or changes in condition of existing patients.
- One example of excellent multidisciplinary working had been introduced following analysis of a serious incident. A patient had received inappropriate treatment which it was identified could have been avoided had the endoscopy department been involved in the diagnosis. The trust now had a policy that any tumour of 1cm in size was discussed at the multidisciplinary meetings to ensure all options were fully considered.
- The trust had introduced systems with the local ambulance trust to ensure that patients were taken to the appropriate district hospital in respect of the centralised services.

- When patients had to be transferred between hospitals because they were found to have a condition covered by a discipline based at the other hospital, staff told us that transfers were completed by ambulance. Best practice requires a doctor to accompany the patient; however, there were insufficient doctors available.

Seven-day services

- Both Eastbourne and Conquest hospitals had emergency departments which were open seven days per week, and consequently the assessment units and wards receive patients throughout the day and night, every day of the week.
- Consultant cover out of hours was provided on a shared basis. We were told that not all consultants had consented to provide cover. However, there were sufficient consultants on the rota to do so.

Are medical care services caring?

Good 

Medical services were caring.

All the staff we spoke with: cleaners, technicians, doctors, nurses and healthcare assistants – conveyed a real passion for their work and believed they were providing the best care they could for the people of East Sussex.

Patients, relatives and carers could not speak highly enough of staff, often having a named favourite, but always with the caveat “they are all good”.

We had received information before our inspection from people who had not experienced good care. However, during our visit we heard little or no criticism of how people were treated.

We observed staff interact with patients and saw that they were polite, respectful and friendly.

Care and treatment were delivered in a way that protected people's dignity and privacy.

Compassionate care

- We spoke with a number of patients and their carers or family members during our inspection. We received unanimous praise of the care people had received. Nursing and healthcare staff were said to be “brilliant, incredible, wonderful” and many other compliments.

Medical care (including older people's care)

Patients told us that they were seen quickly, and knew which staff were looking after them. The Cancer Patient Experience Survey 2012/13 confirmed these comments. Out of 34 criteria measured, the trust were in the top 20% of all trusts in 10 areas, and in the bottom 20% for only one area relating to the degree of privacy afforded to patients.

- People told us that their privacy was respected. If clinicians wanted to speak with them in bay areas, curtains were drawn and voices lowered. We observed this process in a number of areas. People told us that they expected a loss of privacy in these circumstances but they believed they could ask for a private consultation if they felt this was necessary. Staff confirmed that, if a patient requested a private consultation, they would accommodate this in a side ward or office. None of the patients we spoke with had considered they needed to do this.
- Patients told us that staff respected their dignity, and any personal care or treatment was carried out with curtains drawn or if in a side ward with the door closed.
- We were able to speak with one patient who had experienced previous stays at the hospital. They confirmed that the care, treatment and the friendliness of the staff had been just as good on each visit.
- We did receive two comments to the effect that some doctors had displayed a degree of arrogance towards patients. One patient commented, "They have a 'you can wait for me' attitude". However, the majority of people we spoke with were as complimentary of the doctors as they had been of the nursing staff.
- Patients at Eastbourne District General Hospital were asked to comment on the care they received using the NHS Friends and Family Test which asks patients whether they would recommend the service to a friend or relative. We saw data for some wards which scored over 80% satisfaction rates.
- Patients were able to enter their responses to the Friends and Family Test directly into the hospital's IT system using mobile tablets which were available on the wards. There were also comment cards available for those who preferred to write their responses.
- The trust do receive a higher-than-average number of complaints for its size, although numbers of complaints have fallen over the last two years. Full analysis of the reduction has not been completed but the consensus

with staff across the trust was that waiting times had reduced and care was more person-centred now than it had been previously, and that these factors had made the patient experience more pleasant.

Patient understanding and involvement

- Patients we spoke with confirmed that they understood their treatment and care plans. They described conversations with the doctors and consultants and had been told how their illness or injury might improve or progress. Where alternative treatment options had been available people said they were given details of the options and how these might affect their condition and overall health so they could decide which treatment to undertake.
- Patient told us that they had seen clinicians complete notes and make computer entries during consultations. Patients said they recognised that the notes were in relation to them and would be part of their medical record but that they had not asked to view their record and felt no need to do so.
- Patients did have named nurses in accordance with the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report). However, the feedback we received was that they were happy to talk with any of the staff as they were all helpful.
- Friends and family test results showed that in July 2014 328 patients responded to the test in relation to medical wards and departments but excluding A&E and surgical areas. Of those 216 said they were extremely likely to recommend the hospital to a friend or relative if they required similar treatment. 86 said they were likely to recommend the hospital, 10 neither likely nor unlikely, two said they were unlikely to recommend it, three said they were extremely unlikely, and seven did not know.
- The friends and family test figures are used to calculate the net promoter score which enables trusts to be compared. The results can produce scores between -100 and +100 a score over 50 is considered to be excellent. The net promoter score calculated from the figures above would give medical services a score of 62.

Emotional support

- We spoke with a relative of a patient who had been admitted to the hospital following a fall. The relative explained how they had been out of the country when their relative was taken ill. They had been supported by staff on the ward who provided regular updates and had

Medical care (including older people's care)

“bent over backwards” to provide support to them and their relative. One issue had been that the phones available to patients would not receive international calls. Staff had arranged that, at set times of the day when the area would not be busy, the patient could be brought to the nurse station and was able to receive calls from their relative. We were told how this had helped reduce anxiety for patients and relatives.

Are medical care services responsive to people's needs? (for example, to feedback?)

Good



Eastbourne District General Hospital provided care which was responsive to people's needs.

The trust had undergone a transformation process over the preceding 18 months which had seen many services centralised. This included centralisation of two small stroke units into one larger unit based at Eastbourne which took place in March 2013. The changes had been effected under public scrutiny as being in the best interest of local people.

Centralised services meant that more specialised staff and equipment were available to deal with the specialities concerned, care pathways were clearer and patient flow had fewer obstacles.

At ward level every patient was treated as an individual, integrated patient care documents enabled assessments to be completed and care and treatment was tailored to the individual. The document also provided staff with a comprehensive picture of the patient, their needs and their acuity.

Trials of the VitalPAC system were proving to reduce the likelihood of recording errors and provided automatic warning of unexpected changes or deterioration in health. Alerting the relevant clinicians and enabling speedy response and reassessment of care.

Service planning and delivery to meet the needs of local people

- The trust had, over the last 18 months, undergone a large transformation process. Many services had been centralised. The proposals were reviewed by the East Sussex Health Overview Scrutiny Committee who

agreed that they were in the best interest of patients. In May 2013, the trust centralised stroke services at Eastbourne District General hospital. Two small units had operated previously, one at Eastbourne and one at Conquest hospital. Centralising the service at Eastbourne had enabled the trust to bring specialist staff together in one unit. We saw statistics which showed that 71.7% of stroke patients were scanned within an hour of arrival. This was against a national average of 43.2%. Similar above average performance was demonstrated in relation to admission times and proportion of stay on a dedicated stroke unit. Staff we spoke with told us they had seen an increase in the presence of doctors and consultants in the new unit.

- At a local level, medical services at Eastbourne District General Hospital were tailored to meet the needs of individual patients. Multidisciplinary team meetings took place on the wards and teams prioritised their work according to the acuity of patients.
- Wards displayed bed allocation using colour coding to identify the consultant for each patient and additional information to remind staff of individual issues for that patient.
- Wards displayed charts showing the uniforms of the different staff that patients might expect to see. Staff wore colour-coded lanyards with identification badges showing the wearer's position or job title. Staff told us that this had been really well-received by patients who could understand what a person's role was and therefore had a better understanding of what was happening around them.
- Medical outliers were reviewed at trust level. Medical outliers refers to incidents where patients are not treated on wards most appropriate to their needs, but are accommodated in other wards. A consultant had responsibility for reviewing circumstances where this occurred in the trust and reported directly to the trust board.

Access and flow

- On admission to hospital, an integrated patient care document was produced. This document itemised all the information about the person and their condition, and included personal information to help staff understand the person's preferences and needs.
- Different care pathways existed for patients admitted to the hospital, dependent on the speciality concerned. We saw that individual specialities followed national

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guidance on care and NHS patient flow guidance. Staff told us that centralisation of services had made pathways to care easier for those specialities.

Occasionally there had been issues with patients arriving at one location when the specialist treatments were based at the other hospital. Patients received appropriate treatment at the hospital they attended but where patients were admitted this led to transfers being required to house patients on the specialist wards. We did not see any statistics regarding the number of transfers.

- In addition to the two acute hospitals, the trust managed a number of smaller hospitals and community services which enabled patients to be discharged from the acute hospital while still receiving appropriate support outside the hospital.
- Prior to the recent reorganisation, bed occupancy had been below 85% since the latter part of 2013.
- NHS England statistics on bed occupancy between April and June 2014 showed that across the trust bed occupancy had been at 77.6% against a national average rate of 88%. Healthcare information firm Dr Foster, says that when occupancy rates rise above 85% "it can start to affect the quality of care provided to patients and the orderly running of the hospital".
- Eastbourne District General Hospital worked closely with the trust's community-based services and with local GP services. In common with Conquest Hospital, GPs had access to tests and diagnostic services at the hospital through direct referral. Community health framework meetings were held with stakeholders.
- Referral to treatment times were, in most instances, in line with or below (better than) national averages.

Meeting people's individual needs

- We saw many examples of how people's individual needs were met during their care and treatment. We saw special beds in use for people who were prone to falls. We checked their records and saw that full assessments had been completed and the reasons documented for this support. We saw specialist mattresses and beds being used to prevent vulnerable people developing pressure sores.
- We saw how each person was assessed on admission and comprehensive details recorded in their integrated patient care document. The document covered all aspects of the patient's mental and physical health, their

ability to understand and communicate both their current and underlying health issues. It included risk assessments and guidance on recommended interventions.

- We observed staff using the VitalPAC system to record information directly into the patient's medical records. This meant that recording errors from illegible writing or incorrectly completed charts were virtually eliminated. Staff showed us how the system could be interrogated to show charts and graphs over time, which enabled clinicians to monitor a person's health. The system was accessible from any computer terminal in the trust. The system also had built-in alerts if readings were outside expected parameters, enabling speedy response and reassessment of care. VitalPAC was being trialled in the hope that it would be rolled out across the trust.
- We did not encounter any patients with complex needs during our inspection. A matron told us that for these patients, where possible, side wards were used and additional staff could be requested through the head of nursing if needed. Carers were encouraged to be involved with patients with complex needs to provide familiarity and continuity.
- East Sussex has a diverse population and translation services were available to people whose first language was not English. Initially staff would attempt to find a colleague or make use of a patient's family members to translate but, if this was not possible, telephone translation services were used.
- East Sussex attracts a large number of retirees. This, combined with the increase in life expectancy, means that the area has an above-average number of people who present with age-related conditions, including dementia.
- Many of the patients who are treated at Eastbourne District General Hospital are elderly, and some suffer from dementia in addition to their principle need for treatment. We saw that the hospital had dementia champions on the wards. While all staff had a good awareness of dementia and how this can impact on patients' health and behaviour, the dementia champions had received additional training which they were able to pass on to colleagues along with advice and guidance. Patients on the wards and their relatives told us the care and support they received was "excellent".

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Learning from complaints and concerns

- Staff told us that most issues which people raised were managed and dealt with on the ward, including such things as not liking meals, noise at night and waiting to be seen by a nurse or doctor. Where people wanted to make formal complaints, they could be seen by a senior member of staff who would record the issues or refer them to the trust's Patient Advice and Liaison Service (PALS) team.
- Complaints were discussed at weekly management meetings which meant that learning was shared across the trust. Managers then cascaded information to their teams at local level. This was enhanced by circulation of advice by email and newsletter. We saw copies of the minutes of these meetings which confirmed what staff had told us.

Are medical care services well-led?

Requires improvement 

Services were well-led at local level. Staff felt supported and able to approach their immediate supervisors or managers. However, improvements were required to overall leadership of the medical care services within the trust.

Staff were concerned about the transformation of the trust, more so about the pace of change than the actual changes. Many staff felt that cuts to administrative support had placed excessive burden on their department or speciality which impacted on patient care or welfare.

Consultants complained that they were unable to improve services as they had no time to research and no funds to develop. Nursing and ward staff told us that whilst they believed they had sufficient staff to deal with patients immediate needs and maintain their own training there was little time to consider innovative developments or research what other departments or trusts were doing.

No senior clinical oversight was evident in serious incident case reviews relating to three unexpected deaths on wards.

Following an outbreak of MRSA the infection control lead had not been made aware of the circumstances. While this

appeared to be an isolated occurrence, management systems were not in place to ensure the matter was communicated in order to ensure that the issues were considered at the highest level.

Many staff told us that they were afraid to make complaints for fear of retribution from senior managers. They had faith in the own managers but they told us there was a culture that raising personal issues was seen as being disloyal to the trust.

Training and supervision of staff was seen as a priority. Services were tailored to meet individual needs.

The trust had a number of staff in different areas who were recruited from overseas at a time when it had been difficult for the NHS to recruit sufficient qualified people in this country. They told us they were treated well and respected by their fellow workers and managers; however over the years, very few had progressed beyond their original post, despite being qualified and capable of advancing. They felt that staff who had been recruited since were getting preference. Individuals were afraid to raise the issue with senior managers for fear of being seen as trouble-makers and the groups did not have any representation to escalate the issue on their behalf.

Vision and strategy for this service

- The trust have undergone a level of change which is described by the chief executive as “unprecedented” and “a programme of strategic service change as significant as any elsewhere in the NHS”. The new model of care has been designed to “make services safer and better for patients”.

Governance, risk management and quality measurement

- Services were well run and staffing levels and skill mix were constantly reviewed. We did not attend a staff handover session but managers described the process of assessing the acuity and needs of patients on the wards and ensuring staff were made aware. Staff confirmed the process and we were shown how bay notice boards were used to display information as a constant reminder to staff of people's needs.
- We saw evidence in the form of minutes of meetings, which showed that regular team and management

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meetings took place. We saw how these meetings had been used to share information about complaints and incidents but also to share good practice and positive feedback.

- Staff understood their role and function within the hospital and how their performance enabled the trust to reach its goals.

Leadership of service

- Leadership at local service level was very good. Staff told us that they were supported by their managers and department heads. Senior managers, matrons and heads of departments met regularly. Issues which required escalating were taken forward to the board to be dealt with. Results were communicated back to teams. .
- All the staff we spoke with supported the vision of making services safer and better for patients; however, not everyone believed the trust was achieving its aim. Many staff, including consultants, were concerned about the cuts to and centralisation of administrative roles
- Diabetic services had lost a full-time receptionist and now had part-time cover just during clinics. We were told that the full-time receptionist used the time outside clinics to update computer records and help typists in the general office. Other staff had been lost from the clerical team and this had resulted in a backlog of clinic letters. Instead of letters going out within five days they were now taking three to four weeks. The department had a backlog of 500 letters. This situation was compounded by the senior secretary resigning and no replacement being identified. Our inspection coincided with the last working day of the senior secretary. They told us that, despite having experienced an increase in workload, administration staff had been reduced to a level which they felt was unsustainable. While this person did not wish to leave, and had no job to go to, they no longer believed they could work for the organisation.
- We saw evidence of nursing numbers and skills mix being reviewed regularly. Wards had strong leadership from matrons and the director of nursing was well-known to staff and seen in clinical areas.
- No senior clinical oversight was evident in serious incident case reviews relating to three unexpected deaths on wards.
- When we discussed an outbreak of MRSA which had occurred, the infection control lead advised us that they

had not been made aware of the circumstances. While this appeared to be an isolated occurrence, management systems should have been in place to ensure the matter was communicated in order to ensure that the issues were considered at the highest level.

Culture within the service

- Many staff told us that they were afraid to make complaints for fear of retribution from senior managers. They had faith in the own managers but they told us there was a culture that raising personal issues was seen as being disloyal to the trust.
- The trust had a number of staff in different areas who were recruited from overseas at a time when it had been difficult for the NHS to recruit sufficient qualified people in this country. We spoke with some of these staff. They told us they were treated well and respected by their fellow workers and managers; however, they complained that, over the years, very few had progressed beyond their original post, despite being qualified and capable of advancing. They felt that staff who had been recruited since then were getting preference. Individuals were afraid to raise the issue with senior managers for fear of being seen as trouble-makers and the groups did not have any representation to escalate the issue on their behalf. We noted from the staff survey results that 84% of staff who responded believed the trust provided equal opportunities for career progression or promotion.

Public and staff engagement

- The trust conducted staff satisfaction surveys in line with national policy. The latest published survey results for 2013 show that only 36% of staff responded.
- We saw that dedicated publications had been circulated on the trust's website and local press to update and inform patients and stakeholders about the transformation process and how it affected services. Patient satisfaction surveys were conducted by the trust and in addition staff told us that they regularly canvass patients to ensure they were happy with the treatment and care they received, they explained that this wasn't routinely recorded unless an issue was raised which couldn't be addressed there and then.
- The trust had a patient experience strategy with the motto 'What matters to you matters to us'. We saw how

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patients were able to use portable electronic devices to complete satisfaction surveys while they were on the ward. We observed staff encouraging a patient to complete the survey.






- The trust operated a Patient Liaison and Advice service (PALs), to provide information about NHS services and support to deal with concerns or complaints.
- The trust also signposted patients and carers to the local Healthwatch organisation, including having a Healthwatch promotional video on the trust website.

Innovation, improvement and sustainability

- Innovation had suffered as a result of the transformation process, staff explained that their time had been

focussed on ensuring the major changes had been implemented with as little disruption to patients as possible. The lack of free time had been compounded by the financial position the trust was in. Consultants complained that they were unable to improve services as they had no time to research and no funds to develop. Nursing and ward staff told us that whilst they believed they had sufficient staff to deal with patients immediate needs and maintain their own training there was little time to consider innovative developments or research what other departments or trusts were doing.

Surgery

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

Information about the service

The surgical departments at East Sussex Healthcare NHS Trust provide care for a population of 525,000 people, making it a large healthcare organisation. The surgical department offers multiple speciality services across multiple sites, including the Conquest, Eastbourne District, Lewes Victoria and Bexhill hospitals, while a recent service reconfiguration saw the acute services moved to the Conquest site.

The CQC undertook announced and unannounced inspections at the Conquest, Eastbourne General, and an unannounced visit at Lewes Victoria. In order to carry out this inspection, the CQC reviewed information from a wide range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, other external stakeholders, and held listening events where members of the public were invited to share their experiences. We visited the surgical wards and theatres and observed care being delivered by staff. We reviewed online patient feedback from a range of sources and took the information we received before, during and after the inspection process from members of the public into consideration. The CQC held a number of focus groups and drop-in sessions where staff could talk to inspectors and share their experiences of working at the trust.

Summary of findings

Overall, we found that surgical services were inadequate.

Our inspection identified concerns relating to the under reporting of clinical incidents within the surgical department.

We identified a disparity in staff competence relating to the emergency equipment checks and a lack of consistency and continuity which demonstrated that best practice guidance was not being followed. In particular, we found discrepancies in the approach to speciality-specific mortality and morbidity reviews.

We saw problems with medication management within the department and subsequently undertook a specialist pharmacy inspection as part of our unannounced visits. Our observations and subsequent conversations with staff revealed that the trust infection control policy was not being adhered to.

The quality of the medical notes we viewed were unsatisfactory.

We were also made aware of ongoing issues relating to the frequency of medical notes not being available.

We identified concerns with the staffing levels in most surgical areas. We found a lack of evidence to demonstrate that temporary staff had undergone an induction to their particular clinical area, or that the trust's policies and procedures were adequately

Surgery

explained to temporary staff. In areas where long-term agency employment was the norm, there was no oversight of their mandatory training records or annual appraisals or monitoring of their learning needs.

We saw a very dedicated, committed workforce whose main focus was delivering quality care to patients. However, we also noted an exhausted staff group, who were under enormous pressure to deliver safe care due to staffing shortages. Staff appeared to be under so much pressure to maintain patient safety and deliver care that there was little time to adhere to hospital policy and procedures, for example, incident reporting, mandatory drug checks and emergency checks.

We observed task-orientated nursing care which was not individualised or holistic in its approach because of the unrealistic demands placed on staff to manage with low staffing levels, poor skills mix and an unpredictable transient workforce. The NHS Staff Survey 2013 demonstrated very low staff morale and we found high staff sickness levels at the trust.

The trust had initiated some incentives which had the potential to make services more effective and responsive to patients' needs. An example of this was the nurse-led discharges and the introduction of advanced practitioners on wards and in theatres with a very specific skill set which supported the service. But we noted a lack of quality assurance measures to monitor the quality of service delivered. We saw the introduction of the VitalPAC computer-based monitoring system, which is a valuable tool to monitor deteriorating patients. However, the trust relied on agency and bank (overtime) staff who reported not having access to the system when they needed it because they did not always have a log in password.

There was a lack of consultant input and support for junior doctors and the telephone support system provided by the Conquest Hospital was insufficient to ensure that the medical staff were supported, with prompt access to the specialist knowledge they need.

We found all the clinical areas we visited to be clean and tidy and clearing records were available to view. There was an ample supply of personal protective equipment available.

We found the department supported advance practitioners in some areas to bridge the gap between healthcare assistants and nurses.

Overall we found that staff at the trust were caring and delivered care which promoted patients' dignity and respect. Staff on the surgical ward phoned patients who were discharged to review their progress.

Surgery

Are surgery services safe?

Inadequate 

We have judged safety in surgery at Eastbourne District Hospital to be inadequate. This judgement is based on our inspection findings and concerns which we have relating to the reporting of incidents, the checking of emergency equipment, and medicines management in the department.

We identified an under-reporting of incidents within the surgical department. This meant that incidents, errors and near misses which had occurred in the service were not learned from, thus the risk of recurrence was not reduced. We found an inconsistent approach to mortality and morbidity reviews and noted that the general surgeons had not held a review since January 2014.

We found that there was a varying degree of understanding on the checking process for emergency equipment: in particular, the emergency resuscitation trolleys (used to transport emergency medication) and emergency intubation trolleys (a trolley carrying medicine and equipment for use in emergency situations).

The emergency bell in the day surgery unit (DSU) is inaudible.

We found that the trust 'bare below the elbows' infection control policy was not being adhered to by staff from all roles and grades. The staff we spoke with demonstrated an inconsistent understanding of the trust policy. We identified several other breaches of the trust infection control policy during the inspection. We had concerns about inadequate storage for contaminated operation sets and general waste in main theatres.

Doctor cover in its current configuration was insufficient, and was not meeting the needs of the patients on this site.

The quality of the medical notes which we viewed was unsatisfactory. Where the volume of pages exceeded the covers, notes were wrapped with rubber bands in an attempt to avoid pages being lost or mislaid. We were made aware of ongoing concerns relating to the frequency of medical notes not being available.

We identified concerns about controlled drugs being signed-out for patient use and a lack of consistent daily checks across the department.

However, all the areas we visited during the inspection appeared to be well cleaned. NHS Safety Thermometer data (analysing patient harms and harm-free care) was displayed in a public place for patients and relatives to view.

Incidents

- The trust used an electronic incident reporting system to aid the reporting of incidents. The permanent nursing staff who we talked to were able to give an example of how this system worked and confidently gave examples of reporting incidents relating to pressure damage and falls. The data we reviewed demonstrated the trust had a good track record of reporting this type of incident. However, during our inspection we were told of numerous incidents which had not been formally reported by staff. When we challenged this with staff, the reasons given for the under-reporting were as follows: staffing levels, lack of feedback and learning from incidents and, in some areas, a lack of computers to enable reporting. We also identified a disparity among support workers who did not report incidents but relied on escalating their concerns to whoever was in charge with an expectation that they would report the incident. Staff were very open about the lack of reporting in the department.
- There was also a disparity noted in reporting incidents from the medical staff within the department. Some said they did report and others perceived it to be a nursing responsibility to report. We encountered different rationales for the under-reporting of incidents and we witnessed the difficulty which staff face in short-staffed clinical areas due to their primary focus being on the clinical demands of their patients, and this taking priority over incident reporting.
- We found that staff felt disconnected from the importance of reporting issues because they did not receive feedback from incidents, or they felt that nothing changed as a result of reporting.
- The trust reported nine serious untoward incidents using the Strategic Executive Information System (STEIS) in 2013/14. Five out of the nine STEIS reported incidents were related to falls.

Surgery

- There were no Never Events reported in the last six months. A Never Event can be defined as a serious, largely preventable patient safety incident which should not occur if the available preventative measures have been implemented.
- We found evidence that incidents relating to falls and pressure area care were appropriately investigated, information which was fed back to staff and learned from. However, we had a concern that the current culture toward reporting and learning from other events was not robust enough to ensure that incidents would be avoided in future.
- We found inconsistent approaches to mortality and morbidity meetings used to review deaths as part of professional learning. These meetings had the potential to provide hospital boards with the assurance that patients were not dying as a consequence of unsafe clinical practices. We were told that the mortality and morbidity data was discussed at clinical governance meetings, but the minutes of these meetings did not show the detail about these reviews at clinical unit level.

Safety Thermometer

- All clinical areas participated in NHS Safety Thermometer reporting.
- All the clinical areas we visited had their Safety Thermometer data displayed for patients and members of the public to see.
- Staff were able to tell us the rationale and importance of collecting information for the Safety Thermometer and could discuss how it was used to improve the service delivered.

Cleanliness, infection control and hygiene

- We found all the clinical areas which we visited to be cleaned to a high standard.
- We found cleaning records to be in place and curtain changes were recorded in line with hospital policy.
- We found an ample supply of personal protective equipment available for staff, and saw it being used appropriately in clinical areas.
- We found a lack of clarity among staff regarding the trust's own 'bare below the elbow' policy and observed numerous staff from all positions and staff groups in clinical areas not adhering to this policy. We spoke to these individuals and ascertained that this was due a lack of clarity and understanding about the policy.
- Examples of the non-adherence to infection control measures included: staff wearing cardigans, full suits

and watches in clinical areas. We were very concerned that the infection control policy was not being adhered to in theatres. We counted 15 breaches of the policy in a 25-minute period. We addressed this with the management and with the individuals concerned during the inspection.

- The trust collected hand hygiene data which demonstrated good compliance and adherence to national guidance. We were not confident that the audit reflects the disparity in staff compliance observed during the inspection.
- We noted that the Trust's surgical site infection rates were reported nationally and were available on the NHS Choices website which allows patients to score services out five stars for care and involvement. We remain unsure about how the trust's surgical site infection monitoring is undertaken. But we did note that the orthopaedic speciality reported and monitored their infection rates regularly.
- We saw theatre teams preparing surgical trolleys and scrubbing for surgical procedures. This was found to be a thorough process and reflected national guidance.
- Patients had their MRSA status checked at their preoperative assessment so that their status was checked before admission.
- We saw patients who had been isolated due to an infection and witnessed staff taking the appropriate infection control precautions.

Environment and equipment

- The emergency bell in the DSU was not fit for purpose and presents a significant risk to patient safety in its current state. We tested the bell and found that it was inaudible. A member of staff commented, "We feel very alone, today we sounded the emergency buzzer and no one came because no one heard it".
- We did a review of the safety equipment checks in the clinical areas we visited. We took particular interest in the completeness of crash trolley and defibrillator machines checks.
- There were discrepancies in the frequency and understanding of the checking procedure.
- Junior staff appeared competent in completing a defibrillator check but every clinical area had a different perception on the frequency of the defibrillator and emergency trolley checks.

Surgery

- We found a different approach to these checks in each clinical area we visited. None of the staff we talked to were able to demonstrate an understanding of the trust policy on checking equipment.
- Staff confirmed that they had attended annual resuscitation training. However, our findings may suggest that the training delivered was not meeting staff learning needs.
- A significant concern was identified in the theatre areas relating to the frequency of emergency intubation trolley checks. This meant that, if an item was used, not replaced and not identified as missing, it posed a significant risk to patients who required emergency airway interventions.
- The trust may wish to explore equipment suitability and availability in theatres at the Eastbourne and Conquest sites.

Medicines

- Our inspection identified concerns with medicine management within the surgical department.
- We found that controlled drugs registers were not maintained in line with local guidance. We found that some registers did not adhere to the double sign-out policy for controlled drugs. We also found that some areas were not undertaking daily checks of their drug stock.
- We did carry out random checks and found the stock balances to be accurate.
- In the areas where we identified a concern with medicine management, it was discussed with the staff member in charge during the inspection.
- We found that the wards we visited at the Eastbourne site did not have suitable areas for staff to prepare intravenous and infusion drugs. We witnessed staff preparing intravenous medication by the nurse's stations/desk areas where they were distracted by telephones ringing, patients and visitors requesting their assistance, and other members of staff.
- This demonstrates that best practice for infection control prevention is not being followed. It also highlights concerns about patient confidentiality and carries the potential for an increase of risk of medication errors.
- During our inspection we carried out spot medication audits in ward areas. This was supervised by the ward pharmacists. We identified several medication errors per medication chart, ranging from low to moderate in severity. This raised a concern about the quality assurance related to medication at the Eastbourne District Hospital.
- We also identified a disparity in different clinical areas towards the checking of medication fridge temperatures. This meant that there was no way to prove that medication was being stored at the recommended temperatures.
- One clinical area which we visited did not have its drug trolley chained securely to the wall.

Records

- We found that patient records contained the relevant risk assessments which demonstrate that patients were having their care needs risk-assessed.
- However, on our unannounced inspection we reviewed the care plan of a patient who was on 'bed rest' and being nursed in a flat position. The documents we reviewed suggested pressure area checks were in place regularly. The patient told us that he was only turned once a day despite the charts indicating that this was happening more frequently. The pressure care risk assessment had a line drawn through it which suggested that it was not applicable to this patient. We noted that there was no pressure-relieving mattress in place. However, this patient had been lying flat on bed rest for five days with only one turn a day. We spoke to the staff and about our concerns during the inspection but were unable to verify the integrity of the nursing documentation or obtain a satisfactory explanation.
- We looked at the condition of the clinical notes and found them to be too full to hold the information securely and held together by elastic bands. This was the condition of the vast majority of the notes we reviewed all clinical areas.
- We do not consider this to be an appropriate and safe way to handle personal, sensitive and highly important patient data, due to the increased risk of loss and damage thus effecting continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that the notes we reviewed and the patients we talked with demonstrated that consent was being obtained in line with hospital policy.

Surgery

- The staff we talked with were able to demonstrate an understanding of mental capacity and could vocalise when and how to escalate a concern.
- We did not see completed mental capacity documentation during the inspection. However, the staff we talked to were able to demonstrate knowledge of the systems they would use should they identify a concern relating to a patient's mental capacity.
- Staff were less clear on what Deprivation of Liberty safeguards were, and their implications on nursing practice.

Safeguarding

- We saw that the trust had a safeguarding policy in place which reflected national guidance.
- Staff were able to demonstrate what constituted safeguarding and the process for reporting a concern.
- We are aware of the constant support given to the trust by the adult social care team to investigate and learn from these incidents.
- Staff told us that they were given feedback to aid their learning from reported incidents regarding falls and pressure ulcers. However, they were unable to give examples of learning from other incidents.
- CQC were made aware of a succession of thefts from a surgical ward between the 07/03/2014 and 26/03/2014. The investigation process found that staffs were not implementing the policy's to ensure that patients were protected from the risk of financial abuse accruing. The police identified weakness in the department and a lack of guidance to advise staff to report all thefts and to raise a safeguarding referral.
- This meant that the trust failed to ensure that patients were protected from the risk of abuse occurring.

Mandatory training

- We found that local training records varied in most clinical areas. We identified areas where the person in charge had a fully completed and up-to-date training matrix and could identify staff learning needs and future dates for mandatory training.
- Staff told us that the current and unsatisfactory staffing levels frequently had an impact on whether they could attend training.
- The local records we were able to review, demonstrated good compliance rates for staff attending mandatory training.

Management of deteriorating patients

- Deteriorating patients had their conditions monitored by the use of the national early warning score (NEWS).
- The department had implemented a VitalPAC (electronic vital signs system) for monitoring deteriorating patients.
- When the NEWS escalated, the patient was reviewed by a doctor and or a member of the critical care outreach team. This team provided specialist nursing support and advice for patients and ward staff.
- Compliance with the WHO safety checklist was audited regularly and the records demonstrate good compliance. However learning and safety could be improved by auditing all of the 5 steps. We observed an outstanding and thorough team brief in main theatres led by an orthopaedic consultant. The entire team were engaged and freely communicated with each other during the brief. The briefing demonstrated excellent communication between members of the theatre team.

Nursing staffing

- Our observations of the workforce in action led us to the conclusion that staffing in all areas generally appeared stretched. The areas we visited identified a staff group who were working at exceptional rates to deliver the care.
- Staff told us that they frequently "missed their breaks" and "worked extra hours" to ensure patients got the care they needed.
- This was also vocalised by the patients we spoke to who raised their concerns about the staffing levels, but frequently commented on how hard the nursing staff worked and how well they were looked after. An example of the comments received were: "the staff are brilliant, but there aren't enough of them", and, "I felt the staff done amazing with the time and resources they had, if the hospital provided extra staff it would relieve the pressure".
- When we asked patients and staff if they could change anything about the services they received, the majority responded by suggesting increasing the staffing levels.
- We found that permanent staff were heavily relied on to do extra shifts to fill the staffing gaps. Staff told us it was not always possible to get cover and on these occasions staff "just managed".

Surgery

- The trust used a staffing acuity tool to monitor nursing staff levels. However, given the observations by staff, patients and CQC personnel during the inspection, we cannot be confident that the output from the trust acuity tool was being acted upon.
- We found the following comment on a ward information board in response to patient feedback about the lack of staff: “Due to a high level of unforeseen sickness and an incorrect establishment alignment with bed occupancy, steps have been put in place to reduce the risk to patients”. However, we note that this ward was short-staffed during our unannounced visit which suggests the action may not have been effective.
- We visited one area where the staffing model was still running at four trained nurses, despite the acuity tool identifying patient acuity and high patient turnover which required five trained nurses. We observed nursing staff delivering safe care in this area, but at a cost to their own welfare by skipping breaks, working late and delivering task-orientated nursing care due to the pressures placed on them.
- Ward areas displayed their agreed and actual staffing levels alongside the Safety Thermometer data. These boards demonstrated that staffing was not at its desired levels..
- There was no evidence available to demonstrate that the department had oversight of mandatory training, skill competency, supervision or appraisal records for agency staff who had long-term contracts.
- We asked ward areas to demonstrate that bank and agency workers had undertaken an induction. We did not see evidence that staff received induction in any clinical area.
- The trust acknowledged the problem of recruiting staff and we were told there was an active recruitment drive in Portugal in progress.
- Specific concerns related to accessing specialist advice because of registrars’ workload at the Conquest Hospital. It was felt that, if advice was obtained, it was often conflicting and resulted in patients being transferred unnecessarily between locations. This affected all surgical specialities.
- Support for registrars is currently provided by the Conquest Hospital via telephone. Staff reported that this was not sufficient or effective due to doctors’ workload at Conquest and to “being given conflicting information”.
- There are also serious concerns regarding anaesthetic cover at this location. It is currently provided by registrars who do not feel competent to intubate paediatric patients. Although paediatric services have been moved to the Conquest, parents are still taking their sick children to the A&E department at Eastbourne. We were told about two incidents within the last year where two babies required intubating for transfer and the registrars on duty on both occasions did not feel competent to perform the task and lacked consultant support. On one of these occasions, a retrieval team came to the hospital and intubated the paediatric patient before transfer. Both paediatric cases were kept in the recovery area with no specialised paediatric support.
- We were also made aware of the proposed plan to withdraw the operational department practitioners from this location. Although this change had not been implemented at the time of the inspection, we had concerns about this plan to withdraw a vital support mechanism to an already fragile anaesthetic service which will pose a potential risk to patient safety at the hospital.
- We found the majority of care on the Eastbourne site was delivered by middle grade and junior doctors. Staff reported not being able to access consultant support or reviews for patients.
- Some patients reported not seeing a consultant during their admission.
- Medical staff told us that there was confusion between the different processes in place at the different sites which caused confusion and an inconsistent approach to care delivery.
- The provider may wish to note that we consider the doctor cover at EDH to be inadequate to maintain safety and meet the needs of patients.

Medical staffing

- Staffing skills mix data from the trust showed consultant numbers to be below the national average (15% vs. 23%)
- The trust was heavily reliant on locums to deliver services. Locum use is currently running at 7.9% which is above the national average of 6.9%.
- The CQC has received several concerns from staff, patients and members of the public regarding the reduced doctor cover at Eastbourne District General Hospital.

Surgery

Major incident awareness and training

- Staffing records revealed that major incident training has not recently been received by staff. The last training was delivered in 2010/11. With recent changes to work environments, medical specialities and mobility of staff, this poses a potential risk to the organisation.
- Staff knew of the policy to defer elective activity in order to prioritise unscheduled emergency procedures during a major incident.

Are surgery services effective? (for example, treatment is effective)

Requires improvement 

We judged Eastbourne District General Hospital's rating for being effective as 'requiring improvement'.

With its current structure and staffing limitations, the pain service was unable to deliver an effective service to patients. Contact from the public revealed dissatisfaction with the way that their pain was managed, and there were also concerns about the difficulties which patients faced when trying to access chronic pain services at East Sussex Hospital Trust.

We carried out spot checks in clinical areas to test if national venous thromboembolism (VTE or blood clot) guidance was being followed. We carried these out with staff from pharmacy and our results raised concerns about VTE guidance compliance within the department.

Nurse-led discharges were in place in the department. We were told that this meant that the process avoided discharge delays. However, ward areas were not auditing the process, so were unaware of how successful or problematic the process might be.

We identified concerns with quality measurement of patient's pathways and new processes in the surgical department. This meant that quality of service could not be measured effectively. The lack of quality audit meant that the service was unable to improve as a result of learning from comments and incidents and was unable to measure the impact of pathways on the patients and service delivered. This was most evidence when reviewing VTE compliance, Nil By Mouth (NBM) pathways, and nurse led discharges.

Evidence-based care and treatment

- The trust VTE policy reflected national guidance. However, we did a sample audit with the supervision of the pharmacist in different wards and found that the VTE protocol was not being followed. This suggested that patients may not be receiving appropriate VTE prophylaxis and that national guidance was not being followed.
- The trust was not following national guidance for patients who were required to be 'nil by mouth' prior to surgery. We mostly found a blanket approach to 'nil by mouth' status being used in the department. This meant that patients were without food and fluids for unnecessary and extended lengths of time. This does not reflect national guidance or individualised patient care.
- Data received showed that the trust was not meeting its referral-to-treatment time targets.
- We saw evidence of trust involvement in national audit programmes. However, we noted that audit activity within the department could be significantly improved. Staff reported not having enough time to engage meaningfully with audit processes.
- We found evidence that national guidance was being followed in the department and that hospital policies were based on guidelines from the National Institute for Health and Care Excellence (NICE and the Royal Colleges).
- We saw evidence in the care plans and notes we reviewed which demonstrate people's needs were identified and reviewed.
- Records we viewed demonstrated that the trust was adhering to and following NICE guidance CG50 (Acutely ill patients in hospital).
- We found a general lack of quality monitoring in place in the department. Audit process and outcomes should lead to changes in clinical practice to ensure a high quality services, improve compliance and demonstrate compliance with national standards.

Pain relief

- The pain service was currently unable to provide specialised support for trust staff and relied on the recovery staff and anaesthetic department to provide support for clinical areas.
- The patients we spoke to during the inspections told us that their pain was adequately controlled and this was evidenced in the records we viewed.

Surgery

- However, CQC have received information from the public which identified a theme relating to patients not receiving adequate pain relief in a timely manner.
- CQC were aware that the epidural pain service had been severely affected by the recent service reconfiguration and by the retirement of the team's lead anaesthetist.
- We are aware that steps were being taken to improve the epidural service and that training for staff was made available.
- However, CQC were concerned that the contingency plans to ensure the service was unaffected by the recent retirement of the team lead and the service reconfiguration were insufficient.
- Patients who attended preoperative assessment clinics had their pre- and post-operative pain concerns discussed.
- CQC also received concerns from the public regarding access to the chronic pain services.
- We saw a dedicated and standardised pain assessment tool for recovery in place to measure pain, and that staff were able to demonstrate its use.

Nutrition and hydration

- Patients contacted CQC prior to the inspection to give their views about the quality of the food available at the trust.
- The trust recently changed its food provider and we found a positive response to the improvements in both the quality and variety of food available.
- Patients were asked for their daily food preferences and there was a sufficient range of meal choices available to them.
- People who required specific diets had their needs met.
- Patients told us that they were happy with the quality of food available to them during their hospital admission.
- Comments received from patients included, "The food was good", and "it's definitely better now".
- The staff told us they believed the quality of the food had improved and staff told us that they "would be happy to eat it".
- We found the notes we reviewed used the malnutrition universal screening tool – a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also included management guidelines which can be used to develop a care plan.

- Where a risk was identified, we found that the appropriate measures were put in place to monitor that risk. These included regular weight checks, food diaries, food supplements, and dietician input.
- Patients had their hydration needs monitored and where a risk was identified a fluid chart was implemented to monitor patients daily fluid balances.

Patient outcomes

- The trust contributed to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), the National Emergency Laparotomy audit and the National Bowel Cancer audit and performed in line with the national averages.
- The trust contributed data to the annual National Hip fracture audit. It performed below the England average in six areas and above the England average in four areas.
- Day 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. We are unsure of why day surgery activity in the trust has reduced given its challenges to meet surgical RTT targets. The data may therefore suggest that day surgery efficiency has been affected by the recent service reconfiguration..
- Overall the average length of stay at the Eastbourne District General Hospital was above the average for England particularly in general surgery.
- There were arrangements which reflected the RCS standards for unscheduled surgical care and emergency surgery. This included handover of information between medical teams and access to operating theatres or diagnostics. The trust also participated in a 'trauma network' with another hospital and patients admitted with various trauma problems were managed with combined input and decisions by speciality consultants as appropriate.
- Comparative outcomes by individual surgeon have been published on the NHS Choices website.

Competent staff

- Staff records showed that staff had annual appraisals.
- The staff we talked to confirmed that they had received an appraisal and the appropriate level of training to be able to do their jobs.
- Nursing pin numbers (proof of professional registration) were checked by team leaders to ensure that staff registered annually with the Nursing Midwifery Council.

Surgery

- Medical staff underwent an annual revalidation process to ensure their skills were current and relevant.
- Clinical supervision was not widely available in the department.
- We were made aware that there was little opportunity to access training other than mandatory training due to financial restraints and staffing pressures.

Multidisciplinary working

- We identified a multidisciplinary approach to care at Eastbourne District General Hospital. We found evidence of a multidisciplinary team approach to care in patient notes. However, we also noted that physiotherapy ward rounds were separate to the ward rounds.
- There were arrangements for the transfer of patients between the Conquest, Eastbourne District Hospital and the community sites.
- The physiotherapy and occupational therapists told us that they had recently recruited staff and this would improve multidisciplinary team working within the trust.

Seven-day services

- Medical cover was predominantly provided by middle grade registrars with telephone support from the medical teams at Conquest Hospital.
- We were told that consultants were “generally busy in theatres” and were not visible in ward areas during normal working hours.
- Physiotherapy services were available five days a week and there was a limited call cover provided at weekends.
- There was no weekend out-of-hours cover for occupational therapy, dietician or speech and language therapy team services.
- We found limited pharmacy cover over weekends.
- There was access to out-of-hours imaging services.

Are surgery services caring?

Good



We judged the surgical services at the Eastbourne District General Hospital to be caring.

Staff who worked in the surgical department delivered care which ensured patients had their privacy, dignity and independence respected. The patients we spoke to during

the inspection were very complimentary about the staff and the service they received. They told us that they had their views and experiences taken into account and had their care and treatment options explained to them. Some comments received were: “Brilliant care”, “Everyone has been fantastic” and “I have no complaints, everyone works so hard”.

Patients were confident they could raise concerns or complaints with the nursing staff and have it resolved in a timely manner. They also told us that staff were respectful of their decisions and individual wishes. Patients felt involved in their care and all reported having access to their consultants.

Patients raised their concerns with CQC about “staff attitudes” which were perceived as “lacking empathy and understanding” and “lack of communication”. The people who brought this to our attention were concerned about the environmental pressures placed upon staff. However, we observed that staff interacted well with patients and each other and felt they did their best to make patients feel comfortable and cared for given the demanding and difficult environments they worked in.

We spoke to a relative who brought a personal complaint to our attention. CQC does not investigate individual complaints; however, we noted the severity of this issue. We substantiated this event with the staff on the ward during the inspection. However, we were unable to ascertain if it was reported as an incident. We had contact from a member of the public who wished to make CQC aware of a serious personal complaint which related to the same surgical discipline.

We were informed by staff in theatres that colleagues generally treated each other with dignity and respect, however, there had been occasions where nursing staff had been treated inappropriately by some senior staff. We were unsure if there was a link between these examples of inappropriate behaviour, but the provider may wish to explore this further.

Whilst Eastbourne is on par with the Friends and Family test England average of 33%, there were four wards that fell significantly below the England average.

Compassionate care

- We observed staff treating patients in a kind and compassionate way which promoted their dignity and respected their privacy.

Surgery

- The staff we talked with were recognised by their patients as being hard-working and dedicated to delivering the best care they could.
- Curtains were drawn when personal care was delivered.
- CQC received a number of comments from patients who wished to raise concerns about the care they received as lacking compassion.
- Ward areas had 'You said, we did' information displayed on their noticeboards. This is where patients had their feedback addressed and the action taken by staff was displayed.

Patient understanding and involvement

- The patients we spoke to during the inspection were very complimentary about the care they received.
- They told us that they felt involved in their care planning and had access to enough information to help them make informed choices.
- Patients also told us that they were treated with dignity and respect by the staff during their admissions.
- We did see a named nurse in place, however, most patients were not aware of who their named nurse was.
- The NHS Friends and Families Test score for inpatient services in June 2014 was 67. This was below the England average for NHS organisations of 73 and the Surrey and Sussex average score of 74. The quarter one scores nationally ranged from 67 to 78.
- We noted that staff encouraged patients to complete the NHS Friends and Family Test feedback prior to discharge.
- The trust's website also had a facility for patients to leave feedback.

Emotional support

- 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 support for staff.
- We did not see evidence of support for patients who had anxiety or depression. We were told that, if necessary, staff would refer patients to the mental health team.
- We were not made aware of any specific counselling services available for patients. We were told that counselling was available for patients via the clinical specialist nurses and the chaplaincy service.

Are surgery services responsive to people's needs? (for example, to feedback?)

Requires improvement 

We have judged responsiveness in surgery to require improvement.

Both theatre departments were underused which may have had an impact on the ability of the trust to meet its 18-week referral to treatment time.

Our conversations with the public, staff and patients highlighted concerns about multiple bed moves during admissions. One patient we talked with told us that she was moved four times in three days.

Staff told us that they had raised concerns about staffing levels and the impact on care delivery, staff morale and stress but were told "No one listens".

The department had implemented a nurse led discharge pathway. However, CQC received a large volume of concerns regarding the effectiveness of the discharge process in particular.

We were also concerned about the lack of audit activity to demonstrate compliance with the VTE compliance at this site.

There was a lack of evidence to suggest that the service listened to, or learned from complaints. We found that staff on the wards personally addressed patients concerns whilst on the ward. However, if a formal complaint was made then the learning from that complaint was not cascade to the ward staff. We were told that information regarding the Trusts formal complaints system was not shared at a local level with staff. Staff were not always involved with reviewing complaints relating to their clinical areas.

The NHS Choices website also gathered feedback about services provided at the trust. We noted that when people complained on the website, they were responded to, and urged to contact the Patient Advice and Liaison Service (PALS) to discuss their concerns further. Eastbourne District General Hospital was rated as 3.5 stars (out of five).

Surgery

Service planning and delivery to meet the needs of local people

- Members of the local population did not see the reconfiguration in the same way as the trust.
- We were concerned about how the service would cope with further busy times given how stretched the service appeared to be. Staff appeared to be working with little reserve from which they could deliver much more. Staff told us that they already worked hard as a team, skipped breaks and stayed on duty for prolonged times to ensure that patients were cared for.
- Staff talked to us about how, at very busy times, they ensured that patients had sufficient medical reviews to allow them to be discharged to create extra capacity. Theatre staff told us they would stop elective lists to ensure emergencies were treated in the event of unexpected demands on the service.
- The trust was in the process of training nurses as 'dementia champions' to ensure they could meet the care needs of this patient group.
- The trust informed us that the rationale for the recent reconfiguration of services. They said it was carried out to ensure that the trust could deliver services which met the needs of local people.
- The trust provided a wide range of food to meet individual people's dietary needs and offered patients the option of a hot meal outside of scheduled meal times.
- We found an outstanding surgical service for patients of the Jehovah's Witnesses faith, led and delivered by a very enthusiastic consultant surgeon with a special interest in this area.
- The trust had a learning difficulties team which provided "invaluable support" to patients and staff.

Access and flow

- We did not observe any problems with patient flow within the surgical department during the inspection. However, we were able to review data which demonstrated delays in discharging patients after surgery. Staff in theatres told us, "We frequently have to feed people here" and "This area is not equipped for patients who require toileting or want to see their relatives after surgery". The staff were innovative when providing food for patients whose discharge was

delayed in an area where other patients were 'nil my mouth'. However, this is an inappropriate area for patients to be in once they have met their discharge criteria.

- Staff also described leaving theatres to go to the wards to clean beds to expedite the movement of patients from theatre to the ward. This demonstrated positive attitudes towards team working, but also indicated a stressed patient pathway.
- We identified concerns with the frequency of patient ward moves. The staff we talked with agreed that multiple moves occurred regularly due to capacity pressures.
- We received information from members of the public regarding multiple bed moves during inpatient stays and swift, but poorly implemented nurse led discharges. This may suggest continuous pressures on bed capacity and problems with access and flow in the department.
- We found that both theatre areas were underused and lists were not starting until after 9am which resulted in lists overrunning. Staff raised concerns about the new theatre central booking system which was recently implemented.
- The trust reports maintaining its bed occupancy at 89%. The recommended bed occupancy is 85%.
- The trust had a nurse-led discharge programme. This is an effective and efficient approach to patient discharge. Discharge letters and records for take-home medicines were produced electronically and copies sent to the patient's GP. Staff told us about the numerous benefits, both to patients and the trust, of the nurse-led discharge procedure. We observed one discharge and found it to be satisfactory. The patient was given all the information they needed in verbal and written format and was given a contact number to call if they had any concerns. We were told that the wards area provided a phone clinic daily where a nurse called patients on the day after their discharge to check on their progress. A record was kept of these communications. Where a nurse discharge was not deemed appropriate, patients were reviewed by a member of their medical team before discharge.
- We identified a lack of a regular robust audit process in place to demonstrate the effectiveness and efficiency of the department.

Surgery

- The data table below demonstrates that over the past four quarters, this trust has been better than the England average for cancelled elective operations being re-booked within 28 days.
- The trust data we reviewed suggest that it was meeting the standards for cancelled operations and emergency care.
- However, there was evidence from members of the public, and Trust data that suggested the department was struggling to meet its Referral To Treatment times. This may suggest there are problems gaining access to surgical services.
- We found that some surgical ward areas provided care for medical outliers. Staff reported great difficulty in accessing medical reviews and of rarely seeing a consultant.

Meeting people's individual needs

- We found evidence during the inspection that the trust had a robust and effective system to support patients of the Jehovah's Witnesses faith who have surgery. We found evidence in the medical records which demonstrated that the patient was given the relevant information needed to be able to make an informed decision about their care and treatment. We also found an advance directive – a document in the medical notes expressing a person's wishes about critical care when they were unable to decide for themselves. One patient told us how satisfied they were with the individualised treatment received and way the service took their religious needs into consideration.
- We were told that the hospital had access to a translator via a telephone service. However, the staff we spoke to on various wards were not able to demonstrate how to request the service.
- We were told that the staff working at the trust provided the majority of the translation services to patients.
- CQC were concerned on two levels about this approach to translation services. Using staff as translators rather than a separate translation service meant that patients were not guaranteed confidentiality. As different cultural groups tend to socialise in groups with people from similar backgrounds, it's possible the member of staff may know this person from a social perspective. The accuracy and standard of the translations available to

patients by different members staff was not checked and raised the risk of miscommunications. The hospital was unable to provide us with written information for patients whose first language was not English.

- The trust had a learning disabilities team that provided specialist knowledge and support for staff and relatives of patients who had learning difficulties. The support from the team was described by numerous staff as being “brilliant”.
- Staff raised concerns with CQC about recent changes to the service offered to patients who required advanced intravenous (IV) access. We were informed that the changes had resulted in long waits for line insertions and changes, and frequently meant patients had to travel long distances to other hospitals to have lines inserted.
- We found that most areas had a ‘dementia link’ nurse to provide support and advice to staff and relatives.
- We were made aware of the physiotherapy support available for amputees and the vascular team. The provider may wish to note there is a concern about the sustainability and quality of the service given its allocated 13 hours of physiotherapy time to deliver inpatient care at two hospital sites and deliver a community service.
- The patient-led assessments of the care environments (known as PLACE) showed the trust was rated below the national averages in all four key areas: cleanliness; food; privacy, dignity and wellbeing; and facilities.

Learning from complaints and concerns

- We were told by staff that, when a patient raised a concern, it was dealt with by a nurse on the ward.
- However, if a formal complaint was raised with the complaints team, or via the PALS team, the staff at ward or department level would not necessarily get sight of the concern, or receive feedback.
- One ward sister told us that each department would know the number of complaints generated by their clinical area, but these were not broken down into specific categories, and would not necessarily contain enough information to facilitate learning and improving the service.

Surgery

Are surgery services well-led?

Inadequate 

CQC have judged the leadership for surgery to be inadequate.

The board of management did not have a vision or strategy for the surgical service. The trust struggled to provide CQC with the relevant data to demonstrate compliance with the five areas we assessed. We were told that the trust sees itself as one provider of acute and community services and therefore amalgamated performance data. This is not considered to be effective data management.

We found a culture of worry of retribution, resulting from raising concerns, and a staff group who appeared to have lost faith in the organisational structure and leadership of this service. We found major service changes being proposed and implemented, often without meaningful communication. When changes were communicated, the majority of the communication appeared to be conducted electronically. The majority of staff we talked with told us they had little faith in the board leadership. One very senior member of staff broke told us, "It's the first time that anyone has ever taken the time to listen".

The staff generally felt supported by their immediate team leaders but feel "abandoned" by management above this level. Nursing staff felt very supported by the director of nursing who "listened and cared" about staff and their welfare. We asked staff if they were being listened to at director of nursing level. Some staff responded with "her hands are tied". Staff told us that they understood the financial challenges faced by the trust and were supportive of the need for change.

When we asked staff in clinical areas what they were proud of, we continuously received the same answers: "We are proud of our team" and "I'm proud of the way we work well together" and "We are determined to make the changes work".

Members of public contacted CQC to express concerns about the standard of care at the trust, complaints handling, staff welfare and management at board level. We acknowledge that the recent service reconfiguration has caused distress in the community.

We did talk to some staff who were very complimentary of the trust, its leadership and achievements regarding the reconfiguration, and of their own team's ability to deal with the challenges in light of the recent changes. However, the provider may wish to note that this was from a small minority of staff.

Vision and strategy for this service

- CQC recognises that the financial position of the trust and recent surgical services reconfiguration will have had an impact on the vision and strategy for the surgical services at the trust.
- However, CQC are concerned about the lack of a future vision or strategy for this service.

Governance, risk management and quality measurement

- There was a governance board in operation at the trust. We were aware that it was subject to a recent reconfiguration and had acquired a new lead before the inspection.
- Staff we spoke to were unable to identify the governance structure or provide us with any feedback on its function, successes or any learning that had led to changes in practice.

Leadership of service

- We identified pockets of good clinical standards but they were not applied throughout the surgical department. There was a perception among staff that this was because of the constant changes to leadership and the way changes were communicated.
- The surgical department had undergone recent changes to its management structure in the two weeks before our inspection. We noted that the theatres management structure was changed during the inspection. We asked staff how this was communicated and they told us it was via email and unexpected. However, the theatre staff told us they welcomed the change and felt the service would benefit from the change in leadership.
- Ward managers were perceived as enthusiastic, supportive of their staff and the structural changes. However, most of the managers we spoke to had limited knowledge of the service they managed and the challenges it faced. They relied on the senior nurse management in each clinical area to answer the majority of the questions asked by CQC. We identified the lack of insight and organisational memory which was a potential risk to the surgical service.

Surgery

- Staff told us that things were changing all the time and it was impossible to keep on top of the changes. One nurse commented, “I’ve had three managers in three months and none of them were visible in the clinical area”. We were concerned that the constant rapid and unplanned changes were having a negative impact on patients and staff.
- We found that staff in managerial positions were unable to demonstrate sound knowledge of the surgical service, its strengths and its challenges, due to the amount and pace of the change they had experienced.
- Staff told us that some managers did not receive a formal handover from their predecessors.
- We spoke to one staff member who told us that she was not included in the consultation process as it was felt it “didn’t affect her”. However, her position changed and location of work changed with little notice without being involved in any meaningful consultation process.
- Staff reported feeling very supported in their teams and by their immediate line managers and colleagues of a similar grade. However, they did not feel supported by middle management and above, except by the director of nursing.

Culture within the service

- We identified a very hard-working and dedicated staff group who demonstrated an unquestionable desire and dedication to delivering quality patient care. However, they were also a staff group with low morale, lack of confidence in the trust management and fearful of raising concerns.
- Staff reported working in the organisation with a perceived culture of bullying and harassment.
- Staff told us, “We are determined to make the changes work” and were found to be very dedicated to their own teams, the patients they cared for and resilient to the obstacles that they faced on a daily basis.






Public and staff engagement

- We had a significantly higher than expected level of contact from the public before, during and after the inspection.
- Some members of the public contacted us to tell us about their positive experiences at East Sussex Healthcare NHS Trust.
- However, the majority of contact with CQC was to raise concerns about the standard of care, ineffective complaints processes and the welfare of the staff.
- We saw that the Trust had information about the surgical department on its website and encouraged feedback about its services.
- We also noted that ward areas had letter and cards on display which demonstrated that patients appreciated the care they received during their inpatients stay.

Innovation, improvement and sustainability

- The trust implemented VitalPAC, an electronic system that records and monitors patients’ observations. It also takes patients’ NEWS scores into account and will prompt the user to take action and require a medical review for a deteriorating patient.
- The preassessment clinic introduced a system that communicated patients’ individual needs before admission for surgery. Needs were recorded in a letter and disseminated to the anaesthetic department, theatres, recovery and ward areas. This promoted effective multidisciplinary communication to focus on individual needs and alleviate potential risks. Staff told us that this was a very valuable incentive driven by the preassessment nurses.
- The theatre team were very proud of their advanced scrub practitioner programme.

Intensive/critical care

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

Information about the service

The intensive therapy unit (ITU) at Eastbourne District General Hospital is located on the second floor in the central block with paediatrics and between medical and surgical services. The unit admits adults and young people from 16 years of age and, occasionally, children for stabilisation and transfer to a specialist centre. There are eight beds, including two large areas, which are used flexibly to provide level 2 and 3 care. All nurses are trained to care for level 3 patients. There is a critical care outreach service and consultant cover 24 hours a day.

We spent time on the ITU, which was quiet, with three patients in total. We spoke to one patient, one relative and 16 members of staff. These included qualified and student nurses, the matron, trainee doctors, consultants and allied healthcare professionals. In addition, we received feedback from staff and patients at focus groups and listening events.

Prior to the inspection and during the visit, we were provided with performance data relating to critical care. Intensive Care National Audit & Research Centre (ICNARC) data showed satisfactory outcomes, comparable to units of similar size and workload. Mortality data show slightly better outcomes than comparable units. Bed occupancy was below the national average, with occupancy levels falling over the summer.

Summary of findings

The intensive care service used procedures to ensure that patients received safe and effective care. Clinical outcomes were monitored, and practice changed where improvements were needed. Staff were caring and compassionate, working to maintain the privacy and dignity of their patients. However, some improvements were required in relation to bed management processes to ensure that patients did not remain in the ITU longer than needed and patients requiring level 2 care following surgery were nursed in an appropriate setting. Clinical leadership on the unit was strong and supported staff development, but changes to the clinical unit management team had led to a lack of engagement with ITU staff on plans for the future of the unit.

Intensive/critical care

Are intensive/critical services safe?

Good 

Critical care services used effective systems and processes to provide safe care, including systems for learning from incidents. The service had no serious incidents or Never Events (serious, largely preventable patient safety incidents) in the last 12 months. Staff reported incidents, received feedback locally and were able to describe a number of changes in practice resulting from incident investigation.

Consultants were present on the unit seven days a week and the nursing establishment provided recommended levels of care. At the time of our inspection, there were high levels of nurse sickness, which the team were managing to ensure appropriate levels of care. The critical care outreach nursing team used established systems to recognise the deteriorating patient and to respond to their needs.

The environment was clean and well organised. There was one electronic patient record used by all professionals working within the team, which provided all staff with an overview of current observations and patient treatments.

Incidents

- The trust reported that there had been no Never Events in critical care between May 2013 and May 2014.
- The trust reported no serious incidents relating to critical care on the Strategic Executive Information System (STEIS – the NHS reporting system for incidents) in the last 12 months. However, staff told us of one incident from 2013, which was investigated and resulted in change of practice relating to tracheostomy tubes.
- There was evidence that incidents were discussed at unit meetings and training included junior doctors and nurses, where required.
- There were 43 incidents reported by the ITU between August 2013 and July 2014 – one from July 2014 remained open at the time of the inspection.
- The ITU matron produced a weekly newsletter, The Oracle, which had been running for five years. This was available in a folder in the staff room and provided feedback from incidents across the two trust hospital sites, including action taken.
- Issues relating to specific incidents were fed back through working groups. An example provided was an

incident relating to a chest drain at the Conquest Hospital, which identified a knowledge gap. This resulted in additional information being provided to staff and a training programme relating to observations and the national early warning score (NEWS).

- All staff reported learning from the incident reporting system, but one member of staff reported insufficient training in the use of the trust patient safety incidents healthcare software.
- Monthly morbidity and mortality meetings were attended by medical staff and other members of the critical care team. Action points were recorded at the end of each meeting and learning points discussed.

Safety Thermometer

- Safety information was displayed on the 'Releasing Time to Care' board in the entrance to the ward. This reported no instances of new pressure ulcers, venous thromboembolism (VTE or blood clots) or urinary tract infections, but included one fall in the previous month. Analysis of incidents over the previous 12 months recorded two new pressure ulcers and one fall.
- VTE and ventilator-acquired pneumonia were assessed and recorded in the hospital's electronic system (ICIP).

Cleanliness, infection control and hygiene

- The unit appeared clean and well organised. Cleaning schedules were displayed on the wall within the unit. Cleaning audit scores were shared with the matron and housekeepers on the ITU.
- There was a rapid response cleaning service available when needed.
- The unit had no MRSA or Clostridium difficile (C.difficile) acquisitions in the 12 months prior to the inspection. Before that, there had been four MRSA and one C. difficile patients admitted and six isolated as carriers on admission.
- There were two cases of ventilator-acquired pneumonias in the last two months. Both patients had had multiple intubations.
- Staff were observed to adhere to local infection control policies, including hand hygiene and use of personal protective equipment when inside the red lines marked on the floor around each bed space. Each bed had different coloured protective equipment.

Intensive/critical care

- A microbiologist and infection control nurse visited daily during the week. If there were insufficient cubicles to isolate patients, this was discussed and patients were prioritised. Beds 1 and 8, which were easily isolated from other beds, were used where required.
- Rigid screens between the beds prevented staff from moving between bed spaces.
- Infection control information, including antimicrobial use, was available for staff in the staff room.
- The unit submitted data to ICNARC.

Environment and equipment

- The environment was spacious and well-organised.
- The unit comprised six beds and two large cubicles, all used interchangeably as ITU or high dependency unit (HDU) beds. Therefore, patients were not normally moved, except to facilitate staffing two level 2 patients.
- Near the entrance to the ward was a large relatives' room, with comfortable seats and facilities for making drinks and snacks. There was also a local residence where relatives could stay overnight within five minutes' walk.
- The equipment and disposables storage area contained large items of equipment which was noted to be cleaned and checked.
- Resuscitation and airway equipment was available on trolleys in the ITU room, including a paediatric trolley. These were all checked on a daily basis.
- There was a small laboratory, which doubled as a storeroom for patient feeds.
- The ICIP system and equipment was standardised across the trust's hospital sites to make it easier for nurses who work across sites to cover shifts.

Medicines

- Electronic prescribing was used through the ICIP system, which included a formulary providing standardised prescriptions. This was reported to have improved prescribing and provided a simple system for locum doctors working on the unit.
- There was a locked medication room where drugs were stored.
- Controlled drugs were stored in a locked metal cupboard behind the nurses' station and reception. Review of the records demonstrated that there were appropriate mechanisms for managing controlled drugs.
- There were no plans to use of electronic drug cupboards on the Eastbourne Hospital site.

- Since August 2013, five medication errors relating to administration issues were reported through the Datix incident reporting system. All were investigated and cases closed.

Records

- The ICIP record for all patients in ITU collected observations from monitoring, ventilation and blood gas equipment. Nurses reviewed the information before accepting and signing for the information on the system.
- A comprehensive daily record was completed for each patient during the midday ward round. This provided a complete record of treatment in the two records reviewed.
- Staff accessed the ICIP system with an individual password.
- The ICIP data included an assessment of high-risk patients which was recorded weekly and updated as required. This used a system of patient-related activity to identify the intensity of interventions required by individual patients, anticipating the workload needed.
- Records were available for morbidity and mortality meetings, were used for audit and stored indefinitely.
- Until recently, the ICIP system was accessible to all clinical teams across the trust and used to review information relating to patients discharged from the ITU. However, in ITU, the system had been upgraded to Word 7, which was not available to other teams.
- Risk assessments were recorded for individual patients on the electronic system, including pressure area assessments and VTE risk.
- Back-up paperwork was available on the ITU if the electronic system was inaccessible for any reason.
- Nursing and medical discharge summaries and a care and treatment plan were printed off the system when patients were transferred to the wards. The medication chart had to be written for the ward prior to transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There is evidence that staff were aware of how the Mental Capacity Act 2005 and its related Deprivation of Liberty Safeguards related to their work.
- Nurses were observed to explain care to patients prior to providing interventions.
- Staff used the trust's policy for obtaining patients' consent for procedures and surgery.

Intensive/critical care

- All staff received training in the Mental Capacity Act and deprivation of liberty as part of the statutory and mandatory training programme.

Safeguarding

- 96% of nurses had completed adult and children's safeguarding training; the remaining staff had training dates booked, monitored on the board in the staff room by the education sister.
- Staff reported that safeguarding concerns were escalated to trust safeguarding leads and reported through the incident reporting system.

Mandatory training

- Information regarding staff training was displayed in the staff room, including statutory and mandatory training. In some areas, this was below 80% (incident reporting and conflict resolution) but dates were booked for staff to attend. This was monitored and recorded by the education sister.
- 91% nurses had completed Paediatric Immediate Life Support (training, with the remainder booked on courses).
- Various e-learning was available for staff.
- New staff were expected to complete statutory and mandatory training within six months, which included a competency document. This was monitored by the education sister.

Management of deteriorating patients

- The management of deteriorating patients was coordinated by the critical care nursing outreach team, with one nurse available 24 hours a day, seven days a week. This team also provided training and education for clinical staff. This included training doctors and nurses in the use of the NEWS tool and on management of tracheostomy.
- There were plans to increase the number of nurses in the team and also to improve the level of post qualification nursing education provided.
- When a patient required ventilation in PACU following urology surgery, the outreach nurses provided support to the recovery staff.
- The hospital used the NEWS score, which is recorded and calculated electronically on the hospital's computer-based monitoring and recording system. This collected information centrally and was accessible via the ICIP system in the critical care unit in the ITU and mobile devices on the wards.

- The emergency team was informed if the NEWS score reached the alert level.
- We were informed that the trust was in the process of introducing a Paediatric Early Warning Score (PEWS) system.

Nursing staffing

- The unit nursing establishment was 41 whole time equivalent (WTE) nurses providing five level 3 and three level 2 beds. There were 0.5 vacant and fixed-term posts to cover maternity leave.
- Sickness levels were high at around 14%, which included some long-term sickness. The increase in sick leave was thought to be due to low morale following the trust's reconfiguration of services.
- The unit had eight nurses per shift and operated flexible rostering depending on activity levels. We were told that nurses could be moved to the wards if not required in the ITU but were difficult to get back if intensive care patients needed care. Some staff felt that this made the unit unsafe at night when there was only one anaesthetic trainee doctor covering the service.
- We were told that, until recently, nursing turnover was low, at around three nurses per year. Since the reconfiguration of services, this had risen to 12 in the last year, with nurses lost to Brighton and London for wider experience.
- There were no plans to formally rotate nurses between sites, but they covered both sites as required.
- There was a team of 5.8 critical care outreach nurses who provided a 24-hour service to the wards to monitor patients who were discharged from ITU or those whose condition deteriorated. The team was increasing by 0.8 of a post to enable the team to meet teaching requirements.
- Pre-registration nursing students were allocated to the ward in the second and third years of their training. They attended for a 13-week block of 16 hours per week, although only the first six and the last three weeks were spent on the unit. One student reported being taken out of practice for six weeks by the university due to lack of mentors.
- Patient acuity was measured through the electronic recording system, which provided a workload assessment for each patient.

Intensive/critical care

- Handovers were undertaken at the beginning of each shift, with a brief overview of all patients on the unit. Nurses received a more detailed handover of individual patients at the bedside, using the electronic record.
- Healthcare assistants were available to support nurses with bedside care and provision of supplies. In addition, there was an audit lead and an education sister.
- Access to agency and bank (overtime) nurses was difficult and shifts were often covered by nurses working on the unit.

Medical staffing

- There were six consultants in intensive care providing a seven-day service on the unit, with out-of-hours cover. Three consultants also provided out-of-hours cover to Conquest Hospital.
- Overall, medical cover met the guidance for a unit of this size.
- Nursing staff reported good medical cover, with doctors always available. There were supportive working relationships within the multidisciplinary team. However, nurses reported that it was sometimes a struggle to cover vacancies in the medical team.
- Concern was expressed regarding out-of-hours paediatric cover, including whether the A&E should be open for paediatric admissions at night. Paediatric input was provided by a middle grade doctor, usually a locum, with no consultant on call. Anaesthetic and ITU doctors provided airway and stabilisation management where required.
- There was 24-hour consultant cover with a trainee doctor present throughout the 24-hour period.
- Handovers took place on the unit at the beginning of each shift.
- Until recently, locum doctors were usually personnel who had worked on the unit before. However, more recently this changed and some trust grade doctors were used.
- The South Thames Retrieval Service provided training once or twice each year for the whole team in the management of critically ill children.

Major incident awareness and training

- 75% of nurses were booked on major incident training.
- There was an emergency/major incident protocol in place. The nurse in charge of ITU was responsible for

freeing up beds and sending regular information about bed numbers to incident command, who provided all instructions to manage patient flow during the critical period.

- The department's business continuity plan involved using two intensive care facilities in the event of an outbreak of infection. An additional area was set up in recovery.

Are intensive/critical services effective? (for example, treatment is effective)

Good 

The unit followed national guidance for the care and treatment of patients. Staff audited the effectiveness of the service, and made changes in response. There was seven-day consultant presence on the unit and the multidisciplinary team worked well together to support patients and relatives. There was support for staff development and additional training with effective systems to monitor compliance with essential training. Procedures were in place for transfer of patients to other services where required.

Evidence-based care and treatment

- A folder of frequently used policies and protocols was available at each bedside. Less frequently used guidance was easily accessible on the ICIP system or the hospital's intranet. Bedside folders were updated by the education sister.
- Outcomes relating to care bundles and audits were posted in the staff room, including the frequency of use of chlorhexidine mouthwash and ventilator filter changes.
- Cardiac arrest calls were audited through NCAR, part of ICNARC. Survival to discharge rates following cardiac arrest were 18%, which was reported as good based on the demographics.
- Practice was based on National Institute for Health and Care Excellence (NICE) guidance, and work was currently being undertaken to review care against the NICE guidance on rehabilitation.
- Local audit was undertaken by the nursing working groups, the medical team and the outreach team.

Intensive/critical care

- Staff were trained in the resuscitation and stabilisation of critically ill children. There was a paediatric trolley, all staff had paediatric immediate life support training and the South Thames Retrieval Service protocols were attached to the paediatric trolley.
- The South Thames Retrieval Service provided training to all staff on study days and via a simulator.
- There was a paediatric working group. Staff told us that they used to see one child a month, but since children's inpatient services have moved to the Conquest Hospital, they have only seen one child in the last six months.

Pain relief

- Pain management was discussed as part of the daily ITU ward rounds and management adjusted appropriately and recorded on the ICIP system.
- Outreach nurses were involved in the management of pain for patients reviewed on the wards.
- A patient reported that nurses consulted him about his pain management.

Nutrition and hydration

- Starter regimes for enteral and parenteral nutrition were available when a dietician was not available for consultation, such as out of hours.
- The malnutrition universal screening tool (MUST) scores were recorded on the ICIP.
- Staff (and a patient) reported being able to access food for patients at any time and nurses supported patients to eat when needed.
- A patient told us that, while the food did not look appetising, it tasted good.
- The trust's reorganisation had resulted in loss of 0.6 WTE dietician from the Eastbourne site, which we were told had led to a reduction in the hours a dietician was available to ITU. The dietician had previously attended daily ward rounds but now attended late in the day, after patient plans were made. This was reported via the Datix incident reporting system. However, clinical staff told us that dietetic support for the patients was good.

Patient outcomes

- Quality and safety information was displayed on a noticeboard near the entrance of the unit for staff and visitors to see.
- The unit contributed to the ICNARC database. ICNARC data demonstrated outcomes similar to comparable units with a better-than-average mortality rate.

However, the delayed discharge data indicated a significant delay in discharges from the unit. The team were aware of this and systems were in place to reduce these times.

- Infection data showed no acquired MRSA or C. difficile and low levels of ventilator-acquired pneumonia in the last 12 months
- The incidence of VTE and urinary tract infections was low and there were no recent pressure ulcers reported.
- ICNARC information was displayed for the multidisciplinary team to see in the staff room.

Competent staff

- An education sister worked with the matron and band 7s to provide the education required to maintain competence in the nursing team.
- We were informed that consultants and junior doctors had an allocated 10 days per year study leave with agreed funds. However, this was not available for nursing staff
- New nurses attended a structured orientation programme which included training in the equipment, allocation to mentors and a supernumerary period. There was a competency package to be completed within 18 months, which included review of theory and practice with mentors. This was formally reviewed through appraisals.
- There was a range of information regarding training and education available for ITU staff, including mentorship and intensive care courses. All staff, including allied healthcare professionals, reported good access to professional development.
- A range of staff, including outreach nurses and a newly qualified nurse, told us they read The Oracle newsletter to keep up to date with issues such as infection control, incidents and complaints. They reported that there were not many incidents or complaints, but they had read feedback about incidents they had reported.
- Nurses reported through working groups for specific areas of practice, and they were then responsible for cascading training to colleagues.
- We were told that appraisal in ITU was based on the trust values and additional requirements for critical care. Managers informed us that 93% of ITU staff were compliant with local guidance on appraisal and the remainder had dates booked.

Intensive/critical care

- The unit supported nurses to undertake a post-registration qualification in critical care nursing and 56% of nurses had attended a critical care course with three nurses seconded onto the course each year.
- Student nurses working on the unit received a minimum of four weeks supervised practice and were encouraged to participate in and assess advanced care under supervision.
- The ITU used the Sussex Critical Care Network competence documents for healthcare assistants, new nurses and leaders.
- All staff on the cardiac arrest teams completed paediatric and adult immediate life support training annually. All foundation training doctors had to complete advanced life support training to be able to progress to specialist training.
- There was a standard induction process for junior doctors, who also received a regular programme of training.

Multidisciplinary working

- Staff reported good multidisciplinary teamwork within ITU, with good communication, shared teaching and awareness among the medical staff of the needs of new nurses.
- A physiotherapist attended the unit every day in the morning and returned in the afternoon as required. There was access to physiotherapy out of hours. The physiotherapy and nursing teams were trialling more suitable chairs for patients across the ITU service.
- A speech and language therapy service was available within 24 hours.
- A pharmacist attended the unit daily and was available for discussion as needed, although one member of staff said that it is sometimes difficult to speak to a pharmacist during the day.
- There were clear procedures for the transfer of adults and children to other services. We were told that it could take a long time to access a surgical bed at Conquest Hospital when a patient transferred for surgery.
- Staff told us that, on the whole, specialist teams were accessible, but it could sometimes be difficult to access an opinion from the gastroenterology team.
- There was an operating department assistant available to the emergency team out of hours, but we were told

that this post was under review and may become an on-call service. There had been discussion about training the outreach nurses in this role for the emergency team.

- The education sister was one of a team of educators working within the East Sussex network and with the local university. They met three to four times a year to share ideas. They ran the university-accredited network leaders course, healthcare assistant programme and the newly qualified nurse programme, and supported pre-registration and ITU students.
- Patients were invited to attend a three-month follow-up clinic after discharge from critical care.
- The critical care outreach team were part of the 'hospital at night' team, including the on-call doctors, which provided them with an overview of activity and the sickest patients within the hospital. They were also part of the cardiac arrest/emergency team. All care provided by the outreach team was recorded in the patient record.

Seven-day services

- Staff reported a recent change in the rota to provide consultant presence on the ITU seven days a week between 8am and 6pm.
- Consultant rotas show dedicated out-of-hours consultant cover for the ITU. We were told of plans to increase consultant numbers to a total of 15 to improve cover across the whole service.
- The critical care outreach team were available 24 hours a day, seven days a week.
- If a patient needed an endoscopy out of hours, then they may have to be transferred across the site or to another centre.
- The team could access physiotherapy, pharmacy and imaging out of hours.

Are intensive/critical services caring?

Good 

During our visit we observed staff providing care and communicating in a caring and compassionate way. Patients were provided with explanations about care and staff maintained patients' privacy and dignity. Written

Intensive/critical care

information was available for patients and relatives, but not in languages other than English. Staff actively sought feedback from patients following discharge and used this to improve services offered to patients and relatives.

Compassionate care

- During our inspection we saw that patients were treated with kindness and compassion and nurses protected individual privacy and dignity.
- One patient told us that all staff were kind and kept him informed.
- There were facilities to provide privacy for meetings with families.
- We observed that overlapping curtains were used at each bed space to maintain privacy and dignity.
- The ITU did not use the NHS Friends and Family Test (which asks patients if they would recommend the department to others) but has its own system for gathering patient feedback.
- Feedback from families was reported on a staff noticeboard and in the unit entrance where relatives could view the information. Action taken as a result of feedback was included.
- Protocols for end of life care were available for staff, including contact details for key staff such as the chaplain. Other faith leaders were available through the Patient Advice and Liaison Service (PALS) or the switchboard.
- Staff reported some flexibility regarding visiting hours for those families who could not visit between 2.30pm and 10pm. They told us they would like to see visiting hours standardised across the trust to create less confusion for relatives.

Patient understanding and involvement

- A range of written information was available for relatives, which was all in English. Staff could access interpreting services for families where English was not the first language.
- Action taken following feedback from patients and relatives was displayed in the relatives' room.
- Nurses were allocated to patients on a shift-by-shift basis with the aim of providing continuity of care.
- One patient informed us that staff clearly told him about the treatment and care provided.

Emotional support

- There was an 'ICU Steps' support group which held meetings off-site at the local fire station. The group included past patients who support recent patients.
- The most common feedback from families was about the time taken to receive information about their relatives and the lack of information regarding the support group. Information about the support group was now sent to all patients six weeks after discharge as part of discharge information.
- Staff reported aiming to keep relatives informed on admission and to explain procedures and answer questions as required.
- Access to other professionals was available depending on individual patient need.

Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Requires improvement 

The service was managed with the needs of the patient in mind and nursing resources were looked at across the hospital sites to ensure that nursing numbers met patient demand. Staff catered for individuals with special needs and learned from feedback and complaints about the service.

There was a procedure for bed management within the critical care unit. Pressure on beds during busy periods impacted on the number of patients whose discharge was delayed or who were discharged from the unit out of hours. Patients requiring high dependency care following urology surgery were not cared for in the designated critical care unit. Recently improved procedures for monitoring bed availability in ward and critical care areas had been introduced to reduce the number of patients transferred to wards out of hours. Although, because they were new, the impact of these procedures was as yet unclear.

Service planning and delivery to meet the needs of local people

- The matrons working across ITU services had regular discussions, covering issues such as activity and staffing.

Intensive/critical care

- Matrons from the theatres and support services clinical unit meet every five weeks to explore a range of service issues, including complaints and quality monitoring.
- Following urology surgery, patients requiring level 2 care or extended recovery were cared for in the post-anaesthetic care unit. We were told that nurses had not completed relevant competences to manage this group of patients and it was often difficult to get these patients to wards in the morning. This service was under review.

Access and flow

- The unit had a below-average bed occupancy of 71%, which was lower in the summer than the winter (60% and 80% respectively). We were told that the unit averages five patients per day and had eight nurses per shift.
- The majority of patients admitted were medical patients, as urology patients were kept in recovery and all other surgery is on the Conquest Hospital site.
- There were 3.6 critical care beds per 100,000 of the population served.
- Staff reported that 100% of patients were admitted within the national target of four hours of referral.
- ICNARC data indicated higher levels of discharges from the unit in out of hours periods (17%) when compared with similar services. Datix information for the period August 2013 to July 2014 recorded 15 out-of-hours discharges. Thirteen were between 26 November 2013 and 18 March 2014 when bed occupancy was higher than average. Eleven were delayed discharges due to lack of ward beds, and the remaining four were late discharges due to demand for ICU beds.
- The critical care unit risk register cites late discharge of patients to the ward as a problem with instances where patients have been discharged home from critical care beds. This impacted on the quality of discharge planning. There is a bed management policy and a process to monitor this through four times daily bed meetings and escalate concerns as they arise.
- The unit received one formal complaint about cancellation of surgery on the day, due to lack of an ITU bed.

Meeting people's individual needs

- The use of VitalPAC to collect NEWS scores enabled outreach nurses to identify patients who needed the most care and prioritise them for review early in their shift. A protocol was used to indicate the level of review

needed, depending on the individual patient scores from 5 and upwards. The outreach nurses reported that this had made their service more responsive to patients' needs and improved medical involvement in NEWS scoring and response.

- Patients following urology surgery did not have an appropriate environment to ensure privacy and dignity, nor to manage their nutritional needs.
- There were learning disability and dementia leads on the unit to support staff with specific patients, such as those with complex needs.
- Translation services were available through the switchboard.
- One relative reported the care provided to her disabled son was good. Staff listened to her, so that care was tailored to his needs.

Learning from complaints and concerns

- There was only one formal complaint received relating to critical care between September 2013 and September 2014, which related to cancellation of surgery.
- Senior critical care staff reviewed all complaints when received.
- Staff reported that most complaints and concerns related to communication with relatives. Outcomes from complaints investigations were discussed with individual staff, highlighting the changes needed. Unit induction now included information regarding the importance of time spent communicating with relatives.
- Information reporting what action had been taken following concerns raised in ITU was displayed on a noticeboard for staff and relatives to see.

Are intensive/critical services well-led?

Good 

Clinical leadership on the ITU was effective and enabled a wide range of staff to develop leadership skills and take responsibility. There were good governance and risk management systems with a positive learning and development culture.

Despite this strong local leadership, the staff were unclear about the future of the service. The senior management structure within the clinical unit was not embedded, leading to a lack of engagement and planning with the clinical leadership team.

Intensive/critical care

Vision and strategy for this service

- There was a high level of uncertainty on the unit regarding the future direction of the ITU at Eastbourne.
- Nurse leadership at clinical unit level was currently in transition, making it difficult for the unit senior nursing staff to develop a future vision and strategy for the service.
- The new senior management structure needed to be embedded for effective team working above unit level.
- Medical leadership was strong with innovation from the clinical leadership in ITU.

Governance, risk management and quality measurement

- Senior unit staff attended meetings of the clinical unit but were not present at meetings outside this area. For example, matrons within the clinical unit met regularly, but there was no forum for senior nurses to meet with colleagues from other clinical groups to share concerns and best practice.
- Information from governance meetings, safety data and audit information were displayed on noticeboards for staff to see. Quality, safety and user feedback was available for visitors to see.
- The unit is part of the Sussex Critical Care Network, which enabled staff to share learning.
- Risks relating to the bed management were on the risk register and monitored using Trust-wide procedures.
- Doctors attended monthly morbidity and mortality meetings. Notes from these identified that issues were discussed, with some learning identified.

Leadership of service

- Staff informed us that the unit matron was “firm but fair” and there was a high level of respect as they provided staff with support, while giving autonomy to lead on specific aspects of unit work.
- All senior nurses were described as “approachable”, providing a “well-run and friendly” working environment, which was “organised and efficient”.
- There were three monthly multidisciplinary team meetings on ITU led by the matron, which all staff, including temporary personnel, could attend. The meetings were organised by the working groups, who circulated agendas and minutes of the meetings. Dates for these meetings were advertised in The Oracle newsletter and staff were able to add items to the agenda.

- There were cross-site meetings of senior ITU staff, attended by all staff from band 7 upwards. These meetings were led by an ITU consultant, but were not well-attended by consultant colleagues.
- Some staff informed us that there had been frequent changes of managers above unit level and they did not always inform teams of changes.

Culture within the service

- The service was reported to be “nurturing” and “a family”, with all staff from across the multidisciplinary team, including bank staff, reporting this to be a good place to work.
- Individuals across the multidisciplinary team were concerned about the loss of the range of experience available to them in ITU. There was a feeling of uncertainty about future changes and the impact this would have on the team, which many felt was responsible for increased sickness levels and staff turnover.
- Staff felt that there needed to be a time to settle following recent changes and further proposed changes were not in the best interests of the local population – for example, the move of trauma and orthopaedics to the Conquest Hospital.
- We observed good team working on the ITU.

Public and staff engagement

- Brief information about the ITUs was available on the trust’s websites.
- The 2013 NHS Staff Survey reported low levels of satisfaction with the quality of work provided. The nurses in the ITU were highly motivated professionals, who reported good job satisfaction in relation to the service delivered but there was uncertainty about the future. They reported feeling well-informed by immediate managers about proposed changes, but a lack of engagement from the level above.
- Staff acted on feedback received from patients and relatives, dealing with this proactively to improve services.






Innovation, improvement and sustainability

- Staff reported being able to bring ideas from conferences and courses to develop services on the unit.
- Individual nurses and allied healthcare professionals were supported to lead service change by senior colleagues.

Intensive/critical care

- Staff were not deterred if funds for equipment was not available within the trust and used sources such as the League of Friends to fund additional equipment such as that needed for rehabilitation.

Services for children & young people

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

Information about the service

The children's service is managed as a single integrated service across the East Sussex Healthcare NHS Trust acute locations. Services for children and young people are provided at the Conquest Hospital and Eastbourne District General Hospital sites.

In 2013, the Board agreed to take action to ensure the safety of obstetric and neonatal services. They did this through the temporary consolidation of a consultant-led obstetric service, neonatal (including the special care baby unit), inpatient paediatric and emergency gynaecology services at the Conquest Hospital. A standalone midwifery-led maternity unit, short stay paediatric assessment unit and children's outpatients department are located at Eastbourne District General Hospital.

The trust introduced these changes in May 2013 and had been monitoring the services since the reconfiguration. In the interim, the local clinical commissioning groups undertook a consultation on the proposed options for permanent changes to maternity and paediatric services. The consultation closed on 8 April 2014. The trust kept the public informed of its 'Changes to children's services' through its website and in its 'frequently asked questions' document.

On 4 September CQC received some information of relating to children's services at East Sussex Hospitals NHS Trust. We included these issues as part of the planning of our inspection. Following the inspection we were told of some additional concerns, some relating to the Eastbourne hospital's children's services. The link inspector to this service will be following up the concerns which have been raised with the trust.

During the last 12 months, the trust's accident and emergency (A&E) departments treated 17,243 children under the age of 16 years. We have also seen statistics covering a 12-month period identifying that a total of 695 young people aged under 18 years had been admitted to adult inpatient wards across the trust sites.

During our inspection of Eastbourne hospital, we visited the short stay paediatric assessment unit (SSPAU) and the children's outpatient department. The SSPAU operated seven days a week, has 10 day beds and is open from 9am to 7pm. The SSPAU is located next to the children's outpatients clinics. We spoke with nine medical staff, 18 staff, one child, and four parents at the hospital's children's service.

Services for children & young people

Summary of findings

Services for children and young people at Eastbourne District General Hospital were caring and well led, however improvements are required to be safe, effective and responsive.

The Trust does not have a non-executive director who could champion children's rights at Trust board level and currently there is no children's services strategy.

Effective working partnerships did not exist between all consultants and the children's services management team. There were mixed views communicated from consultant paediatricians regarding the merger and whether it had improved care and support within children's services. Staff raised concerns about the lack of support and involvement during and post reconfiguration of children's services.

We found shortfalls in nursing staff attendance in mandatory training which meant that staff skills and knowledge had not been regularly updated. This meant that nursing staff may not have the necessary skills to care for the critically sick child.

We did not see a consistent picture of how risks had been identified and monitored which could impact on children's care.

Staff spoke about clinical decisions being delayed on Friston ward which meant that children had been transferred late in the evening to Kipling ward at Conquest Hospital in Hastings. We were also told of ambulance delays on two occasions in the last six months which had resulted in nursing staff staying overnight on Friston ward to wait for the ambulances.

Concerns had been raised about access and flow because children's outpatients' clinics had been cancelled due to the lack of registrar cover. This meant children had long waits to see the paediatric specialist doctor. Difficulties had been experienced arranging appointments for children through the child and adolescent mental health service.

Parents said they were fully informed and involved in decisions relating to their treatment and care.

Are services for children & young people safe?

Requires improvement 

Improvements are required to ensure this service is safe.

Staff we talked with demonstrated awareness of how to report incidents through the trust's reporting mechanisms. A paediatric risk register was in place which identified current risks to the service. There were two risks identified specifically to the Eastbourne District General Hospital site.

We did not see a consistent picture of how children's services assessed and responded to patient risk.

The SSPAU and the children's outpatient department were clean and well-maintained. Infection prevention measures were in place. Clinical areas had equipment suitable for children and young people which had been serviced, tested and/or repaired.

Pharmacy controls were in place and the trust adhered to National Institute for Health and Care Excellence (NICE) guidance.

Staff were aware of the trust's consent policy and demonstrated an awareness of how to safeguard children.

Children's services training strategies had not been developed. Staff had received a range of mandatory training. However, we noted shortfalls in staff attendance.

The majority of nursing staff had not completed advanced paediatric life support (APLS) training to enhance their skills when caring for the deteriorating child.

Staffing of the children's outpatient department was not satisfactory because there was not always a readily available registered children's nurse to oversee the clinics if the rostered outpatient nurse took annual leave. Staffing skills mix and support in some areas of duty within the SSPAU was not always meeting national best practice guidance.

Incidents

- The trust had a comprehensive policy for the investigation of incidents, complaints and concerns (issued October 2013). We noted that the policy had clear guidance and associated procedures in place. The importance of following up action plans to ensure that

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lessons were learned and changes in practice implemented was emphasised. We noted that this policy worked in combination with other trust policies such as risk management and complaints to ensure that all aspects of the incident had been covered. The trust used the National Patient Safety agency (NPSA) risk matrix to identify risk severity.

- Staff demonstrated awareness of how to report incidents through the trust's Datix incident reporting facility.
- The trust recorded information relating to incidents. We saw two examples of this information in statistic and graph format.
- The trust demonstrated that it had identified incidents and that risks had been discussed through its monthly risk meetings and monthly quality governance meetings. In addition, meeting minutes of the nursing quality performance review group, patient safety and essential compliance group and the Trust Board confirmed that discussions about incidents and risk management took place.
- One serious incident had been reported for children's services in August 2014. The investigation relating to this incident was in progress at the time of our inspection. The staff we spoke with demonstrated the knowledge of how to report a serious incident. We saw that two serious incident root cause analysis documents had been shared with the clinical commissioning group and that the trust was awaiting feedback.
- We reviewed one report relating to an incident dated 25 November 2013. We saw this was well completed.
- The current paediatric risk register identified nine risks relating to children's services. The register identified the controls in place and actions against each risk. Discussions with some staff confirmed their knowledge of what risks were identified on the risk register and what involvement they had had with this process.
- Two risks were identified specifically to Eastbourne District General Hospital. The first related to the delays in transfers of patients from the SSPAU to Kipling Children's Unit at Conquest Hospital. The second was the lack of availability of paediatric consultants to manage sudden unexpected child death. Discussions with staff identified ongoing concerns relating to both areas.
- The delayed transfer issue was specifically to do with ambulance availability. Staff told us that this had extended their working day and in the last six months

two staff had not finished work until 2am and 6am. A trust patient safety report dated 22 July 2014 contained information about serious incidents, root cause analysis and the risk register. Information showed that there had been an increase in delays of transfers for Friston SSPAU to Kipling inpatient unit or external transfers to other hospital providers. The trust mitigation was that the nurses were to be aware of trust status as shift progresses, especially from 5pm onwards or from 4pm at weekends.

- Staff told us that early clinical decisions were not always made which resulted in children being transferred late into the evening to Conquest Hospital for further treatment. We were given an example of a late clinical decision being made at 8pm for a child with an exacerbation of asthma. This meant that the deteriorating child may not receive the medical care and support they require, therefore putting their recovery at risk.
- Nursing and medical staff told us of handover issues between Eastbourne and Conquest hospitals which had resulted in handovers being repeated.
- Staff told us that the process for child deaths had not been completely risk-managed as there was no lead and a lack of monitoring was in place. One consultant we had spoken with previously at the Conquest Hospital expressed concerns about covering Eastbourne remotely for sudden infant deaths and abuse cases.
- We saw protocols and flowchart guidance for unexpected child death. Detailed guidance could also be accessed through a joint agency protocol for unexpected child deaths (2014).
- The paediatric consultants at Eastbourne and Conquest hospitals had raised concerns relating to the safety of the paediatric service. Concerns had also been raised about the content of the paediatric operational policy. These concerns were raised on 29 August 2014 and had been sent to key people at the trust, including the paediatric general manager and new paediatric clinical lead. We saw that, following these concerns, the paediatric operational policy had been ratified in September 2014. The consultants we spoke with said they were still unhappy with the latest version of this policy.
- Three remaining concerns were identified:
 - The first related to the supervision and governance of the paediatric middle grade registrar covering A&E at Eastbourne when the SSPAU was closed at the

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hospital. We raised this with the senior paediatric management team during the inspection and were told that the initial management of the locum registrar had been through the emergency department; now paediatric services under took this role

- The second related to the attendance of paediatric consultant to Eastbourne hospital after hours in emergency situations and at times when there was a sudden unexpected infant death.
- The third related to the transfer of acutely unwell patients who did not need ventilator support from Eastbourne's SSPAU and the A&E out of hours. We did not see the trust's response to the paediatric consultants in relation to these concerns.
- We saw discussions relating to morbidity and mortality had taken place at trust level. Information was seen in the minutes of the Patient Safety and Clinical Improvement Group dated 9 June 2014. The information presented did not identify that it related to children. Minutes of the 'Joint Obstetric and Perinatal Morbidity and Mortality Meeting dated 27 June 2014 identified there had been 10 paediatric alerts.
- Each clinical area had a 'Quality & Safety Board' displayed. Staff told us that the information displayed on this board was updated as required. The type of information displayed related to staffing levels, the last *Clostridium difficile* (*C. difficile*) infection and the last MRSA blood stream infection diagnosed on the ward.
- Information from the healthcare associated delivery plan dated 12/08/14 for Friston Ward identified that in 2013/14 the trust reported four small outbreaks of *C. difficile* with evidence of cross- infection between patient bays, between isolation rooms and from the ward environment or equipment. One MRSA case was reported in December 2013 which related to a peripheral line infection in a patient receiving essential parental nutrition.
- Staff told us that safety alerts were received at ward level and had been actioned as appropriate.
- Information provided through the CQC data pack dated August 2014 for this trust identified that there had been no never events in children's services.
- The trust had previously invited two external bodies to review its paediatric, maternity and gynaecology provision. These bodies were the National Clinical Advisory Team and the Royal College of Paediatrics and Child Health. The outcome of these reviews resulted in

recommendations. We have noted that some of the paediatric recommendations were implemented from both reviews. Action plans were in place for the RCPCH recommendations. We noted that the last update had taken place in April 2014. This updated action plan identified actions specific to recommendations which required final sign-off, for example, the paediatric operational policy. We saw a copy of the paediatric operational policy and noted that it had been ratified in September 2014.

Cleanliness, infection control and hygiene

- The SSPAU and children's outpatient clinic were clean and tidy and well-maintained. Infection prevention measures were in place, for example, hand sinks and wall-mounted hand sanitizers were placed outside each clinical and waiting area. Hand sanitizers were also located on entry to different clinical areas. The ward matron said that staff also carried their own hand gels. Hand-washing guidance was also displayed throughout the clinical areas.
- We observed members of medical, nursing and other staff regularly performing hand hygiene throughout the inspection on all clinical areas.
- Nursing staff told us that hand hygiene audits had taken place in the clinical areas. We saw performance documented on the 'Quality & Safety Boards' in clinical areas.
- The trust has a designated infection prevention and control management team. A director of infection prevention and control and assistant director of infection prevention and control led the team. The team also included infection control nurses, practitioners and intravenous nurses and practitioners. The ward matron told us that they had taken on the infection control link nurse role a month ago and was yet to receive additional training to be equipped to undertake this role.
- The trust infection prevention and control (IPC) team reported to the Trust Board via the trust infection control group (TICG). This group has responsibility for assessing the trust's compliance against the 'Cleanliness & Infection Control' element of the Health and Social Care Act 2008.
- A HCAI (Healthcare Acquired Infections) delivery plan for Friston Ward identified key priorities for IP&C practice for 2014/15 by the IP&C team. Specific local risks related to incidents or specialised care was addressed. The plan

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identified key lessons for shared learning, an action plan with target dates and key responsibilities. Two areas had been rated 'amber'. These areas related to the cleaning of beds and hand hygiene training and audits. Ongoing monitoring had taken place against the progress of the action plan in these areas.

- The trust provided us with infection control training statistics for 2013 and 2014. 78% of inpatient paediatric staff had completed infection control training.
- We asked who was responsible for checking and cleaning the toys in children's areas. We were told that there was no designated responsibility. The toy room is cleaned daily and toys are cleaned weekly and checked for damage. The toys we saw were clean and in good condition. We asked to see the records which confirmed these checks and cleaning had taken place and were told there were none. We saw that a risk assessment had been developed dated September 2014.

Environment and equipment

- We found the SSPAU and children's outpatient clinic well-maintained. We observed some equipment stored in a disused bay on the SSPAU.
- Facilities for children, young people and their families and/or carers were available. For example, on Friston Ward, there was a large spacious play area, and parents could also make drinks or microwave meals in the kitchens.
- We saw that all clinical areas had equipment suitable for children and young people. The trust provided equipment and maintenance logs which confirmed that equipment had been serviced, tested and/or repaired. We checked the paediatric resuscitation equipment on Friston Ward and saw that it had been checked daily and the contents checked at weekly intervals. We saw the completed sheets confirming these checks had taken place.
- Concerns were raised by staff about the loss of equipment to the paediatric department at Conquest Hospital in Hastings. Concerns were also raised about limited bed space in Friston Ward. This was because bays had been closed.
- We saw clear signage in place identifying the clinical areas within children's services. We observed that access to the clinical areas was by a swipe card. Parents and visitors had to ring the access bell to inform staff of their arrival.

Medicines

- The trust identified medicine management policies and procedures. For example, we saw children's guidance in the 'Procedures for patient self-administration of medicines' dated November 2013. The guidance related to self-administration of medication by children. This guidance identified that consent from the parent or guardian was desirable and the child's competence would be assessed using the Fraser guidelines / Gillick competence. We did not see any specific guidance relating to administration of the child's medication by parents. We saw that the trust had identified an equality and human rights statement in relation to patient self-administration.
- The trust adheres to NICE guidance in relation to medication management.
- The management team confirmed that a 'safe handling of medicines course' had been attended by staff at the trust induction. Three yearly medical devices update courses, which related to the administration of medicines, were also offered. We saw competency documentation which confirmed that medicines management training included administration of oral medication, administration of subcutaneous /intramuscular and intravenous medications. 43% (35 out of 81) of the current acute nursing staff had undertaken medicines training.
- We observed that pharmacy controls were in place. For example, on Friston Ward, we saw that all the drug store cupboards were locked, records of controlled drugs had been completed and stock checked daily. We saw evidence detailing the controlled drug checks. We were told there had been no incidents involving controlled drugs identified at the six-month pharmacy review. Daily checks of the drug fridge had taken place; records of checks were seen confirming this.
- We were told that children's discharge medication had been prescribed on the child's drug chart and dispensed through pharmacy. We looked at two children's discharge letters which identified the medication they would be discharged home with.
- We reviewed five drug charts and saw that they had been signed, dated and reviewed by the doctor where necessary.

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Records

- The trust had corporate and health records management policies in place. Both policies had been issued in 2014. Compliance against these policies was monitored through the trust 'Information Governance Steering Group'.
- We spoke with the governance lead about the management of patient records and were told that medical records had been identified on the risk register. We reviewed the paediatric risk register and found there to be no reference to children's medical records identified as a risk.
- The trust had both paper and electronic patient records. The corporate records management policy identified that records must be kept securely. We saw that some records had not been locked away, for example, current patient notes had been stored in an unlocked notes trolley in the prep room on Friston Ward. We were told that, when the ward was closed, all children's records would be locked away.
- We observed inconsistency in storing notes and no central storage area was identified. We were told that live notes were stored off-site at Hampton Park and that recently two sets of patient notes had been mislaid. We observed some notes to be falling apart and incomplete.
- We were told that a band 3 staff role had been lost in the reorganisation. This had resulted in documents being incomplete or individual children's notes not being filed. Staff told us that there was a backlog of 200 letters and notes waiting to be filed. Some of these documents required a signature and when they were filed they were not filed in chronological order.
- We were told that the problem with patients' notes had happened since the movement to two sites. Staff told us that children's notes for those who came through the A&E could either be in the office at Conquest Hospital or off-site.
- A paper scanner had only been available to scan children's records for two weeks which meant that current information had not been put on to the electronic system. The combination of these issues had meant that information had not been available for the doctor to base their clinical judgements on.
- One member of staff summed up their experiences when trying to access children's notes as, "Can be a nightmare sometimes to get children's notes. Happens regularly".
- The trust used a multidisciplinary care pathway document which was used by all staff disciplines. Two pathways were in use: 0-12 years and 12-16 years. We saw that the pathways contained information required from admission to discharge.
- We reviewed two sets of children's notes. The information had been collected within the paediatric pathway documents. We found both sets of notes to be fully complete, risks identified where necessary and consent obtained where necessary. Despite, these notes being complete we have seen examples of where information had not been filed in the child's notes which meant that some children's notes were incomplete.
- The trust's policy identified that, when patient information was shared with other agencies, the patient was asked for their consent. Evidence was documented in the person's records. Staff said that information for babies and children was shared with members of the multidisciplinary team such as health visitors and the child's GP prior to discharge. We saw two children's completed discharge summaries which were complete and informed the GP of the event relating to the child's stay while on Friston Ward.
- We were told that monthly records audits had been completed and the results communicated to staff by the ward matron or clinical service manager. The outcome of these audits had also been discussed at the paediatric quality meeting. In addition, three-monthly documentation audits had been completed and the last audit on SSPAU at Eastbourne had taken place approximately three weeks before our inspection.
- Training statistics identified by the trust identified that 72% of inpatient paediatric staff across all sites had attended information governance training in 2014. A separate training matrix for Friston Ward confirmed 100% attendance by staff in 2014.
- At the time of our inspection, the 2014/15 trust training statistics for health and safety and moving and handling training for inpatient paediatrics identified a shortfall in attendance. Health and safety attendance was 51% and moving and handling training was 65%.
- We asked what staff recruitment checks had been undertaken and were told that references had been collected and DBS checks undertaken prior to staff starting in post. We saw documentation for one employee and staff we spoke with confirmed that these checks had taken place.

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Consent

- One member of staff told us about the trust's consent policy. This person was knowledgeable around the content of the policy, the importance of consent and how to obtain consent.
- We saw staff training records for 2014/15 which identified that inpatient paediatric staff had completed training for Mental Capacity Act 2005 (72%) and Deprivation of Liberty Safeguards (71%).
- We reviewed two sets of children's notes and saw that written consent had been obtained on two occasions for one child. This was due to the child requiring two different consents for different procedures. This meant that where necessary the consent process had been employed so that the child and parent(s) understood the rationale for the treatment and what to expect.
- Staff told us that verbal consent would be obtained from the parent and child before procedures took place, for example, monitoring blood pressure.

Safeguarding

- The trust had child protection systems and support in place. The trust's safeguarding child protection policies and systems were last reviewed in March 2014. A whistleblowing policy and a new 'Allegations relating to staff involved in child abuse' policy (issued February 2014) also provided guidance to staff.
- The director of nursing was the trust executive lead for safeguarding children and young people. The acute hospital currently did not have a lead consultant for safeguarding. The trust's named nurse for children identified that medical support for children's safeguarding issues was provided by two community paediatricians. A specialist nurse supervisor and two specialist nurses had also been appointed into the children's safeguarding team. These were senior nurses. We were told that the specialist nurse supervisor was responsible for updating protocols and providing supervision to staff across the trust sites. We did not see any completed staff supervision records or supervision schedules to confirm what had taken place to date..
- The trust's named nurse for child protection and safeguarding children said that new safeguarding pathways were being introduced which related to bruising and intoxicated children. No guidance or pathways existed for young people admitted to the trust to undergo a termination of pregnancy.

- The trust's named nurse for children said that an electronic alert system had been introduced to the A&E department.
- The trust met the statutory requirements for Disclosure and Barring Service (DBS) checks. All staff employed at the trust had a DBS check prior to employment and those working with children had an enhanced level of assessment. One member of staff we spoke with confirmed that these checks had taken place.
- We were told that staff who worked with children had been trained to level 3, which complied with NICE safeguarding guidance. The trust's records for 2014/15 identified that 83% of inpatient paediatric staff had received safeguarding children level 3 training. Staff showed an awareness of safeguarding and what to do should an incident be identified. Staff were also aware of the trust's children's safeguarding policy and supporting procedures. 73% of inpatient staff had completed safeguarding children level 2 training.
- The trust's named nurse for child protection and safeguarding children said that dealing with domestic violence had been incorporated into staff training. Domestic violence champions worked in the A&E department.
- We saw that children's safeguarding training had been provided at inductions for very junior doctors.
- Annual formal supervision had recently been implemented for nursing staff. We were told that it was the responsibility of the paediatric specialist nurse supervisor to ensure that the supervision was completed by nursing staff. Medical staff received supervision from the community paediatrician. We were told that informal supervision was in place for doctors but not for locums.

Mandatory training

- Members of staff of all grades confirmed they had received a range of mandatory training and other training specific to their roles.
- We saw the trust's mandatory training rates for 2013/14 which confirmed the percentage of paediatric staff attendance at identified mandatory training sessions. The highest attendance rates for inpatient paediatric staff related to safeguarding children level 3 – 83%; fire safety – 79%; and blood transfusion – 78%.
- We were told that staff should attend annual resuscitation training. Training statistics for the inpatient paediatric staff attendance rates for 2013/14 were 70%

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and for 2014/15 (to date) 71%. The ward matron told us that all but one nurse had completed their paediatric intermediate life support training on Friston Ward in 2014. We did not see confirmation that nursing staff had completed advanced life support training in paediatric resuscitation. This meant that the trust did not meet RCN guidance for ambulatory care services identified in services providing healthcare for child and young people, which states that at least one member of staff should be trained in advanced paediatric life support at all times.

- We spoke with the sister working in the children's outpatient department who confirmed their yearly paediatric intermediate life support training had been arranged for 29 September 2014. Their previous training had been completed in October 2013.
- The trust had a three-day induction programme for all new staff. Following this, an induction planner would be completed for each person. The new staff member would be supernumerary on the ward for their first two weeks and competencies would be identified for them to complete and be assessed on. New staff members were regularly reviewed throughout their first year.

Assessing and responding to patient risk

- Our listening event on 4 September 2014 identified concerns relating to the safe transfer of children. There were also concerns about staff competencies in caring for the deteriorating child and protocols for the management of children in 'cardiac distress' not being followed or adequately developed.
- The trust paediatric risk register identified nine risks in total. Six of the risks were attributed to all hospital sites, while two were attributed to the Eastbourne hospital site. One risk related to delays in the transfers of patients from Eastbourne's SSPAU to Conquest's Kipling Children's Unit. The risk register identified specific controls to ensure timely transfers. However, discussions with staff identified that transfer delays were still a problem.
- We were also told that trained staff regularly did not leave the ward until 1am or 1.30am after their shift ended. This means that staff who were working an early shift the next morning would not have an 11-hour break between their shifts which would contravene the working times regulations 1998.
- The trust's operational policy for children's and neonatal services identified the arrangements for the transfer of

sick babies or children requiring specialist support out of hours. Staff told us that children would be transferred with the assistance of South East Coast Ambulance (SECAMB). Sick babies and children requiring airway support and ventilation were collected by the retrieval team who used the appropriate equipment to take the patient to the most appropriate hospital. Babies who were sick but not ventilated were transferred in baby pods.

- The trust had a dedicated 'Transfer to special care baby unit' policy issued in January 2013. We also saw a copy of the neonatal transfer service specification for neonatal critical care retrieval and the SECAMB neonatal service operational procedure, issued on 2 May 2012. These documents identified that neonates and children could be transferred safely through the contracted service provider.
- We looked at what training and support staff had received in recognising and caring for the deteriorating child. Overall, the trust's statistics for the inpatient paediatric staff attendance rates for yearly paediatric intermediate life support training for 2013/14 was 70% and for 2014/15 (to date) was 71%.
- We looked at what tools the trust used to recognise the sick child. We saw that the children's service used the national Paediatric Early Warning Score (PEWS) system developed regionally to detect a sick child or infant who may require urgent or critical care. It allows the paediatrician and children's nursing team to identify when a child's clinical observations may be lying outside the normal range.
- The children's service managed some local environmental risks appropriately. Local health and safety risk assessments were in place for Friston Ward, for example, 'Working at height: shelves over work station behind nurse's desk'. This had been reviewed on 28 June 2014. We saw that a new risk assessment had been developed in September 2014 for playroom safety in the outpatients department.

Nursing staffing

- We spoke with staff about the staffing levels and skills mix on Friston Ward. We were told that, since the reconfiguration, ward staffing budgets had been reviewed, nursing staff budgets had been reduced and the ratios of staff reduced. We saw copies of the March and June 2014 staff budgets which confirmed a reduction in band 6 nursing provision.

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- The ward matron told us that four staff had recently been appointed on temporary contracts for six months to replace staff on maternity leave and that trained staffing levels were at full establishment.
- We also spoke with another 12 staff about acute children's staffing levels and were told there had been a reduction in staff with no liaison with the department about how it functioned. This had resulted in a manager without a paediatric background being appointed to the head of nursing role. Nurses told us that their main contact now for advice and support was the director of nursing. Staff said there had been no meetings. They said that a breakdown in communication had occurred, concerns had not been dealt with.
- We were told that the ward matron role was now 50% clinical. This change had been implemented from April 2014. Prior to this the role was 100% supervisory. This change is in conflict with the 'Services providing health care for child and young people' (RCN 2013).
- We asked whether a senior paediatric nurse was on call 24 hours. We were told there was no senior paediatric nurse on-call rota. Staff who required senior advice would contact the hospital site manager. At times, there had been difficulties accessing assistance through the site manager for staffing-related issues. This was in conflict with the latest RCN guidance.
- We spoke with the senior management team about paediatric staffing levels and the support staff received. We were told that paediatric staffing had been reviewed at trust bed management meetings four times a day.
- Children's service managers told us that they had adopted the RCN guidance identified in 'Services providing health care for child and young people' (2013). The management team did not have a written staffing strategy relating to children's services. Senior management told us that patient acuity had been measured through an audit tool which measured daily patient dependency levels. We did not see any of these completed tools for Friston Ward. Therefore, we were unable to identify whether the staffing levels were appropriate for the dependencies of the children being cared for on the ward.
- The ward matron told us that the agreed staffing for Friston Ward operating on 10 day beds was three registered nurses for morning shifts and two registered nurses for afternoon shifts. The unregistered staffing level per shift was one unqualified staff member. We saw on 11 September 2014, the day we inspected Eastbourne hospital, that two trained staff were identified to work each shift, supported by one untrained member of staff. This information was on displayed on the Friston Ward 'Quality and safety' noticeboard.
- We looked to see what skills mix and staff cover was identified on the Friston Ward duty rota. We looked at two dates initially and found shortfalls in experienced staff (band 6 nurses and above). RCN guidance identifies that, in addition to a band 7 sister or charge nurse, a competent, experienced band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team.
- On Friday 22 August 2014 the staffing complement was: one band 6 qualified staff working from 7am to 2.50pm, one band 5 nurse and one healthcare assistant. We noted that there was not a band 6 sister allocated to work from 2.50pm until 9.30pm.
- On Saturday 13 September 2014, the Friston duty rota identified no sisters at band 6 or band 7 had been allocated to work. The Friston duty rota confirmed that the two band 5 trained nursing staff were allocated to work on the ward.
- We looked at the staff rota for Friston outpatients from 18 August – 14 September 2014. We saw that, when the band 6 sister was on annual leave or off sick, the clinics were mostly run by a healthcare assistant. We had observed that the agreed staffing levels on the quality and safety board were one trained nurse for the day and one untrained nurse for the afternoon. This meant that the agreed staffing levels had not been achieved in full for the children's outpatients department for this time period. The most recent RCN outpatient departments guidance advises that "a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children".
- We looked at three duty rotas for Friston Ward – 3 March to 30 March 2014, 16 September to 12 October 2014 and 18 August to 14 September 2014. We found shortfalls in band 6 qualified nurse cover for partial shifts. The shortfall in band 6 cover was usually from 2.50pm We also saw that there had been no band 6 cover allocated to work on some day shifts.

Medical staffing

- The trust had 11 paediatric consultants providing acute cover for children's and newborn services: five at Hastings and six at Eastbourne. A new medical clinical

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lead had been appointed for children's services. We spoke with the existing consultant lead for paediatrics and a second paediatric consultant. We were told that there was currently one vacant consultant post, with one locum paediatric consultant employed at the trust.

- The March 2013 Trust Board report identified that poor working relationships existed between the consultant bodies. Working practices, policies and procedures had not been harmonised across the trust. We found that concerns continued to be raised by consultants, for example, about the provision of consultant cover for paediatric services at the Eastbourne hospital in situations such as sudden infant deaths and abuse cases and the continuing use of a locum paediatric doctor to cover at Eastbourne when the SSPAU was closed.
- We were told by senior managers and the ward matron there had been some joint paediatrician working in paediatric polices development. For example, the development of the paediatric operational policy.
- Staff told us there was acute anaesthetic cover, with a resident middle grade registrar and a consultant who was on call from home.
- We saw a selection of paediatric consultant and registrar rotas for March, August and September 2014. These rotas identified the consultant of the week cover for Eastbourne from 9am to 9pm. Consultant cover from 9pm until 9am the next morning was not identified on these rotas. It was therefore difficult to determine whether there had been sufficient consultant cover overnight.
- Two junior doctors at Eastbourne told us that consultant presence and support had been good. They said that the hospital was much less busy than Conquest Hospital and there were always junior and middle grades present throughout the SSPAU's opening hours.
- The trust's paediatric middle grade doctors consist of a combination of non-training grade doctors (speciality doctors) and trainees (speciality registrars). We were told that the trust had been unable to recruit to establishment levels for middle grade paediatric doctors. There were two middle grade doctor vacancies until recently. One new middle grade doctor was due to start work at the trust at the time of our inspection.

Senior managers told us that interviews were due to take place for the second middle grade doctor. Once these posts had been appointed, the trust said they would have a full complement of middle grade doctors.

- We saw that locum doctors had been employed to replace shortfalls in medical staff. Locum statistics provided by the trust confirmed a monthly use of between 4.7 to 12.8 locum doctors over a 12-month period.
- We were told that formal supervision arrangements of locums by consultants were not in place.
- We found that the Royal College of Paediatric and Child Health 'facing the future' standards had been fulfilled.
- Discussions with community medical staff identified concerns about the lack of doctors as jobs for doctors had not been filled. We were told that the trust had recruited locum and community doctors. A consequence of this was that children could be waiting to see a paediatrician for over a year. For example, we were told that children with autism had long waits.

Major incident awareness and training

- There was trust major incident plan, business continuity plan and paediatric ward closure procedure. These documents set out the actions to be taken for major incidents and other events such as insufficient nursing, medical staff or beds/cubicles.
- One staff member told us a major incident plan, business continuity plans and winter managements plans were in place. We were told that, to ensure sufficient staffing levels during busier periods such as winter, less staff holiday requests would be granted. Staff also told us that there had been a major incident exercise a few weeks prior to our inspection, however, the person we spoke to was not aware of the learning or feedback from this exercise.
- We did not review any training records which showed there had been specific training in the use of the major incident plan.

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Are services for children & young people effective?

(for example, treatment is effective)

Good



There was no formal written agreement with the Sussex Partnership Trust for CAMHS.

There was evidence of multidisciplinary working across various disciplines and specialities. However, difficulties had been experienced accessing CAMHS appointments. We were told this was because CAMHS had very high thresholds, for example, children would have to have severe problems before they were seen.

The CQC data pack for this trust identified that the rate of multiple emergency admissions was worse than the national average for epilepsy and diabetes.

Children's services made improvements to care and treatment where these had been identified by audit findings or in response to national guidelines. Children were provided with pain relief when they needed it.

Evidence-based care and treatment

- Clinically endorsed guidance from authorities such as the RCPCH and NICE was used to inform children's care.
- The trust had systems and processes to review, implement and audit clinical guidance and evidenced-based best practice guidance. We saw minutes of meetings relating to the auditing of clinical practice. The audit and paediatric mortality meeting notes dated 9 July 2014 identified recent clinical audits. Learning points and actions had been identified. For example, the learning points from the 2011/12 National Paediatric Diabetes Audit stated that every child over the age of 12 needed extra monitoring annually; compliance was below the national average.
- We saw a brief update on some of the learning from serious case reviews in East Sussex had been shared at an audit meeting on 14 May 2014.
- Staff told us the trust used the Brighton Hospital guidance for children's services and that, as yet, the guidance had not been ratified by the trust. We saw that paediatric policy development had been identified as a

risk on the paediatric risk register as current paediatric and neonatal policies were out of date. The risk register identified that the policies had been sent to the consultants to review.

- We reviewed 10 paediatric policies and saw that all had been ratified and dates of review identified. We noticed that some policies had been ratified in 2014.
- For do not attempt cardio-pulmonary resuscitation (DNACPR) decisions, the trust had a policy for staff to refer to. Staff told us that documentation relating to DNACPR decisions was kept in the child's notes and a copy was given to the child's parents or carers. We saw that the question relating to resuscitation status had been included in the paediatric integrated patient document used by children's services.
- There were separate children's outpatients areas. Staff told us that a mixture of clinics operated from this area although, on occasions, some children were also seen in adult outpatient clinics, for example, the ear, nose and throat clinic. Staff told us that consultants from other hospital groups sometimes saw children at the Eastbourne children's outpatient clinic.
- The children's outpatients' clinics followed NICE guidance, for example, guidance for constipation, asthma. An information folder was also available for individual consultants to refer to.
- We were told that when the children's nurse was off sick, the ward matron arranged a healthcare assistant to cover the clinics. This practice contradicts the RCN guidance stating that "a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children".
- The trust has just appointed a band 6 research nurse in paediatrics. This person worked three days a week. Their research included diabetes, cystic fibrosis, dermatology and childhood obesity.

Pain relief

- Children and young people had access to a range of pain relief if required, including topical, oral and intravenous analgesics.
- The trust had a dedicated pain management team based at Eastbourne to provide support when necessary.
- The children's service used an evidence-based pain scoring tool to assess the impact of pain. The tool had

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been adapted to measure pain in children aged under one-year old as well as for older children. We saw guidance on the chart for ongoing pain assessments. Staff we spoke with confirmed the use of this tool.

- Staff told us that parents were involved in ongoing discussions on effective pain management for their child. The medication given for the child's pain would be reviewed with the parent and child by nursing and medical staff if needed.

Nutrition and hydration

- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment of the child's activities of daily living. Children were able to choose their food with the support of the housekeeper or parent from the daily menu. We were told there was a children's menu which had been reviewed every three to four months by the catering department. It was a nursing responsibility to ensure that children's food and fluid needs were met.
- Children's special dietary needs or a specific dietary status identified, for example, nil by mouth, halal, diabetic diets were identified. Housekeeping, medical and nursing staff were informed of the child's nutritional and fluid needs.
- We saw an information booklet given to parents called Your child's general anaesthesia containing guidance on fasting (nil by mouth) for parents to follow prior to surgery. Information about the latest times the child should eat or drink were also given.
- We saw that parents had their own parents' room on the ward. A sign advising parents they could make drinks in the parent's room was displayed opposite the main play area on the ward. Discussions with staff confirmed that parents were able to help themselves to drinks as needed
- A vacancy for a dietician existed to cover paediatric diabetes and staff said that this shortfall in expertise had been identified as a risk on the paediatric risk register. We were told that, in the interim, another dietician was providing a limited service. We spoke with a recently appointed band 6 diabetes nurse who also worked on Kipling Children's Unit at Conquest Hospital. This member of staff felt that care was good, with patient contact in homes and schools. Good consultant availability and supervision were also identified as being in place.

Patient outcomes

- We reviewed information which demonstrated that children's services participated in national audit monitoring patient outcomes. For example, we reviewed information relating to the National Neonatal Audit Programme (NNAP) and the National Paediatric Diabetes Audit.
- We discussed the poor outcomes identified from the 2013 NNAP audit with the ward matron. We were told that this audit had been completed at the time of the merger and that some of the outcomes related to very small numbers. We were told that the trust was confident that the 2014 results would improve. Actions had been implemented, such as training and the introduction of a family support group, to try to encourage new mums to breastfeed their babies.
- We reviewed a selection of audits which had been completed by the trust in 2014: The CAMHS pathway audit, a re-audit of the paediatric use of the drug palivizumab and audit of A&E attendances by children and young people aged under 17 as a result of alcohol intoxication. All of these audits identified learning points, recommendations or action plans.
- The trust's audit dashboard identified a list of the audits that had been completed and progress made. From the 16 audits submitted, the trust identified that 14 of the sets of recommendations had been effectively implemented.
- The CQC data pack for this trust identified that the rate of emergency readmissions was worse than the national average for epilepsy and diabetes.
- Minutes from the nursing quality performance review group showed that clinical effectiveness issues had been discussed weekly and improvements noted. We also saw that quality, safety and performance were standing agenda items on the Trust Board report.
- We received some positive feedback from a local GP on 6 September 2014 about the children's service at Eastbourne District General Hospital. They said that the majority of patients had been happy with the care received at the hospital. They said there had been an inspection visits of the trust as part of the clinical commissioning group role and found the nursing and medical staff within children's and other services had a strong desire to provide a high-quality service.

Services for children & young people

Competent staff

- Formal processes were in place to ensure staff had received training and an annual appraisal. One of the staff we spoke with told us they had received yearly mandatory and equipment training sessions and appraisals in 2013 and 2014.
- Records showed 71% of staff had an appraisal in 2013/14; while, to date for 2014/15 records showed a slight increase as 77.3% of staff had had an appraisal. Staff told us that their appraisals had identified future development such as attendance at specific courses. We spoke with two junior doctors who confirmed they had an educational supervisor and received regular appraisals.
- Our discussions with two paediatricians confirmed that all middle grade doctors had appraisals and supervision. We were told there was good provision for teaching and that the advanced paediatric life support course was held yearly. The trust also hosted the clinical exam for Membership of the Royal College of Paediatric and Child Health. Two junior doctors we spoke with confirmed regular teaching activities take place at Conquest Hospital, for example, perinatal meetings, radiology meetings, audit meetings, weekly teaching sessions and a journal club.
- NICE safeguarding guidance recommends that permanent staff be trained to a level 3 standard. The trust's training statistics for 2014/15 identified that 83% of inpatient paediatric staff had received safeguarding children level 3 training. Four of the staff we spoke with confirmed attendance at safeguarding training in 2014. Staff were also aware of the trust's children's safeguarding policy and supporting procedures.
- Annual formal supervision had recently been implemented for nursing staff. One member of nursing staff told us they had attended safeguarding supervision. Medical staff received supervision from the community paediatrician. We were told that informal supervision was in place for doctors and that locum doctors did not receive supervision.
- We were told by staff that they had also attended yearly equipment training updates, for example, blood glucose monitoring machine, infusion device training, oxygen delivery and the use of thermometers. One-off equipment training sessions also took place, for example, use of oxygen saturation monitors.

- We spoke with a range of staff who told us that they felt supported by their ward matron. We also spoke with two junior doctors and asked them about consultant support. They said they felt well-supported.
- Some staff told us that there had been no training for junior nurses; they did not feel valued and their feedback had not been dealt with by management.
- We were told that all new nursing staff had completed competency assessments when they started work in children's services. One nurse we spoke with confirmed this.
- Staff told us that the A&E staff had completed a paediatric module to enhance their skills and knowledge when caring for children and young people.

Multidisciplinary working

- Staff told us how they worked in partnership with other healthcare professionals such as dieticians, physiotherapists and health visitors to ensure children and their families received the care and treatment required. Nursing staff gave positive examples of multidisciplinary working. We were told that paediatricians and nursing teams worked closely to ensure positive outcomes for children and their families.
- The consultant paediatricians told us what multidisciplinary working existed between the trust and other providers. They said they had been able to access specialist advice from tertiary centres.
- Rheumatology was shared care with an adult rheumatologist.
- Tertiary paediatric specialists visited clinics at one or other site for all major sub-specialities.
- Staff told us that they had access to a paediatrician who specialised in oncology and palliative care. Children's care was shared with the Royal Marsden Hospital. Shared care with Great Ormond Street Hospital was in place for children under the age of two years.
- The children's services management team told us that the service had no formal written agreement with the Sussex Partnership NHS Foundation Trust for CAMHS. They said that a care pathway had been developed with the trust. They said that, should a child or adolescent be admitted with mental health problems, a mental health nurse would be brought in. We were told that acute CAMHS training had been given to staff on Kipling Children's Unit, but we saw no training statistics to confirm this. The paediatric diabetic team said they could access psychology support from CAMHS.

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- The ward matron told us that the SSPAU took CAMHS patients, for example, children who had taken overdoses. We were told that the CAMHS referral either took place in A&E or once the child arrived in the SSPAU. Staff said there were identified people to call for CAMHS support. We were told that out-of-hours children would be admitted to Kipling Children's Unit. A staff focus group identified there had been difficulties getting through to CAMHS. One example highlighted the problem getting CAMHS appointments because they had very high thresholds, for example, children would have to have really severe problems before they were seen.
- Staff from both hospital sites told us that the secretarial team had been centralised and that they had had no discussions about their futures.

Seven-day services

- We asked two junior doctors from the Eastbourne hospital about consultant support. They expressed no concerns and told us they felt well-supported.
- We were told that there were no problems accessing out-of-hours investigations, for example, urgent lab tests and computerised tomography (CT) scans would be done quickly. One area where difficulties had been experienced was getting ultrasounds done.
- We were told that pharmacy support and advice was available. The service had two paediatric pharmacists who job-shared.

Are services for children & young people caring?

Good



Services for children and young people were caring.

Children, young people, parents and one carer told us they had received compassionate care with good emotional support. Parents felt they were fully informed and involved in decisions relating to the child's treatment and care.

Compassionate care

- Throughout our inspection, we saw members of medical, nursing and other staff providing compassionate and sensitive care that met the needs of the child, young person and parents/carers.

- We observed that members of staff had a positive and friendly approach towards the child and parents. Staff explained what they were doing, for example, when completing their clinical observations. One mother and son told us that "Staff explain as they go along and you can also ask questions".
- Another mother whose children attended the hospital regularly said that local anaesthetic cream was always used prior to blood being taken, and blood tests were done sensitively. This mother also said that they had been dealt with sensitively in the x-ray department.
- The environment was warm and welcoming in the children's areas. There were facilities available to assist staff in ensuring the child and family's privacy and dignity were met.
- We spoke with one child and four parents while on the Eastbourne site. They told us that they had been happy with the nursing care received.

Patient understanding and involvement

- We observed that spiritual and cultural information could be collected within the child's integrated documentation. The ward matron told us that children's cultural needs were accommodated in areas such as diet – for example, halal and kosher meals could be ordered.
- We observed members of staff who talked with children and young people at an appropriate age-related level of understanding.
- We spoke with four parents about their experiences. They told us the medical and nursing care received had been satisfactory. The trust had a DNACPR policy for staff to refer to. Staff told us that documentation relating to DNACPR decisions was kept in the child's notes and a copy is given to parents/carers. We saw that the question relating to resuscitation status had been included in the paediatric integrated patient document used by children's services. We were not made aware of any children currently using the service where this decision had been made. Whilst checking some children's notes we saw that the question relating to resuscitation status had been included on page three of the paediatric integrated patient document used by children's services.

Emotional support

- Parents and children told us they had been well-supported during their visits to the children's areas.

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- Paediatric specialist nurses such as diabetic and child protection nurses were available for parents and staff to access for support and explanations if required.
- The paediatric diabetic team said they could access psychology support from CAMHS.

Are services for children & young people responsive to people's needs? (for example, to feedback?)

Requires improvement 

Improvements were required for this service to be responsive to patient's needs.

During the inspection we spoke parents who expressed concerns about the reconfiguration of children's services. The main areas of concern were: the distance parents from Eastbourne would have to travel to access inpatient children's services; and the cost and time taken to reach Hastings to attend the Conquest Hospital.

Concerns were also raised about access and flow within the paediatric service. We were told of children's outpatient clinics being cancelled and due to be cancelled due to the lack of registrar cover. This had meant that children had long waits to see the paediatric specialist doctor.

The trust had good support from tertiary centres such as Brighton and Sussex University Hospital, Great Ormond Street Hospital and the Evelina Children's Service at St Thomas' Hospital in London.

We found there were good transitional arrangements for adolescents with diabetes. However, the service did not have effective transition arrangements for adolescents moving across to other tertiary adult services, such as cardiology or cystic fibrosis.

We received some positive feedback from a local GP about the children's service at Eastbourne District General Hospital who said that the majority of patients had been happy with the care received.

Service planning and delivery to meet the needs of local people

- The trust's clinical strategy, 'Shaping our Future', was developed to ensure that it could deliver clinically and financially sustainable services in the future. The

strategy was approved by the Trust Board in March 2012. The strategy identified eight primary access points to the trust's services, for example, maternity and paediatrics. Future models of care and delivery options for these services had also been identified.

- In 2013 the Trust Board took action to ensure the safety of obstetric and neonatal services. They did this through the temporary consolidation of a consultant-led obstetric service, neonatal (including the special care baby unit), inpatient paediatric and emergency gynaecology services at the Conquest Hospital. A standalone midwifery-led maternity unit, SSPAU and children's outpatients department were located at Eastbourne District General Hospital.
- The trust kept the public informed of its changes to children's services in its frequently asked questions document which could be accessed on its website.
- The trust identified that capacity planning for children's services was based on current demand. This exercise identified a total capacity of 27 inpatient beds for Kipling Children's Unit would be sufficient at Conquest Hospital to manage the level of inpatient demand. We were told that when the children's service was busy an additional six beds could be opened on Kipling Children's Unit.
- Managers told us that the paediatric consultants had attended an away day on the 20 June 2014 to discuss acute operational issues. We saw the agenda and minutes of the away day. Issues such as neonatal support, review of the second on-call rotas, reducing length of stay, streamlining patient management, outpatients and processes such as getting notes from one site to another were discussed. The afternoon session involved both the acute and community paediatricians and discussed joint operational issues. For example, update on pathways for surgical children, operational policy, child protection duties and consultants responsibilities around the strategy for dealing with the unexpected death of a child.
- Free car parking was available for parents of children with long-term conditions and oncology patients. Vouchers were also available for some parents to help them with food. Drinks could be accessed directly from the ward.
- We were told that the service had close links with health professionals in the community such as health visitors,

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GPs, paediatric community nurses and paediatricians. Prior to discharge, letters were written by the acute paediatricians and referrals made to community professionals such as health visitors as needed.

Access and flow

- Throughout the inspection we spoke with staff and parents who expressed concerns about the reconfiguration of the children's service. The main areas of concern expressed by parents from the Eastbourne areas related to the distance they would have to travel to access in-patient children's services. The cost and time taken to reach Hastings was also identified as an area of concern.
- We spoke with three parents of four children who were frequent attenders to the service. They told us that the open access system worked and their children had always been seen promptly. One mother told us that her child would often be seen by their own consultant despite not being on call.
- The 10-bed SSPAU was located next to the children's outpatient department. The SSPAU accepted referrals from A&E and from GPs. Children also attended for blood tests and investigations. The ward took up to six children for day surgery Monday to Friday. The ward matron said that the throughput of children often amounted to more than the 10 day beds they had on the ward.
- We were told that if a child was not fit for discharge by early evening, arrangements were made to transfer them to Kipling Children's Unit at Conquest Hospital.
- The children's outpatient clinics saw around 500 to 600 children every month. Generally three children's clinics operated, although sometimes a fourth clinic may run.
- Children were also seen in some adult outpatient clinics, for example, ear, nose and throat, and ophthalmology. We were told that this was because these clinics had the specialist equipment necessary.
- Children from the ward were followed up in clinic at six weeks; GP referrals were seen in two to four weeks and outpatients were seen on time.
- We were told by staff that three registrar's children's outpatient clinics were to be cancelled at Eastbourne from 29 September 2014. This was because there was insufficient registrar cover.
- There had been a rheumatology breach of the waiting target due to consultant capacity.

- We were told that children's outpatient clinics had been cancelled on the 29 and 30 September 2014. Four children had their appointments cancelled four times due to the lack of registrar cover.
- We observed and were told there had been other children's outpatient clinic cancellations because of the lack of registrar cover. These cancellations had occurred twice in May and June, once in July and twice in August 2014.

Meeting people's individual needs

- Staff told us that children's and family's needs could be accommodated by accessing the necessary support, for example, interpreters could be enlisted through the Patient Advice and Liaison Service (PALS) and information could be provided in different languages. The service could also access special needs nursing team and a well nurse to ensure that children's individual needs had been met.
- A staff focus group identified that there were difficulties getting through to CAMHS to arrange appointments.
- The trust provided staff with training to help their understanding of people's needs. We saw that staff had attended training sessions in equality and diversity, Mental Capacity Act, and Deprivation of Liberty Safeguards.
- Facilities to meet children and young people's needs were sometimes limited in areas that saw mostly adults, such as the x-ray department and adult outpatient areas.
- We found there were good transitional arrangements for adolescents with diabetes. However, the service did not have effective transition arrangements for adolescents moving across to other tertiary adult services, such as cardiology and cystic fibrosis.
- Staff we spoke with said that specialist nurses in areas such as diabetes and asthma were available to assist with transition arrangements.
- We saw children and young people being cared for in child-friendly surroundings. We were told that adolescents would be given a choice of where they wanted to be cared for in the ward and could share a bay with younger children or with older children as preferred.
- There was a range of information leaflets about various treatments and other care available within the children's clinical areas. Leaflets available at this trust were written

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in English. Staff explained they could get leaflets interpreted should this be required. We were also told that a translator could be arranged through the PALS if needed.

- We saw examples of the information leaflets given to parents and children involved in clinical research. The children's information was age-appropriate.
- We saw information boards throughout the children's service and photo boards of staff to identify them to patients and visitors. A parent's information board was located on Friston Ward. The board displayed a variety of information, for example, car parking charges, a sign advising parents they could make tea and coffee in the parents' room, Seaford Children's Centre opening times and the parents' survey.

Learning from complaints and concerns

- The trust had a guidance booklet, Let us know your views to inform people how to provide a comment or suggestion and how to make a complaint. Information about PALS was incorporated into this booklet as well as available separately. A leaflet, How have you found today's hospital experience? was also available for people to provide feedback.
- The trust submitted complaints data prior to the inspection which identified 32 complaints in total for all of children's services. We saw that there were 13 complaints relating to children at the Eastbourne location. We saw that all but one complaint had been investigated by the trust and cases were closed. Nine complaints related to parents' concerns about the reconfiguration of services and the impact on them, for example, longer distance to travel to get to paediatric inpatient services at Conquest Hospital.
- We discussed this with the service general manager who said this was still being investigated through the trust's complaints process. We were told that a meeting had been arranged with the parents.
- Staff told us that any learning from complaints had been communicated back to them. For example, we were told that, following one complaint where a child had sustained an extravasation (inflammation caused by leakage of the white blood cells into tissue cells) staff had been advised to undertake hourly intravenous checks on children with an intravenous infusion.
- We saw documentation showing that complaints had been discussed at Trust Board level and reviewed in clinical unit governance meetings with learning shared

across the organisation. The Trust Board meeting agenda dated 30 July 2014 confirmed that the trust complaints report for quarter one (April – June 2014) had been discussed.

Are services for children & young people well-led?

Good 

The trust children's services strategy was in development. Managers told us that the commissioner's strategy was being used in the process to inform the children's services strategy, involving acute and community paediatricians. We were told that the new strategy would be included in the 2014/15 trust business plan.

The trust did not have a formally nominated non-executive director to champion children's services at board level.

The trust did not have an acute services paediatrician to lead children's safeguarding services or acute children's services. Advice and support was received through two community paediatricians for safeguarding issues. The director of nursing was the executive lead for children's safeguarding.

Governance processes were in place and identified that clinical risks were monitored. The views of children, young people and parents were sought. There was a culture of openness and flexibility at ward level which placed the child and family at the centre of decision-making processes.

There was a leadership structure in place within the women and children's division. The children's services were well-led at ward level. Staff told us that there had been no leadership direction for frontline staff from senior management

We could not establish how cohesive the culture was within the leadership team, in part because some clinicians continued to identify concerns relating to the reconfiguration of services.

The majority of staff had received their annual appraisal for 2014. The staff we spoke with said they had received good

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levels of support from the Friston Ward matron. However, concerns had been raised about the lack of support and involvement during and after the reconfiguration of children's services.

Vision and strategy for this service

- The trust's clinical strategy 'Shaping our Future' was developed to ensure that it could deliver clinically and financially sustainable services in the future. The strategy was approved by the Trust Board in March 2012. The strategy identified eight primary access points to the trust's services, for example, maternity and paediatrics. Future models of care and delivery options for these services were also identified.
- In 2013 the Trust Board took action to ensure the safety of obstetric and neonatal services. They did this through the temporary consolidation of a consultant-led obstetric service, neonatal (including the special care baby unit), inpatient paediatric and emergency gynaecology services at the Conquest Hospital. A standalone midwifery-led maternity unit, SSPAU and children's outpatients department were located at Eastbourne District General Hospital. The trust monitored services after the reconfiguration. In the interim, the local clinical commissioning groups undertook a consultation on the proposed options for permanent changes to maternity and paediatric services. The consultation closed on 8 April 2014 and the outcome was the following configuration of paediatric services: SSPAUs at Eastbourne and Conquest hospitals. Inpatient paediatrics and the special care baby unit at Conquest Hospital. Children's outpatient clinics were also based at Eastbourne and Conquest hospitals.
- We asked the children's services management team whether a local trust children's strategy had been developed. Managers told us that this was currently in development, based on the commissioner's strategy. They said that acute and community paediatricians were involved and the new strategy would be included in the 2014/15 trust business plan.

Governance, risk management and quality measurement

- Children's services sat within the integrated care division's women and children's services governance committee. The governance lead told us that a reconfiguration of the committee was taking place and

that governance responsibilities were going to be devolved to clinical managers. They also said that children's and neonatal services had a designated clinical governance lead.

- The trust has a paediatric risk register which identified nine risks in total. We saw that the risk register identified controls.
- Combined meetings took place within the women and children's clinical unit relating to governance, risk management and quality measurement. These included monthly business management meetings for quality and governance, monthly risk and budget meetings, quarterly health and safety meetings, nursing quality performance review group and five weekly ward matron meetings, bi-monthly community children's nursing meetings, accountability review meetings and consultant meetings.
- We saw meeting minutes from the monthly Trust Board meetings which confirmed that children's issues had been discussed. For example, minutes from the board meeting dated 3 June 2014 provided an update on the action plans which related to the external reviews of maternity and paediatric services. One part of the update identified that the majority of actions from the joint review by the Royal College of Obstetricians and Gynaecologists and the Royal College of Paediatrics and Child Health had been implemented. The risk rating was 'green'. The trust said that the remaining actions could not be implemented until the outcome of the Better Beginnings consultation was known. We saw that the board had noted the action plans and agreed that they would be monitored by exception through the quality and standards Committee.
- One member of staff we spoke with on Friston Ward told us that they were not aware of quality walks undertaken on the ward.
- Minutes seen from the nursing quality performance review group confirmed that staff had been kept informed of issues and updates relating to patient safety, patient experience, clinical effectiveness, health and safety, cleanliness and infection control, workforce and area-specific quality issues. Staff members we talked with confirmed that information had been regularly shared with them.

Leadership of service

- A clear leadership structure within the SSPAU and children's outpatient departments was identified. For

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example, on Friston Ward, the band 7 ward matron was supported by band 6 sisters. The ward matron and sisters had processes to ensure that staff were supported and received training and personal development. Staff we talked with on all children's clinical areas told us they had felt supported by their immediate line manager. We directly observed a good standard of leadership at ward/unit level regarding the day-to-day management and organisation of the clinical area.

- The children's outpatient department was managed by a band 6 sister.
- The band 7 ward matron reported to a senior leadership team, a combined children and family services team for acute and community services. The leadership team for acute services included a general manager who was also a paediatric nurse, head of nursing who was not a paediatric nurse by background, clinical unit lead and consultant paediatrician who was the operational lead.
- The women and children's management team reported to the assistant director of operations and the chief executive officer. We were told that the director of nursing would be approached for nursing issues.
- Children did not have adequate representation at Trust Board level. During our interviews of the management team and consultant staff we did not establish that children had a formal board-level non-executive director to promote children's rights and views as required by the National Service Framework for Children Standard for Hospital Services.
- The trust did not have a dedicated acute services paediatrician identified to lead children's safeguarding. Advice and support was received through two community paediatricians and the director of nursing was the designated executive lead for children's safeguarding.
- We were told by staff that they had been encouraged to undertake extra training and courses, for example, leadership courses, and that requests for specific training could be made. The ward matron told us they had received training in a management module and action learning sets.
- The ward matron told us she had been supported through monthly matrons meetings, meetings with paediatricians and had attended twice-yearly matron's away days.
- We saw meeting minutes from the paediatricians' away day on 20 June 2014 and from a consultants' meeting

which confirmed that consultant job plans had been discussed. We did not see or receive any information confirming what the outcomes of these discussions had been.

- Staff told us that they had been kept informed by the chief executive update and the director of nursing's weekly messages to staff.

Culture within the service

- We found there was a culture of openness and flexibility among all the nursing teams and staff we met within the children's clinical areas. Staff spoke positively about the service they provided for children, young people and parents. One sister said they were proud of their service and said "we work well together as a team".
- We saw that staff worked well together clinically and that there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of acute health services. We were told that paediatricians and the nursing staff from the children's service had supported staff in other areas, for example, the A&E unit when a child was admitted to that area.
- The leadership team had clear ambitions for the success of the reconfiguration of the children's services.
- We could not establish how cohesive the culture was within the leadership team, in part because some paediatricians continued to identify concerns relating to the reconfiguration. Discussions we had with two paediatricians identified differences in opinion about the reconfiguration. One paediatrician felt that the merger had improved care; the other paediatrician was less positive and was concerned about having to cover Eastbourne hospital remotely for sudden infant deaths and abuse cases.
- Some staff had struggled with the reconfiguration and said there had been "teething problems". There had been a meeting with the paediatricians in May 2014 which resulted in positive actions, including guidance relating to which paediatrician the child was assigned to when locum doctors were working in the children's unit.






Public and staff engagement

- The trust used their Let us know your views booklet to provide guidance on how to make a comment or suggestion and the complaints process, and PALS. A leaflet How have you found today's hospital experience? was also available for people to use to provide feedback.

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- PALS offered help, support, information and advice to patients and their relatives, friends and carers. People could provide feedback to PALS in person or by completing an online form, by phone, post, fax or email.
- The trust compiled comments and complaints from patients, family and friends on the Meridian system.
- We asked some of the staff whether whistleblowing procedures were in place. We were told that this procedure had been used by staff to raise concerns.

End of life care

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

Information about the service

East Sussex Healthcare NHS Trust provide end of life care services across the trust which was not seen as the sole responsibility of the specialist palliative care (SPC) team. There were 2,749 deaths across the trust from January to December 2013. The SPC team worked collaboratively with all the trust's clinical teams and with the community teams to support end of life care. There were strong working relationships with frontline staff on the wards, the site-specific clinical nurse specialists in cancer and non-cancer and the community teams. Eastbourne hospital's SPC team consisted of two part-time consultants in palliative medicine, two full-time Macmillan clinical nurse specialists, end of life facilitator (covering the acute and community services) and a patient pathway coordinator. In addition, a chaplaincy team provided multi-faith support.

The number of new patients referred to the SPC team had increased in recent years, with 577 people being referred in 2013/14. The new patient referrals increased steadily since 2010/11.

We saw evidence that systems were in place for the referral of end of life patients to the SPC team for assessment and review. This ensured that patients received appropriate care and support with up-to-date holistic symptom control advice for adults with advanced, progressive and incurable illness in their last year of life. The SPC team were available five days per week, Monday to Friday 8am to 4pm. Outside these hours, the SPC service was covered by telephone support from St Wilfrid's Hospice.

During the inspection we visited a variety of wards across the trust, including MacDonald, Jevington, Seaford 2 and 4, Hailsham 4 and Berwick to assess how end of life care was

delivered. We also visited the mortuary and spoke with palliative care leads, ward staff, patients and relatives. We looked at patients' notes and reviewed documents relating to the end of life service provided at the trust.

We reviewed the medical records of four patients at the end of life and observed the care provided by medical and nursing staff on the wards. We spoke with two patients receiving end of life care and their relatives. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

End of life care

Summary of findings

Services for end of life care at Eastbourne District General Hospital were caring; however, improvements were required to be safe, effective and responsive. Improvements were also required in leadership.

The SPC team were available five days a week, with St Wilfrid's Hospice providing out-of-hours and weekend cover. A telephone and bleep system is in place for referrals to the SPC team which ensures patients are seen and assessed in a timely way. We saw data that confirmed that high percentage of patients referred were seen within 24 hours. Medicines were provided in line with guidelines for end of life care.

The trust had a Resuscitation Policy that was available to all staff, setting out the use of 'Do Not Attempt Cardio – Pulmonary Resuscitation' (DNACPR) orders. The quality of the hospital's DNACPR orders varied and there were no standardised processes for completing mental capacity assessments.

Training relating to end of life care was provided at study days however it was not mandatory across the Trust. End of life champions were being introduced across the trust's wards, however, uptake into these positions was patchy. Leadership of the SPC team was good and the quality of the patient experience was seen as a priority.

All patients requiring end of life care could access the SPC team. ESHT formulated a document highlighting the 'Key Elements of Good Care in the Last Hours to Days of Life' that would support the removal of the LCP after the 14th July 2014. Staff were asked to follow these steps and complete this document for all patients approaching the end of their life.

On reviewing medical records of four end of life patients across the wards we visited, we did not find individualised care plans. We saw evidence that care was delivered and recorded but we did not see any information on how individualised care would be delivered around patients' needs and preferences. There was a multidisciplinary team approach to facilitate the rapid discharge of patients to their preferred place of care.

Relatives of patients receiving end of life care were provided with free car parking. Patients were cared for with dignity and respect and received compassionate care.

End of life care

Are end of life care services safe?

Requires improvement 

End of life care services at Eastbourne hospital required improvements.

End of life staff training was not mandatory across the Trust.

A true picture of end of life care incidents across the Trust was not available. We found no evidence of systems in place to discuss and review end of life incidents at the 'End of Life Steering Group' were actions and learnings could be disseminated across the Trust.

Syringe drivers were available across the Trust to support end of life patients with complex symptoms to deliver consistent infusions of medication. We found the daily syringe driver prescription charts had no date section and a new sheet was required daily which could easily fall out of the medical records and be lost. This introduced a level of risk into the prescribing process.

The Trust had 2 types of syringe drivers in use across the hospital. In 2010 the National Patient Safety Agency released a rapid response report (NPSA/2010/RRR019) relating to ambulatory syringe drivers and the reporting of fatal errors. In this alert NHS providers have an expected date of compliance of December 2015. We saw evidence on the wards of the mentioned syringe drivers being used across the wards even although the Trust had purchased an adequate supply of the recommended T34 McKinley syringe drivers. We saw no action plan around the removal of the mentioned ambulatory syringe drivers to become compliant with the alert. The Trust was running a dual system leading to the risk of delivery errors and therefore a risk to patient's safety.

The trust had a Resuscitation Policy that was available to all staff, setting out the use of 'Do Not Attempt Cardio – Pulmonary Resuscitation' (DNACPR) orders. The quality of the hospital's DNACPR orders varied: of the four orders across the hospital we reviewed, only two were signed by a consultant. In the most recent audit, 99% of forms were dated, however only 31% of forms were completed thoroughly according to Trust guidelines. An action plan has been developed which highlights a continuing need to educate all doctors on the need to complete all boxes of

DNACPR orders to ensure they are valid and to avoid any confusion in the event of cardio-pulmonary arrest. Our findings showed that the trust's policy was not always followed; indicating that more work was needed to improve this area.

Where DNACPR orders were in place, we saw that patients with capacity were involved in discussions. Where the patient lacked capacity, we saw no evidence of assessments being undertaken or documented.

Incidents

- Incidents related to end of life care were reviewed by the Lead Cancer Nurse who ensured that actions were taken to address any issues identified. There is no recognised coding system so identification is made by highlighting words such as: bereavement, end of life, dying, Liverpool Care Pathway (LCP), and Key Elements within text. Data from April 2014 – 10th June 2014 (sourced 11th June 2014) showed 21 incidents. On the Trust's analysis 5 showed a reduced standard of care for end of life care patients. This information was shared at the multiagency Verification of Expected Death Group and the multiagency Pressure Ulcer Prevention Group. However we found no evidence of systems in place to discuss and review end of life incidents at the 'End of Life Steering Group' were actions and learnings could be disseminated across the Trust.
- The SPC team had been inputting drug related incidents/near misses into an electronic reporting tool but no end of life care report had ever been raised. This had been highlighted at the end of life Steering Group. A true picture of end of life care incidents across the Trust was not available and learnings from these incidents did not inform improvements the quality of care delivered to end of life patients.
- In all the areas we visited we found that staff were encouraged to report incidents. Mortuary and portering staff could not remember if there had been any incidents in the last year that involved deceased patients, however, the trust submitted a report from the electronic reporting tool that highlighted three incidents involving end of life care equipment in the last year. We saw that the incidents were managed appropriately and actions taken to prevented further incidents happening.
- There were no Never Events (serious, largely preventable patient safety incidents that should never happen) relating to end of life care services.

End of life care

Cleanliness, Infection control and hygiene

- We saw that the wards and mortuary viewing area were clean, bright and well-maintained. In all the patient areas, the surfaces and floors were covered in easy-to-clean materials which allowed high levels of hygiene to be maintained throughout the working day.
- We saw that ward and departmental staff wore clean uniforms with arms bare below the elbow and that personal protective equipment was available for use by staff in all clinical areas. In the mortuary we observed adequate supplies of protective equipment for use by undertakers, porters and visiting police officers.
- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or caring for people after death.

Environment and equipment

- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. CCTV was evident in all areas in the mortuary with 24-hour, seven-days-a-week records of activity. Fridges were lockable to reduce the risk of unauthorised access and the potential for cross-infection.
- Service records were available for equipment in the mortuary. Servicing took place by outside contractors and the hospital estates department. On the day of our inspection all equipment was working correctly and there were no issues around getting equipment repaired or replaced in a timely manner.
- All the people we visited who were receiving end of life care were being cared for on pressure-relieving mattresses that were correctly set.
- Syringe drivers were available across the Trust to support end of life patients with complex symptoms to deliver consistent infusions of medication. We observed that the T34 McKinley syringe drivers were being attached to mobile patients and patients being discharged. The majority of patients on the wards we visited had the Graseby Omnifuse syringe drivers attached. This introduced a level of risk as 2 different types of syringe drivers are in use with different methods of delivering the medication. Staff were unfamiliar with the McKinley T34 syringes and required the SPC CNS to attach the pumps.
- In 2010 the National Patient Safety Agency released a rapid response report (NPSA/2010/RRR019) relating to ambulatory syringe drivers and the reporting of fatal errors. In this alert NHS providers have an expected date

of compliance of December 2015. We saw evidence on the wards of the mentioned syringe drivers being used across the wards even although the Trust had purchased an adequate supply of the recommended T34 McKinley syringe drivers. We saw no action plan around the removal of the mentioned ambulatory syringe drivers to become compliant with the alert. The Trust was running a dual system leading to the risk of delivery errors and therefore a risk to patient's safety.

Medicines

- Medication guidance had been agreed and implemented for 'symptom control and prescribing for adults' which clearly set out the medication necessary to support the management of dying patients. These included pain, agitation, nausea and vomiting. The guidance was available in the end of life information boxes which were available in all ward areas for staff to refer to.
- The guidance included supportive information which signposts staff to the SPC team or pharmacists where there were complex medical conditions, such as renal and liver failure, to ensure patient safety was paramount and specialised skills supported the prescribing process.
- We were told by staff that medication for end of life care was available on the ward and was easily accessible. Matrons were confident in the ability of the nursing staff to care well for patients with syringe drivers with support from the SPC team.
- The SPC team had two non-medical prescribers and used this skill to prescribe medication regularly. We saw evidence on Seaford 4 Ward, that one patient's medical notes included pain management prescribed by the SPC clinical nurse specialist. This was reviewed daily and had also been reviewed by the palliative care consultant.
- The choice of medications for end of life care was aligned to local community guidelines to support safe and consistent practice between care providers. Consultants from the SPC team worked across the community and at the local hospice which improved safety and continuity of care for patients.
- On Hailsham 4 Ward we found medicine administration records for individual patients receiving end of life care. Our checks found that one chart had not been signed after three days of use.

End of life care

- Through direct observation we found the new prescription booklets difficult to navigate. We found no separate section for syringe driver's prescription; therefore the prescriptions had to be written in the regular portion.
- We were told by a junior doctor that a system had been introduced to protect the safety of patients having medication delivered through a syringe driver. A database recorded all patients with complex symptoms, including plans for treatment over the weekend. This data was backed up by handing over patients to the second on-call doctor and hospital at night, supporting the delivery of safe, effective care at all times, day and night.

Records

- Across the wards we found evidence that paper medical records were in use which documented the patient's personalised care and treatment. In the intensive therapy unit (ITU) we were shown electronic patient records that contained a specific page to be completed when a patient was placed on end of life care.
- The SPC team completed the patients' medical records along with inputting information onto the 'Somerset Cancer Register' database. This enabled the SPC team to keep accurate care and treatment records for discussion at the multidisciplinary team meetings.
- The SPC team told us that end of life patients received an initial holistic assessment to identify previous medical history, physical, psychological, social and family concerns. We reviewed one patient's medical records. The holistic assessment was clearly documented, signed and dated. This showed that accurate personalised records were kept and maintained.
- From the holistic assessment, a care plan was developed by the ward nursing and medical staff, taking into account patients' individual needs. We observed how a holistic assessment, on Seaford 4 Ward was transferred to frontline care to meet the needs of the patient.
- The trust had a Resuscitation Policy that was available to all staff, setting out the use of 'Do Not Attempt Cardio – Pulmonary Resuscitation' (DNACPR) orders.
- We randomly checked four medical records containing DNACPR orders. We saw that all decisions were recorded on a standard form with a red border at the front of the notes, allowing easy access in an emergency. In the

most recent audit (February 2014) it was recommended that all ward staff needed to be made aware on the importance of the DNACPR order being kept at the front of the notes so it is easily found when needed. In the four medical records we reviewed, we found the DNACPR orders in the front of medical records as per the trust policy.

- To monitor compliance to the 'Resuscitation Policy' weekly audits along with a 'Resuscitation Committee,' annual audit is led by the Palliative Care Consultant. In the most recent audit, 99% of forms were dated, however only 31% of forms were completed thoroughly according to Trust guidelines. An action plan has been developed and is waiting for sign off by the Palliative Care Consultant which highlights a continuing need to educate all doctors on the need to complete all boxes of DNACPR orders to ensure they are valid and to avoid any confusion in the event of cardio-pulmonary arrest.
- The quality of the hospital's DNACPR orders varied: of the four orders across the hospital, only two were signed by a consultant.
- Our findings showed that the trust's policy was not always followed; indicating that more work was needed to improve this area. Completing the DNACPR forms ensured that appropriate decisions were made about the care of these patients.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- We were told by ward staff that Mental Capacity Act 2005 assessments were carried out by the doctors who would write a summary in patients' medical records. On admission, an 'assessment' would be completed by the admitting doctor and a best interest decision would be made. We saw no evidence of this process during the inspection.
- Where DNACPR orders were in place, we saw that patients with capacity were involved in discussions. Where the patient lacked capacity, we saw no evidence of assessments being undertaken or documented. Where people lacked capacity, we observed that family members were involved in the discussions about the ceiling of care to be provided.

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- On Berwick Ward the matron showed us a nursing care plan for adults lacking capacity to make specific decisions. We saw this plan in use on the ward and staff we spoke to understand the reason the plan was in place.
- There were robust consent arrangements for managing tissue removal after death. The mortuary had passed the Human Tissue Authority (HTA) inspection which meant the procedures met the required standards.
- Staff we spoke with all had a sound understanding of their responsibility in relation to safeguarding adults. The trust had a dedicated adult safeguarding lead nurse.

Training

- The end of life care facilitator and the SPC team were actively involved in staff training. A training needs analysis was performed in February 2014. A five-year training programme was developed to ensure that all staff were trained in the seven core competencies of good end of life care.
- Across the staff groups, end of life care training was divided into the following sections: induction training, training of newly qualified staff, maintenance training and training of students. We saw training records which confirmed that, since March 2014, 419 staff had received end of life training; of these, 240 were from the nursing staff group and 58 were medical staff.
- Monthly workshops covering the 'key elements of care of the dying person', 'priorities of care' and 'national values and beliefs' were available to all clinical staff across the trust. Staff also had access to 150 e-learning modules. Advanced care planning workshops trained staff in supporting patients in completing their future care wishes and preferences.
- Across the trust, end of life care nursing champions were being introduced to the wards and 84 champions had been identified across the trust. The training provided staff on the wards with regular updates around end of life care to keep their knowledge up to date. Staff recruitment to the champion roles was patchy across the wards, with many areas without nurses to take on this role. However, on the medical assessment unit and Seaford 2 Ward, two end of life care champions had been identified but no training had been delivered to date.
- We were told by the matron on Berwick Ward that the end of life link nurses spent time with the SPC team and shared knowledge learned at team meetings. However, on Seaford 2 Ward, information was transferred from the end of life link nurses during the shift as only two registered nurses worked per shift, making the cascading of information difficult. The matron told us there was no training records kept as they "didn't think it necessary for end of life care because we do so much of it".
- We were told by the SPC team that their role included training core teams of staff on the principles of end of life care. This included multidisciplinary team training, medical specialists (foundation year 1, 2 and core medical training), consultants and GPs. This was confirmed when we spoke to a junior doctor on Jevington Ward who told us that they had received end of life and palliative care training and a 'Junior doctor end of life group' had been established to involve junior doctors around the key elements of end of life care.
- The SPC team told us that continuing professional development took place within the team. We saw records that confirmed that the clinical nurse specialists had completed their mandatory training and a non-medical prescribing update. One clinical nurse specialist had attending an advanced end of life symptom control course in the past year.
- Unstructured, on-the-job training for porters (but not from the mortuary staff) included supporting the movement of deceased patients to the mortuary and the use of the mortuary out of hours to ensure that mortuary procedures were maintained. The porters we spoke to were able to describe the process in a knowledgeable manner and were able to demonstrate how they treated deceased patients with dignity and respect.
- One porter we spoke with told us that mandatory training was up to date. Mandatory training included adult safeguarding, fire, infection control, manual handling and mortuary training. We were unable to confirm that all the training had been undertaken during the inspection as the team leader was not available. We did see evidence that updated mortuary training took place after an incident in 2013.
- Another porter we spoke with had recently received infection control training. The porters we spoke to were able to describe the processes that are in place to protect themselves and other patients from harm when dealing with deceased patients.

End of life care

- Advanced Care Planning (ACP) workshops are running to train staff in supporting patients in completing their future care wishes and preferences. We were told by the end of life facilitator that Advance Care Planning Training (ACP) included communication skills and the use and completion of Advanced Care Plans. We did not find any completed ACP on the wards we visited.

Management of deteriorating patients

- The hospital used the Vital PAC monitoring and recording system to identify patients who were at risk of sudden deterioration in their condition. The matron on Berwick Ward demonstrated the tool which monitored the patient's statistics, including heart rate, blood pressure, temperature, urine output. The Vital PAC system was remotely monitored by the critical care outreach team. We were told that, when a patient had an elevated score, the nursing staff contacted the medical staff to review the patient.
- For other patients, where the progression of their illness was clearer, the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible at all times.
- On Jevington Ward, we spoke with one junior doctor who told us that their consultant had spoken to them after the withdrawal of the Liverpool Care Pathway (LCP) for end of life care and asked if he was clear on the new care pathway for the patient. Proactive, anticipatory management instructions were put in place to ensure that non-specialist staff were aware of the best way to manage symptoms likely as part of the disease progression.
- As part of the ongoing discussion with patients and their relatives, the ceiling of care was discussed and documented for patients. Patients recognised as deteriorating or dying would be commenced on the end of life care plan using guidance set out in the Key elements of care of the dying patient, after discussions with the consultant and multi-professional team, including the SPC team, patient and relatives.
- Following referral to the SPC team, patients were reviewed by the team on a regular basis depending on their needs. On assessing the patient, the SPC clinical nurse specialist decided whether a patient needed to be seen daily, weekly or only once.

Nurse staffing

- The Trust 'End of Life Care Policy (Adults)' outlines the expected standards of care for people and their carer's as patients approach the end of their life. End of life care was the responsibility of all staff, and was not limited to the SPC team staff and Clinical Nurse Specialists (CNS).
- The Trust policy stated 'that a patient that is dying without relatives or carers present must have a supportive and caring member of staff with them up to the time of death. The staff we spoke to confirmed that whenever possible a member of staff would be there but at times this was difficult due to staff shortages. The lead Cancer Nurse confirmed there were challenges around achieving this aim that no one should die alone due to staff shortage.
- The SPC nursing team included two full time Clinical Nurse Specialists. Additionally, there is a patient pathway co-ordinator. An end of life care facilitator works across the Trust. This is a full time position to support education and training of all staff around end of life care. A second facilitators post is vacant. Discussions are taking place around how this post will be filled.
- The SPC CNS's are trained in specialist palliative care to master's level, and we saw that they had attended end of life training in the year. This brings a high level of expertise and good understanding of current issues within the nursing team. This expertise was available face to face five days per week across the acute hospital.
- During our inspection we asked ward managers about their staffing levels and whether they had enough staff when they had to manage end of life patients but we found that no extra staff were allocated. This meant that nursing end of life patients was challenging at times due to the lack of staff.

Medical staffing

- Specialist consultant palliative medical advice and support was available five days a week. Out-of-hours support was via a SPC nurse-led telephone advice service provided by St Wilfrid's Hospice.
- The palliative care team multidisciplinary team consists of two part-time palliative medical consultants who work at St Wilfrid's hospice as well as at the trust. This allows improved continuity and management of patients across the different service providers.

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- The palliative medical consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council, with one consultant having attended an advanced symptom control course in the last year.

Major incident awareness and training

- The mortuary had systems in place to ensure that if a sudden surge in demand for refrigerated mortuary space (such as following a major incident or utility failure) the Trust could provide the access needed. At Eastbourne, we saw that 24 extra storage spaces were available.
- We spoke with the lead cancer nurse to establish whether business continuity and escalation plan supported end of life patients should a major incident occur, but we were unable to establish if this was the case.

Are end of life care services effective? (for example, treatment is effective)

Requires improvement 

The SPC team based their care on the NICE quality standard for end of life care for adults.(QS 13)

The SPC Team provided evidence based advice to other professionals as required. ESHT formulated a document highlighting the 'Key Elements of Good Care in the Last Hours to Days of Life' that would support the removal of the LCP after the 14th July 2014. Staff were asked to follow these steps and complete this document for all patients approaching the end of their life.

On reviewing medical records of four end of life patients across the wards we visited, we did not find individualised care plans. We saw evidence that care was delivered and recorded but we did not see any information on how individualised care would be delivered around patients needs and preferences.

The Trust had not contributed to the National Care of the dying Audit. This meant that the opinions of bereaved relatives are not being collected and no service improvement programme can be initiated to improve the quality of care.

A telephone and bleep system is in place for referrals to the SPC team which ensures patients are seen and assessed in a timely way. We saw data that confirmed that high percentage of patients referred were seen within 24 hours.

We saw evidence of continuing professional development of the SPC team through attending outside courses to further develop skills and knowledge, however, internal team development has not been possible within the team due to a lack of capacity and administrative support.

The SPC team had a weekly multidisciplinary team meeting to discuss treatment plans for new and current patients.

Due to capacity issues, attendance of the SPC team at site-specific meetings such as the lung cancer MDT meeting was not possible.

The trust was not part of an Electronic Palliative Care Coordinating System (EPaaCS). This system would support better care and prevent inappropriate admissions to hospital. However, we were told that 'System 1' was being introduced in the community and would allow care records to be shared.

Use of National Guidelines

- East Sussex Healthcare NHS Trust had implemented NICE quality standards for improving supportive and palliative care for adults. The SPC team demonstrated a high level of specialist knowledge and provided wards and departments across the trust with up-to-date holistic symptom control advice for patients in their last year of life.
- The trust responded to the national recommendations of the Liverpool Care Pathway (LCP) review with targeted work on a replacement care policy. The trust formulated a document, Key elements of good care in the last hours to days of life. While the Liverpool Care Pathway was still being applied (up until 14 July 2014), staff were asked to follow these steps and complete this document for all patients approaching the end of their life. In the minutes of the end of life care – last days meeting, May 2014, it "was felt the key elements were not sufficient and that a personalised care plan should be instigated".
- We were told by the assistant nurse director that the use of LCP documentation dropped considerably after publication of the LCP review in July 2013. The Key elements document listed a number of core principles

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which were felt to be crucial to good care in the last few days of life. The format of this document was a simple checklist, which aimed to support healthcare workers as an aide memoire.

- Ward staff confirmed that the trust was not continuing to use the LCP for end of life care. Staff received guidance from the medical director around the continuing use of the pathway until 14 July 2014. This showed that the trust had responded to concerns regarding the pathway and informed staff of conditions to ensure a safe approach to care for patients.
- The 'Key Elements' document was introduced to the workforce in the acute sector through an email to senior staff members, who were to pass the information on to their teams. The SPC nurse told us that the "key elements were introduced with not much training", which is in contrast to the Liverpool Care Pathway where training was good.
- Staff we spoke to told us the SPC medical teams would seek verbal consent from patients and/or families before moving a patient onto the 'Key elements' care pathway. The matron on Berwick Ward told us that care plans were reviewed every change of shift. On reviewing medical records of four end of life patients across the wards, we did not find individualised care plans. We saw evidence that care was delivered and recorded but we did not see any information on how they intended to deliver individualised care plans.
- The Leadership Alliance for the Care of Dying People published One Chance to Get it Right (July 2014), the response to the recommendations set out in More Care, Less Pathway: A Review of the Liverpool Care Pathway. With this in mind, in August 2014, an updated version of the Key elements of the care of the dying was introduced in line with national recommendations set out by the Leadership Alliance. On reviewing the medical records of a patient on Jevington Ward we found the key elements had been completed and this was confirmed with written evidence in the medical records but we found the use of this guidance was patchy across the trust.
- Integrated working of the SPC team and end of life facilitator demonstrated a high level of specialist knowledge which provided wards and departments across the trust with up-to-date symptom control advice for patients in their last year of life, basing the care they provided on the NICE quality standard for end of life care for adults.
- We reviewed the medical records of four end of life care patients, which demonstrated the SPC team had supported and provided evidence-based advice, for example, on complex symptom control and psychological support for the patients and families. This specialist input by the SPC team ensures that a high level of expertise is used to ensure the best possible care is delivered to end of life care patients and that people have a positive healthcare experience.
- NICE quality statement 6: holistic support – spiritual and religious support was promoted by the chaplaincy service. The Anglican chaplains were supported by a Roman Catholic priest and an Imam from the local community. There were good links to other religions such as a local Rabbi providing support to Jewish patients. The Key elements of care of the dying patient included a section to demonstrate that people's spiritual needs had been assessed.
- All patients within the trust requiring end of life care have access to the SPC team. Referral can be made by the patient, their relatives and staff within the trust. A telephone and pager system is in place for referrals to the SPC team which ensures patients are seen and assessed in a timely way. Urgent advice was available from the clinical nurse specialist who could give telephone advice prior to reviewing the patient.
- The SPC team aimed to review urgent patients within 24 hours, however, this time may be extended at busy times such as when one clinical nurse specialist was away. We saw data that confirmed the SPC team saw the majority of referrals on the same day. The staff we spoke to across the wards reiterated to us the availability and effectiveness of the SPC team.
- The trust had introduced a national dementia strategy which supported staff to provide good care to people with dementia, including at end of life. There was a dementia lead nurse and link nurses on wards to support frontline staff to have the appropriate training, development and support to deliver good care.
- A policy was ratified in July 2014 on 'Guidance for staff responsible for care after death'. This was intended for all staff involved in the care of the dying and recently bereaved. The policy considered multi-faiths and ensured that people's faiths were checked and staff were signposted to a Guide to religious belief and lifestyle traditions on the chaplaincy website. Systems ensured that medical certificates showing cause of

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death were processed immediately in order for burial to happen within one day where required by religious practices. Out of normal hours, the clinical site manager was the point of contact.

- The trust had not contributed to the National Care of the Dying Audit. This meant that the opinions of bereaved relatives were not being collected and no service improvement programme could be initiated to improve the quality of care provided.

Pain relief

- Effective pain control was an integral part of the delivery of effective end of life care and this was supported by the SPC team. On reviewing one patient's medical records on Seaford 2 Ward, we saw that the SPC clinical nurse specialist and Palliative care consultant were actively involved in daily reviews of the patient's pain management.
- Care of the dying guidelines included guidance on prescription of anticipatory pain relief for patients at the end of life. Staff were able to locate the guidance placed in the end of life boxes on the ward and on the hospital's end of life care intranet.
- The SPC team were involved in the prescribing of patients' medication. We were told by staff that all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly. The amount of analgesia and sedation did increase as death approached, but made it clear that this increase was always a response to symptoms escalating.
- We were told by a junior doctor that a system had been introduced to protect the safety of patients having medication delivered through a syringe driver. A database recorded all patients with complex symptoms, including plans for treatment over the weekend. This data was backed up by handing over patients to the second on-call doctor and hospital at night, supporting the delivery of safe, effective care at all times, day and night.

Nutrition and hydration

- To ensure nutrition and hydration needs were met, a risk assessment was completed on admission by a qualified nurse. The matron on Berwick Ward told us that a malnutrition universal screening tool (MUST)

assessment was carried out which identified patients at risk of poor nutrition, dehydration and swallowing difficulties. It included actions to be taken following the nutrition assessment scoring and weight recording.

- Patients identified as high risk were directly referred to the dietetics team. The wards we visited used a coloured (red) tray and cup scheme to indicate those patients who needed additional help at meal times. Meal times were protected which meant staff ensured people could eat uninterrupted except for urgent clinical care.
- The new 'key elements' guidance included prompts to ensure patient and family views and preferences around nutrition and hydration at the end of life were explored and addressed.
- We saw the SPC team were involved in reviewing of the nutritional needs of one patient as inadequate nutrition was being received orally. A referral to the dietician was made to support the staff in delivering nutrition orally and through a nasogastric tube. We saw evidence of a next-day assessment by the dietician and guidance for the frontline staff to increase oral nutrition; this was fully discussed and explained to the family.
- On Berwick Ward, the matron told us that food charts were completed and, as supporting eating times could be challenging, at times relatives were invited to get involved.

Patient outcomes

- The improvement in end of life care for adults in East Sussex in 2013/14 was via a locally agreed Commissioning for Quality and Innovation (CQUIN) framework between East Sussex Healthcare NHS Trust and the clinical commissioning groups. The first indicator was for a CQUIN for the trust to complete a baseline audit of end of life care using the End of Life Care Quality Assessment Tool (ELCQuA). The audit commenced in July 2013 with 51 sets of notes being reviewed. The limited information gathered offered some insight in to the practices at that time and areas that would benefit from improvement strategies as well as aspects of care they were delivering well. Coordinated personalised care planning was limited – about 50% of cases (total 51 records). Spiritual and religious support was available; however, documented evidence that spiritual and religious needs were explored was available in only 20% of notes. Timely verification of death occurred within two hours in the

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majority (80%) of care records. As part of the end of life action plan (2014/15) the ELCQuA results are to be improved but how actions will be delivered has not been documented (end of life steering group minutes July 2014.)

- The trust supported patients to achieve their preferred place of care, either through rapid discharge to home, hospice or nursing home or by ensuring high-quality care for patients who wished to die at the hospital.
- The trust did not contribute to the National Care of the Dying Survey so it was difficult to judge how it was performing in areas such as access to information relating to death, compliance to dying medication protocols and protocols promoting patient privacy.
- On visiting the ITU we saw comprehensive systems and processes to support patients requiring end of life care, including 'withdrawal of treatment protocol'. The SPC team told us that end of life care was well-managed in ITU and families and staff were supported by the bereavement councillor and chaplaincy team. Good family facilities were available, such as resting and cooking facilities which ensured families were well-supported.
- We were told the trust was actively engaged in the NHS Improving Quality Transformation Programme (phase 2). This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care by supporting the implementation of five key enablers: advanced care planning; (Assessment Management Best practice Engagement Recovery) AMBER care bundle; coordinated care with community and GP services (electronic system); priorities of care for the dying person; and rapid discharge home to die pathway.
- We found evidence that the trust was in the process of implementing three of the five priorities but no evidence was found around the use of the AMBER care bundles which are used to support patients assessed as acutely unwell, deteriorating, with limited reversibility and where recovery is uncertain nor any evidence of the involvement of an electronic palliative care coordinating system (EPaaCS). This system would support better care and prevent inappropriate admissions to hospital. However, we were told that 'System 1' was being introduced in the community and would allow care records to be shared

Competent staff

- The clinical nurse specialists from the SPC team were well-qualified. They and the palliative care consultants provided support to all grades of staff across the hospital to ensure that ward staff felt confident to deliver end of life care.
- We saw evidence of continuing professional development through attending outside courses to further develop skills and knowledge. However, the internal team development had not been possible due to a lack of capacity and administrative support.
- Direct management responsibilities changed during the year and the SPC clinical nurse specialist team were now line-managed by the Macmillan lead cancer nurse. Appraisals had not been performed in recent years but the aim was to complete appraisals for all staff by the end of October 2014. This aimed to ensure that staff were adequately supported to develop their skills and deliver high-quality care.
- Guidance was available on wards, in the chapel and multi-faith room and on the intranet to support staff in providing care in accordance with people's religious and cultural preferences. Staff had access to specialist advice from the chaplaincy where clarification was needed.
- Syringe driver pumps to deliver analgesia continuously were available to all end of life care patients. The use of two types of syringe drivers within the hospital had allowed insufficient staff to become competent in the use of both types. We were told by staff that the SPC team needed to administer the T34 McKinley syringe drivers for patients as there was a lack of staff with the necessary skills on the wards.

Multidisciplinary Team working

- The Somerset Cancer Register database enabled the SPC team to record activity and link with the cancer site-specific multidisciplinary outcomes. The register collects all the information necessary to make sure that a patient is seen, diagnosed and treated as quickly as possible. The electronic register allows real-time collection of information about a patient. This method of collecting data supports the national and clinical audit requirements.
- The SPC team were visible to staff across the hospital. Nursing staff in all the departments and wards we visited were aware of how to contact the SPC team and

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could cite examples of their involvement with specific patients. One doctor, on Seaford 2 Ward told us they had worked with the SPC team and found them “very helpful”.

- The SPC team had a weekly multidisciplinary meeting to discuss treatment plans for new and current patients. Complex cases would require input from the palliative care consultants who were available to review patients on Tuesday and Thursday morning and all day Wednesday. Extending the multidisciplinary team to look at complex cases in a wider team setting had not been achieved due to capacity issues.
- The SPC clinical nurse specialist worked closely with the cancer site-specific clinical nurse specialists to support patients with complex symptom management at end of life and ensure that all the appropriate care management processes were in place. Attendance at other multidisciplinary team meetings such as the lung cancer meeting was not possible due to capacity issues. However one palliative care consultant attended the weekly upper gastro-intestinal multidisciplinary meeting.
- On Berwick Ward we spoke to the matron who told us that a multidisciplinary ward round took place three to four times per week. A junior doctor on Jevington Ward confirmed that consultant ward rounds took place twice per week and included matron, nurse coordinators, medical teams and physiotherapists. All patients’ management needs were reviewed and updated.
- The SPC team told us that working alongside other specialities, including the acute oncology team, community teams and the medical consultants at the local hospice and in the community, helped to provide streamlined and standardised care across care providers and the local healthcare economy.

Facilities

- Eastbourne hospital mortuary had a viewing suite where families could view their deceased relative. We visited the area and saw that the viewing suite was divided into a reception and viewing room. The suite was neutral with no religious symbols which allowed it to accommodate all religions. We were told families were supported during the viewing and relatives knew what to expect and were safe.

- On our visit to the mortuary we were shown where deceased patients leave the hospital with the undertaker or with family. Staff had adequate systems to ensure the dignity and respect of patients in and leaving the mortuary.
- The hospital had a Christian chapel and a multi-faith prayer room located centrally and available to all staff, patients and visitors. In the chapel, prayer leaflets were available for prayers to be written and placed in the chapel. The multi-faith room had several prayer mats on the floor for use by visitors.

Seven-day services

- No seven-day, face-to-face specialist care was available from the SPC team, however, systems were in place to provide timely SPC advice at any time of day or night for people approaching the end of life. Face-to-face specialist care was available five days per week 8am to 4pm Monday to Friday. Families could ask to see the team via the ward staff.
- Out of hours, St Wilfrid’s Hospice gave telephone advice and support. This was a nurse-led service; however, if the specialist nurses were unable to help, the first doctor on call would be contacted. Data from the hospice showed that out-of-hours calls from the hospital were less than 5% of all the calls received. It wasn’t possible to determine whether the calls had been appropriate. Staff on the wards told us that they felt confident in the support mechanisms in place for end of life patients.
- Chaplaincy cover was provided 24 hours per day, but outside the hours of 9am and 6pm it was for emergencies only. The chaplaincy centre was open 24 hours a day for prayers. The information booklet The Chaplaincy Team listed the services performed within the hospital throughout the week.

Are end of life care services caring?

Good 

Staff at Eastbourne hospital provided compassionate end of life care to patients.

We were told by a junior doctor on Jevington Ward that nursing staff were very good with patients and were able to recognise changes in their conditions. The matron on

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Berwick Ward told us that “consultants are good at communicating with the patients and family” and identifying when further active treatment was not benefitting the patient.

On Jevington Ward we reviewed a patient’s medical records, and found written evidence that it was recognised that the patient was dying; this was recorded on the consultant’s ward round notes and a completed ‘key elements’ document with comments from the family on the needs and wishes of the patient clearly documented.

All clinical nurse specialists had completed the training necessary to enable them to practice at level 2 for the psychological support of patients and carers.

In complex situations the SPC clinical nurse specialist was able to refer end of life care patients and their relatives to the Macmillan family support worker who offers support at level 3 (professional psychological assessment) to manage mild to moderate depression, anxiety and anger. Support could be long term and short term. Extra support was available from volunteer counsellors.

Volunteers were available from the chaplaincy to provide emotional and spiritual support when asked by the patient/families and medical and nursing staff. One volunteer told us that they visit the wards daily and collect prayer leaflets to place in the chapel and talk to patients

We spoke to the relative of a patient receiving end of life care who told us the care was excellent and all the staff were “very caring and so kind and respectful”.

Compassionate care

- Hospital staff we spoke to demonstrated a strong commitment to empathy and enhancing the environment for dying patients. We saw that families were encouraged to participate in care if they wished (such as mouth care and personal care).
- We observed the SPC clinical nurse specialist visit an end of life patient. The nurse was very professional but was very sensitive and empathetic towards the patient.
- We saw that refreshments were made available to visitors and that they were able to use the canteen facilities. One relative we spoke to told us that parking was expensive, however, when their relative was placed on the ‘key elements’ pathway, a weekly exception ticket was given. There was open visiting and free parking tickets for the relatives of people receiving end of life care.

- We were told by a junior doctor on Jevington Ward that nursing staff were very good with end of life patients and were able to recognise changes in their conditions. We spoke to the relative of a patient who told us the care was excellent and all the staff were “very caring and so kind and respectfully”.
- The End of Life Care Policy (Adults) stated that information should be conveyed in a caring and sensitive way. On Seaford 2 Ward a junior doctor we spoke to felt supported by the ward team and would be confident to talk to families in a caring and sensitive manner. We reviewed a patient’s medical notes on Jevington Ward and saw that the conversation with the family was recorded in a caring and sensitive way.
- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were shown the process and the ledger-type book that contained the required information. We observed that the book was completed appropriately and neatly and was completed in a respectful way. Confidentiality was maintained at all times.
- The porters told us that transporting adults and babies to the mortuary was performed ensuring all deceased patients were treated with the utmost dignity and respect. Suitable concealment trolleys were available to support the movement to the mortuary as per trust policy.

Patient understanding and involvement

- We saw evidence that the SPC clinical nurse specialist was actively involved with the patient and the relatives, providing support and keeping families involved in management of the patient with patient consent. We saw evidence where the SPC clinical nurse specialist would listen to families’ concerns and sort out any issues that maybe developing around the management of their relative.
- The matron on Berwick Ward told us that “consultants are good at communicating with the patients and family” and identifying when further active treatment was not benefitting the patient. After a complaint raised in 2013, the matron told us how important it was to get families involved in the care. Staff encouraged relatives to get involved in mouth and personal care. Relatives could be asked to support relatives at meal times.
- We were told by a junior doctor on Jevington Ward that doctors were good at communicating with patients and family about a patient’s management plans. The ward

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doctors, with support from the palliative care consultant in complex cases, would review patients and talk to families when necessary so that patients and family were involved in the decision-making process.

- On Jevington Ward we reviewed a patient's medical records, and found written evidence that it was recognised that the patient was dying; this was recorded on the consultant's ward round notes and a completed 'key elements' document with comments from the family on the needs and wishes of the patient clearly documented.
- After the death of a patient, the ward manager on Berwick Ward told us that some families wished to be involved in the aftercare. The matron was able to give us an example of when a family had been involved in helping to deliver aftercare.

Emotional support

- All clinical nurse specialists had completed the training necessary to enable them to practice at level 2 for the psychological support of patients and carers. The SPC clinical nurse specialists provided ongoing support and advice to patients and their families. They were able to signpost people to additional sources of support, such as those provided by St Wilfrid's hospice.
- In complex situations the SPC clinical nurse specialist was able to refer end of life care patients and their relatives to the Macmillan family support worker who offers support at level 3 (professional psychological assessment) to manage mild to moderate depression, anxiety and anger. Support could be long term and short term. Extra support was available from volunteer counsellors.
- The Macmillan family support worker told us that only a small percentage of end of life patients were referred. Patients were prioritised and would be seen immediately. Interventions were usually short before the patient was referred to the hospice team who continued delivering support. This support would be streamlined as the support worker passed care to the hospice team.
- The chaplain was available to provide spiritual and religious support. At the time of the inspection the chaplaincy post was vacant so the chaplain from the Conquest Hospital in Hastings was covering both sites. We were told by the matron on the ITU that the chaplain provided excellent support within the unit to patients and their families.

- We saw evidence that the trust was providing 'Mindfulness based stress reduction', an eight-week course to support patients and families.
- Volunteers were available from the chaplaincy to provide emotional and spiritual support when asked by the patient/families and medical and nursing staff. One volunteer told us that they visit the wards daily and collect prayer leaflets to place in the chapel and talk to patients.
- The SPC team supported carers with complex issues that could not be helped by the ward team, such as contacting and updating community services as appropriate and providing guidance on carer's benefits and letters of support for employers.
- During our visit to the A&E, we were told by staff that there were links with the SPC team to provide emotional and practical support for relatives and staff in the event of a sudden death of a patient. For patients who needed to go home to be cared for, the SPC team facilitated the fast-track discharge process.
- The bereavement team carried out the administration of a deceased patient's documents and belongings, providing practical advice and signposting relatives to support services such as funeral directors.

Are end of life care services responsive to people's needs? (for example, to feedback?)

Requires improvement 

All patients requiring end of life care could access the SPC team, with 31% of referrals not relating to patients with cancer.

Patients receiving end of life care would be offered a side room if one was available. The lead cancer nurse told us that, because of a shortage of single rooms across the trust, end of life patients were rarely nursed in a single room.

We found little evidence of family rooms on the wards we visited except for the ITU; however, families were permitted to stay overnight by the bedside and stay as long as possible. Three rooms were available in the accommodations block for families who wished to stay overnight.

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In 2012/13, 74% of end of life patients achieving their Preferred Place of Care, however, 17% of patients died in hospital before they were able to be transferred to their preferred place due to poor rapid discharge processes in certain situations. The trust undertook an audit in July 2014 around the fast-track discharge process and found that there was a limited awareness and knowledge about the rapid discharge pathway, which meant patients rarely, got discharged within the 72-hour window.

The trust maintained a mortality database where information about the management of deceased patients was collected. This data was reviewed at monthly mortality meetings where medical consultants reviewed all the deaths across the trust. However this information was not used to support the development of end of life care services.

There was no end of life care alert system in place to inform the SPC team of any emergency admissions to A&E of palliative care patients previously known to the team. This would support the early assessment and management of patient care and sometimes prevented the need for admission.

We found no evidence that complaints were discussed at the End of life care Steering Group. Learning from complaints was not being disseminated through the trust which meant staff were not learning from the complaints.

Service planning and delivery to meet the needs of local people

- The SPC team was widely embedded in all clinical areas of the hospital we visited and we were told by staff on the wards they would refer a high percentage of their patients commencing end of life care.
- Staff told us that patients on end of life care would be offered a side room if this was available. The lead cancer nurse told us that, because of a shortage across the trust, end of life patients were rarely nursed in a single room.
- We observed there was a lack of equipment, such as reclining chairs, for family members who wished to stay at the hospital.
- We found little evidence of family rooms on the wards we visited except for the ITU; however, families were permitted to stay overnight by the bedside and stay as long as possible. Three rooms were available in the accommodations block for families who wished to stay overnight.

- The referral rate of palliative care new patients to the SPC team has steadily increased since 2010/11 by 20.4% and the non-cancer caseload increased to 31%. We saw data in the SPC team annual report that 10% of the team's workload was end of life care, an overall increase from 6% in the previous year. This increase was believed to be due to uncertainty felt by general ward staff about the best way to support these patients; 19% of their time was spent supporting the complex fast-track discharge process so that patients achieved their preferred place of care or death. We saw no evidence of plans to increase the SPC team's capacity to meet the increasing demands being placed on the service.
- The trust maintained a mortality database where information about the management of the patient was collected. This data was reviewed at monthly mortality meetings where medical consultants reviewed all the deaths across the trust. We found no evidence that mortality data was used at a high level in the trust. The lead cancer nurse told us that no end of life leads attended the meeting.
- However, the end of life facilitator told us that information from the database identified the wards that have the most deaths. The end of life facilitator would visit the wards to see if staff need any training to support the delivery of good quality end of life care.
- As part of the dementia initiative, 'My care' documents were used across the trust. The booklet was used to provide individualised patient care for dementia patients who were unable to express their needs. One relative we spoke to told us that they had only noticed the document on the ward corridor and had wished the principles had been applied to her mother's care. We were unable to establish during the inspection how widely this documentation was used.

Access and flow

- In 2011/12 and 2012/13 the trust undertook an audit around the number of patients that were achieving their Preferred Priorities of Care and Preferred Place of Death. In 2012/13, this was achieved in a high percentage of patients, with 74% of patients achieving their preferences, however, 17% of patients died in hospital before they were able to be transferred to their preferred place.

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- We were told that systems were in place to facilitate the rapid discharge of patients to their preferred place of care. The SPC nurse explained that a multi-professional approach was in place, which included an occupational therapist, to secure rapid discharges to the PPC.
- The SPC team coordinated and liaised with the discharge team to provide advice relating to care packages, including care home placement, assessment for future community palliative care support, assessment for hospice admission and assistance with using the rapid discharge pathway for end of life care for patients who wished to die at home or in a care home.
- The trust undertook an audit in July 2014 around the fast-track discharge process and found that there was 'a limited awareness and knowledge about the rapid discharge pathway. Therefore the pathway was not being consistently used with those patients who were being fast-tracked. This was confirmed by a doctor we spoke to who told us that "discharge planning is a problem and fast-track discharge is slow".
- The trust was piloting a Proactive Elderly person's Advisory Care (PEACE) planning tool. This was developed to support the discharge of elderly patients to their preferred place of care, providing advice for community and GPs on the ongoing management of patients approaching the end of life. Seaford 2 Ward was implementing the PEACE tool to support streamlined care across care agencies by including a summary of medical problems, anticipatory medications, advisory/suggested action plan and mental capacity information.
- There was no end of life care alert system in place to inform the SPC team of any emergency admissions to A&E of palliative care patients previously known to the team. This would support the early assessment and management of patient care and sometimes prevented the need for admission.

Meeting people's individual needs

- We were told that patients at end of life would be assessed by the medical and nursing teams to develop care plans that would meet their individual needs. However, we did not see any individualised care plans for end of life care. Building up a picture of the care required was done by reading through the entries by the various healthcare professionals.
- We visited the mortuary viewing suite where families can come and spend time with their relatives.

Appointments could be organised through the bereavement office or mortuary, Monday to Friday. The viewing times were allocated in the afternoon due to the other work the mortuary performed.

- Information leaflets for families whose relatives were receiving end of life care were available and were given out by ward staff. The information leaflets included Coping with Dying, An explanation of the plan of care in the last hours or days of life and Guidance following bereavement. Ward staff told us they would give relatives these leaflets and a brief overview of the information, making themselves available for any questions relatives may wish to ask.
- Across the trust we found considerable respect for the cultural, religious and spiritual preferences of patients. We saw information leaflets were available, one being Organ donation and religious beliefs.
- Christian services were available in the chapel on a Friday and Sunday. The services were recorded so patients who could not attend could still be involved. Volunteers collected patients from the wards to attend the services. Chaplains were on call for all faiths.
- We were told that, on a Friday, the Imam attended the hospital to perform prayers.
- The chaplaincy volunteers told us that they received a list of all the new admissions to the hospital; they visited the wards to say 'hello' and leave a calling card if the patient was asleep. They also received calls from the wards to come and visit patients. We observed a request for prayers to be said for a patient who was receiving end of life care.
- The bereavement office was open Monday to Friday, 8.30am to 4.30pm.

Learning from complaints and concerns

- We were shown a number of complaints relating to end of life care. The lead cancer nurse told us that complaints received would be investigated with the staff involved and letters of explanation would be sent to the complainants. We found no evidence that complaints were discussed at the end of life care steering group. Learning from complaints was not being disseminated through the trust which meant staff were not learning from complaints.
- The lead cancer nurse told us that there had been a reduction in the number of complaints received by the trust which related to end of life care. There were five

End of life care

complaints made from April to June 2014 about communication (x 2), attitude (x 1), infection control (x 1), and standard of care (x 1). Trends in primary subject and location will now be recorded on a quarterly basis.

- The matron on Berwick Ward told us that she was in the process of investigating several complaints around patients who had received end of life care on the ward. We were told a meeting had been set up with the matron and the family to resolve and discuss the complaints. We observed the trust was following the appropriate procedures and resolving issues with families.

Are end of life care services well-led?

Requires improvement 

We found no evidence of an end of life strategic plan. This showed us that the trust did not have a clear direction for end of life care. The trust had developed an end of life policy (adults) in August 2014. Staff delivering care knew about the policy but were unable to tell us about specific details of the policy or what the trust's vision was around end of life care.

The Medical Director was the lead for end of life care at board level and told us that end of life care was not a regular agenda topic at the monthly board meetings. There was good leadership of the SPC team led by the palliative care consultants. We observed that the team worked well together but the team told us they "felt end of life care is not a priority across the trust".

At the time of the inspection the End of life care Steering Group had been disbanded and was being relaunched with engagement with a wider attendance of clinicians across the trust, including an elderly care and A&E consultant.

The trust did not receive structured feedback on end of life care from users and carers. No bereavement surveys were undertaken across the trust. This meant that the views of relatives/carers were not being used to improve the service.

Vision and strategy for this service

- We found no evidence of an end of life strategic plan. This showed us that the trust did not have a clear direction for end of life care.

- We did see an action plan which set out the key areas the trust would like to develop around end of life care in 2014/15. These included: an electronic alert system that highlighted patients recognised as dying in the next few days or hours; the introduction of questionnaire to collect the opinions of patients and carers; introduction of seven-day working; and the introduction of an electronic system to share summary care records across care providers. These key developments would be discussed at the end of life care steering group.
- The trust had developed an end of life policy (adults) in August 2014. Staff knew about the policy but were unable to tell us its details or what the trust's vision was for end of life care.

Governance, risk management and quality measurement

- Governance systems were in place around end of life care. The End of Life Care Steering Group discussed aspects of end of life care. Any actions and reports will be taken to the Trust Nursing and Midwifery and Allied Healthcare Professionals Group and the Clinical Quality and Review Group.
- End of Life Care Steering Group reports into the external End of Life Care Programme Board chaired by the CCGs and Adult Social Care provides trust-wide leadership and overview to end of life care improvements and developments. The aim of the group is to develop and operationally manage the set of actions which are required to embed a culture of change, improvement, education, learning and standards of consistently high levels of clinical performance.
- The End of Life Care Steering Group review and develop policy associated with end of life care across the Trust. The Steering Group membership includes key clinical leads in end of life, palliative care and specialist palliative care in addition to senior representatives from elderly care and Accident and Emergency. At the time of the inspection the End of life Steering Group had been disbanded and was being re-launched. With a wider attendance the Trust conveyed it was serious that End of life care was everyone's business and not just the responsibility of the SPC team.
- A single action group will implement the Trust End of Life Care Action Plan. This group will feed into the end of life Steering Group which reports directly to the Quality and Standards Committee which scrutinised its work, highlighted issues and challenged their processes.

End of life care

- The Medical Director was the lead for end of life care at board level and told us that end of life care was not a regular agenda topic at the monthly board meetings.

Leadership of service

- There was good leadership of the SPC team led by the palliative care consultants. We observed that the team worked well together but the team told us they “felt end of life care is not a priority across the trust”.
- We found little evidence of what happened above the SPC team around the trust’s strategy for end of life care. We were told by the SPC team that general management support was never there and there was no infrastructure to support the development and expansion of end of life care services.
- Staff felt disconnected from the board and felt that there was no connection between frontline staff and the trust’s senior managers. We were told that “the people making policy were too far removed from patients”.
- All the staff we spoke with felt their line managers were approachable and supportive. They were also able to name members of the SPC team and give examples of their involvement in optimising patient care.

Culture within the service

- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.
- We asked the mortuary staff whether the staff working in their department felt a sense of belonging to the wider hospital team. They told us that they had lots of contact with non-mortuary staff and had input into the end of life policy. There were frequent visitors, such as the chaplains, porters and undertakers who they got to know quite well. They were able to see where their work fitted into the provision of end of life care services.

- All the staff we spoke to were positive about the service they provided for patients. Quality patient experience was seen as a priority and everyone’s responsibility and this was very evident in the SPC team in their patient-centred approach to care.
- Across the wards we saw that the SPC team worked well together with nursing and medical staff and there was obvious respect between the specialities and across disciplines.






Public and staff engagement

- The trust did not receive feedback on end of life care from users and carers. No bereavement surveys were undertaken across the trust.
- During Dying Matters Week (12 May – 16 May 2014) the end of life care facilitators from East Sussex Healthcare NHS Trust held public events in the Eastbourne Arndale and Langley Shopping Centre to provide information and answer any questions around dying, death and bereavement.
- We observed that two Listening into Action events were arranged in May 2014 to increase staff engagement. Additional ‘on the ward’ training was undertaken by the end of life care facilitators to promote the ‘key elements’ guidelines.

Innovation, learning and improvement

- The SPC team gave examples of practice that the team were proud of, including providing a holistic approach to patients receiving end of life care, non-medical prescribers and facilitating people’s preferred priorities of care, networking with other providers, community services and GPs for better care closer to home.

Outpatients

Safe	Inadequate 
Effective	Not sufficient evidence to rate 
Caring	Good 
Responsive	Inadequate 
Well-led	Inadequate 

Information about the service

East Sussex Healthcare NHS Trust has 706,534 outpatient (OPD) appointments annually. Outpatient activity took place on either the Conquest Hospital site with 326,363 attendances per annum or Eastbourne District General Hospital, with 280,171 attendances per annum (figures taken from trust data June 2013 to June 2014). There was also significant activity that took place in the trust's community sites which is covered in the separate community services reports.

As part of this inspection we visited most outpatient areas at the two main acute hospitals sites to speak with patients and relatives. We also spoke with staff and departmental managers. Information provided by the trust was reviewed and corroborated for accuracy and then used to inform our judgements.

The OPD ran clinics in anaesthetics, breast surgery, cardiology, chemical pathology, clinical oncology, dermatology, diabetic medicine, endocrinology, ear, nose and throat, gastroenterology, general medicine, general surgery, geriatric medicine, gynaecology, haematology, maxillofacial surgery, neurology, obstetrics, ophthalmology, orthodontics, paediatric diabetes, paediatrics, pain management, palliative medicine, plastic surgery, radiology, rheumatology, thoracic medicine, transient ischaemic attack, trauma and orthopaedics, urology and vascular surgery.

The OPD had recently undergone a service redesign which was still being embedded at the time of our inspection. The trust was centralising OPD booking services, and had restructured its administration staff.

All patients entering the hospital now checked in a central booking desk at the entrance to the hospital. Patients were then sent to the area of the hospital where their clinic was being held.

Outpatients

Summary of findings

The central booking service was not always able to give patients appointments within the NHS England and Clinical Commissioning Groups (CCGs) regulations 2012 18 week targets.

The Trust was falling below national averages with the two week wait timescale for patients with urgent conditions such as cancer and heart disease. Despite the Trust consistently falling below the national average we were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the Trust improved on their waiting times.

The Trust had recently undergone a service redesign of OPD. They had changed processes and job roles in order to centralise the administration teams, and to create a new operating system for OPD both in The Conquest and Eastbourne Hospitals. The Trust told us that they had done this to improve the quality and safety of the services they provided. The changes to the service and ways that patients were managed throughout the department were still imbedding at the time of our inspection.

Staff had been unsettled by the changes and were stressed, unhappy and keen to discuss their experiences of this change throughout our visit. Staff mostly acknowledged the reasons for the changes but felt that they had occurred with little consultation, without a good knowledge of their job roles, and without adequate support. Occupational Health told us that they were concerned about the sharp rise in the numbers of staff needing their assistance with work related stress.

There were examples of poor patient experiences as a result of the changes. This was partly due to patients checking in at a central desk and being sent to the wrong areas of the hospital. The computerised system being used in the department did not allow staff working in each area of OPD to check to see whether patients had arrived at the hospital. As a consequence patients who had been sent to the incorrect areas went unnoticed, and staff were recording them as not having attended clinic. On the week of our inspection fewer patients than usual were booked to attend OPD and yet

the problems caused by the new systems was evident. We saw patients who were lost and in the wrong areas, and we saw staff spending a great deal of time redirecting or searching for patients.

The Trust had issues with the storage and accessibility of patient health records. Many clinics were running without patient health records and using temporary sets of notes. Health records were in a poor state of repair. Staff were not reporting the incidents with medical records consistently through their online reporting systems in accordance with Trust Policy. This was because staff did not have the time due to an already large workload, because there were such a large number of incidents and because staff were unsure of what incidents required reporting.

We found that the OPD was not protecting patient's confidential data as they are required to by law (Data Protection Act 1998). We found patient records in public accessible areas without staff present.

We found that the OPD was not accurately monitoring patient pathways at the time of our inspection. This was due to the redesign of the service which meant that documentation was not being collected and recorded by staff consistently.

We found that staff in OPD were not tracking patient health records because this job had not been considered during the redesigning of the service.

Outpatients

Are outpatients services safe?

Inadequate 

Outpatient Services at Eastbourne District General Hospital was not safe.

Staff were not consistently reporting incidents through the electronic incident reporting system in line with the Trusts policy. This meant that an accurate picture of incidents within the department was not being collected.

Patient records had been left unattended in a public accessible corridor. We were able to look through the records without being challenged by staff. Therefore the OPD was failing to protect patient's confidential information.

Patients Health Records were disorganised and in a poor state of repair. This made it difficult for clinicians to locate important information which could put patients at risk of inappropriate or unsafe treatment.

Essential jobs had been missed in the service redesign as staff were not consulted about the job roles that they completed. As a result health records were not being tracked from the department.

Patient health records were often missing for clinics which meant that patients were seen routinely without clinicians having a full picture of the patient's medical history.

Resuscitation equipment was not being effectively checked.

Incidents

- At the time of our inspection visit there had been three recent serious incidents in the outpatients department (OPD). One of which was a patient fall, one an unexpected patient death, and one failure to act on test results.
- At the time of the inspection there had not been any Never Events relating to the OPD.
- Trust policy stated that incidents should be reported through an electronic 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.
- We were told by managers and staff that the recording of incidents with health records management was inconsistent across OPD. Staff told us that this was because issues with health records were so frequent that they did not have time to report all of these incidents through the electronic system.
- We noted that in different areas of OPD staff were using different systems to record issues with health records. Some staff had reported when health records were unavailable at clinics through the online reporting system. However, we saw many recorded incidents of missing records in nurse documentation that had not been reported through the online reporting system. When we discussed these cases with staff we had various accounts of what would constitute an incident with regard to health records that they would report electronically.
- We also found several incidents which had been recorded on essential care round documentation of incidents in the OPD which were not recorded electronically as per Trust policy. These mostly involved patients being sent to the wrong areas of OPD and no staff being available to redirect them.
- An administration manager told us that missing notes was under reported due to the large numbers of incidents of this nature. We were told that that despite this they had 200 incidents across both sites of missing notes on their system which they were expected to investigate. They told us that they were already working long hours, overtime at weekends, had had their annual leave cancelled, and yet still did not have time to analyse incidents due to the workload they were expected to complete.
- Staff told us that they had never received feedback from incidents that had been reported electronically. The department had not had a clinical unit meeting for over 18 months. This had been identified as an issue by the Trust and meetings for senior staff were due to start in September 2014.
- The matron did attend quality review meetings with other senior staff across the Trust every five weeks. They told us that they used these meetings to discuss incidents.
- The sister of OPD gave us examples of where patient care and experience had altered due to learning from

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incidents. One example was a where a patient had fallen when a door had closed on them. As a result of this incident the doors had been realigned to prevent a further reoccurrence.

Cleanliness, infection control and hygiene

- There were hand hygiene, 'Bare below the Elbow' audits undertaken which demonstrated staff were compliant with best practice guidance. These were done for each clinical area, and documented in the annual clinical governance report.
- Staff working in the OPD had a good understanding of responsibilities in relation to cleaning and infection prevention and control.
- Clinical areas were monitored for cleanliness by the infection control team and results displayed on notice boards in the department. Housekeeping staff could be called between scheduled times to carry out additional cleaning, where staff felt it was necessary. We noted that although the cleaning audit scores met with expected cleaning standards, we found dust on high surfaces, and ingrained grime around door stops and in the corners of the floor in some areas.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place and completed to provide assurance that this was done.
- The equipment that we saw was in good repair but also noted that the green labels the Trust used to indicate that equipment had been cleaned were not always used and this risked leaving staff uncertain as to which equipment was cleaned and ready for use. We saw that some clinical storage trolleys were not clean.
- 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).

Environment and equipment

- All mobile electrical equipment that we looked at had current Portable Appliance Testing (PAT) certification.
- All equipment in the OPD had a process for updating and maintaining contracts with external providers for specialist equipment. A register was kept of the contract arrangements.

- 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.
- The environment was reasonably well maintained and there were no obvious hazards such as worn flooring.
- We found a first aid box in one corridor with bandages in it which had reached their expiry date in 2007.
- We found a number of fire doors particularly in The Gynaecological clinic that had been wedged open by staff.

Medicines

- We found that eye drops in the department were being given to patients without adequate information for patients on how they should be administered. The eye drops had no dispensing labels, and patients had received no written information regarding how many drops to apply and how frequently they should do this. Therefore the trust had not ensured that when medicines are dispensed the dispensing and dispensed product complies with the relevant legislation and best practice.
- Where doctors dispensed eye drops in clinic details of the consultation and medication were recorded in patient health records. However in the records we viewed there was insufficient information recorded for these to act as a prescription. We also found no record in patient health records regarding the dispensing of medications. The trust must ensure that when medicines are prescribed and dispensed the prescription and dispensing complies with relevant legislation.
- Temperature checks were not being completed by staff in line with Trust policies. Temperature records that we looked at were incomplete and did not contain minimum and maximum temperatures to alert staff when they had not been within the required range. Therefore the service was not able to assure us that medicines that required refrigeration were stored within the recommended temperature range.

Records

- During our inspection of OPD we found a diary with patient results in it left in a corridor. There were no staff in the corridor. We were able to look through the diary unchallenged by staff.
- All of the staff that we spoke with including administrators, clerks, secretaries, nurses, and clinicians

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told us that the Trust had an issue with the availability and condition of patient health records. We found that incidents around health records were not being recorded in a consistent manner by any staff groups in the hospital. Therefore we were unable to clarify the exact extent of this issue.

- Staff told us that health records were in a poor state of repair and that some records were so large that staff were unable to handle them safely. We saw multiple examples during our inspection of records that were in a poor state of repair, with documents and test results loose. Clinicians told us that the poor state of records made their job difficult and risked them missing important information in disorganised health records.
- The poor condition of Health records had been on the Trust Risk Register for OPD since August 2005. The Trust had not been able to resolve this issue since this date.
- The availability of records at clinic was also an issue raised persistently with us both by staff and by patients. For example, One patient wrote to us saying, 'We had a pointless visit to the DGH today with my daughter as there was crucial correspondence missing from her file and the consultant could not proceed with further care until this correspondence was found, Our consultant was very apologetic and angry that we could not proceed with any further treatment for my daughter and that we'd had a wasted visit.'
- The unavailability of patient records is also on the OPD risk register. Staff told us that due to staff shortages and the location of medical records clinics frequently ran with several patients having temporary sets of notes. This meant that clinicians would not have access to a complete picture with regards to the patients past medical history which could result in unsafe or inappropriate treatment. We are unable to give exact numbers on how often this happened as Medical records staff, and staff responsible for preparing the notes for clinic all told us that they did not report this through the electronic reporting system.
- We were told by administration staff of an example the previous week where a clinic of 24 patients on the previous week had run with seven sets of notes unavailable. 38 members of administrative staff were present at this discussion and they all agreed that this example was a typical example and not an isolated incident.
- Staff told us that notes were sometimes unavailable because staff were unable to locate them. Trusts have a

responsibility to track all patients' health records. (Records Management - NHS Code of Practice Part 2 January 2009). Due to a recent review of administration in the Trust the task of tracking patients' health records back to medical records had not been allocated to a staff group or job role. This meant that at the time of our inspection health records leaving OPD departments across both sites were not being tracked. Although administration staff, medical records staff and management were aware of this issue there were no plans in place to rectify this. This issue was not on the risk register and had not been reported via the electronic incident reporting system.

- Staff told us that where records needed to be brought from the Trusts offsite storage for medical records and that this caused delays. Staff said that the reason for this was that at times so many records were being requested from offsite that staff were unable to meet the demand.
- We were told that another reason that health records were delayed from this site was that although the delivery van delivered notes from the offsite storage facility four times a day, they sometimes had to leave records behind because they did not have space in the van for the notes required. We did not see documented evidence that this had occurred but many members of administration staff raised this as an issue.
- We spoke with the manager and staff responsible for preparing notes for clinics across both sites. We were told that they did not have enough staff in this department to ensure that health records for clinic were prepared in a timely manner. Because of this staff were working over their hours, and were doing extra shifts over the weekends. We were told that because staff were coming to work on a Saturday to prepare clinics this put a great deal of pressure on medical records staff on a Monday to find the notes that had been requested over the weekend.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had completed training, appropriate to their role and grade, in the Mental Capacity Act 2005 and the impact of this on their work. They had also completed training in Deprivation of Liberty Safeguards.
- Staff we spoke with demonstrated a good understanding of the legislation and their role in this legislation.

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- We viewed two consent forms during our inspection which had been completed correctly by staff.

Safeguarding

- 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.
- Staff working in the OPD had completed the mandatory safeguarding training. 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.
- The OPD matron was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- The Trust had a chaperone policy that was followed by the OPD staff.
- The Trust had a whistleblowing policy that was known to staff that we spoke with working in the OPD.

Mandatory training

- With the exception of staff on long term sick leave all staff in the department were up to date with their mandatory training. Records were held electronically in the department.
- All of the staff we spoke with confirmed that they had received their mandatory training in line with the Trusts policy.

Assessing and responding to patient risk

- We saw that staff were checking resuscitation equipment. However, despite being signed as checked by staff daily Resuscitation trolley D had out of date or undated paediatric equipment. For example, the paediatric self-inflating resuscitator (ambu bag) had an expiry date on it of 2012. The equipment on this trolley was also visibly dirty and in some places sticky. The trolley was also covered with unnecessary bits of paper which made it cluttered.
- We witnessed one situation where a patient became unexpectedly unwell in the OPD. The staff managed the incident competently and in line with Trust policy.
- Staff working in the OPD had completed Basic Life Support training annually in line with Trust policy.

Nursing staffing

- The department used regular bank staff to fill spaces in staffing but was reluctant to use agency staff that had not worked in the OPD before as they were not trained in the specific competencies required to work within the department.
- The Rheumatology Nurse Specialist who worked across both sites had stopped working for the Trust two years previously and had not been replaced. We were told that this service suffered particularly long waiting lists due to lack of staff running clinics in this speciality.
- The Trust had stopped Ad Hoc clinics when the Turnaround team had come in to reduce spending. This had impacted on waiting lists and staff were now being asked to run extra clinics to clear the backlog. However, they were unable to staff these clinics with substantive staff as they were already stretched to the limit. Extra clinics were mostly being nurse staffed by bank nurses.

Medical staffing

- Trust policy states that medical staff give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner. We were told that some doctors ignored this policy. This was not raised with doctors or their managers. The unit did not audit this issue and individual cases where this caused cancellations were not raised through the electronic incident reporting system.
- From January 2014 to June 2014 335 outpatient clinics were cancelled by the Trust with less than six weeks' notice. As the Trust was not auditing the reasons for these cancellations we were unable to determine the cause.
- We were told that the Trust had a particular issue with consultant cover in Rheumatology because staff that had left the Trust had not been replaced.
- Medical staff told us that they were receiving weekly emails asking them to find time to run extra clinics, and urging them to cancel study leave to do this.

Non-Clinical Staffing

- We spoke with 72 members of administration, clerical, medical records and secretarial staff across the Trust during our inspection.
- Administration staff had recently undergone a review of their roles and responsibilities and some staff had changed job roles and locations as part of the review.

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- The Trust had changed processes and job roles in order to centralise the administration teams, and to create a new operating system for to improve the quality and safety of the services they provided.
- At the time of our inspection the new ways of working were still being embedded and staff were telling us that they were under a great deal of pressure.
- Staff told us that they felt that their life at work had become stressful and unhappy. They said that changes had been made without consulting staff on the ground and that as a result processes were failing and patients were suffering.
- Staff across all grades working in administration, clerical, reception, medical records and secretarial support described feeling undervalued, not listened too, deskilled and demoralised.

Major incident awareness and training

- The Trust had a major incident plan which was available to staff on the intranet.
- In the event of a major incident OPD was responsible for providing a room for planning officers, and a police control room. Managing a hospital enquiry point, an identification enquiry point, a space for out of hours General practitioners, and a discharge lounge from the Accident and Emergency department.
- Staff were able to describe to us their role in a major incident. We saw evidence that the major incident plan was discussed at staff meetings.

Are outpatients services effective? (for example, treatment is effective)

Not sufficient evidence to rate 

The OPD was able to demonstrate that it was planning care base on National Institute for Health and Care Excellence (NICE) guidelines for Macular Degeneration, and smoking cessation. However, a backlog of Ophthalmic first and follow up appointments meant that appointments and treatment pathways were not always completed within the required timeframe to meet with NICE guidelines for Macular Degeneration.

Along with mandatory training staff in OPD were expected to demonstrate competencies in the areas that they worked in. Staff attended a Trust Induction on starting work at the service. OPD also ensured that staff completed a local induction programme which related to OPD.

We saw examples of Multidisciplinary working.

Evidence-based care and treatment

- 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.
- The OPD was able to demonstrate that it was planning care base on National Institute for Health and Care Excellence (NICE) guidelines for Macular Degeneration. However, a backlog of Ophthalmic first and follow up appointments meant that appointments and treatment pathways were not always completed within the required timeframe to meet with NICE guidelines for Macular Degeneration
- The ophthalmology department planned that patients referred into the service had been given an Optical Coherence Tomography (OCT) and had seen the consultant and started on a five week treatment plan where needed within two weeks of referral. However, administration staff did raise concerns relating to the rebooking of patients for OCT. They had discovered that because the department had removed administration staff from their speciality clinics administration staff were misinterpreting doctors writing OCT on a referral for an urgent scan thinking it meant October. Staff had therefore been booking patients in for follow up appointment in October rather than for an OCT scan. To mitigate this risk the staff member with the knowledge required was managing ophthalmology follow ups for the time being. They told us that because of a high pressure workload they did not currently have the time to retrain other members of staff.

Patient outcomes

- The OPD ran a continuous patient experience survey which patients were encouraged to complete following their visit to the department.
- Results of these surveys were shared with staff and patients on display boards within the departments.

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- 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.

Competent staff

- Along with mandatory training staff in OPD were expected to demonstrate competencies in the areas that they worked in. For example, we were shown competency assessments for cervical pathology and colposcopy, hysteroscopy, sigmoidoscopy, and proctoscopy.
- Staff attended a Trust Induction on starting work at the service. OPD also ensured that staff completed a local induction programme which related to OPD.
- Records demonstrated that staff had a 100% record for appraisals. These records showed that staff had all received an annual appraisal and a six month progress check.
- We spoke with a matron who worked across both hospital sites. They told us that they were sent on a leadership course and had a buddy who supported them through the programme. They described the course as, "Inspirational".
- We spoke with a Clinical Nurse Specialist who told us that they were supported with their practice development by both the head of nursing and their consultant.
- We spoke with Staff nurses who told us that they valued their annual appraisal and felt that their developmental needs had been recognised, and supported through learning.

Multidisciplinary working

- We saw and were told about a number of other examples of where joint clinics were provided. These included the Nasal Polyp Clinic, Breast clinic, Urology clinic and orthopaedic clinic which had physiotherapists involved in clinics, the diabetic service having podiatrists and dieticians working in clinics alongside the consultants and diabetes nurse specialists.
- We were told that the Trust OPD staff worked collaboratively with community services to the benefit of patients. There was evidence of liaison over individual wound care and copies of letters relating to patients were faxed to the community nurses.

Seven-day services

- OPD did not routinely run clinics seven days a week. The department was currently running extra clinics where possible to clear the backlog of patients waiting for appointments.

Are outpatients services caring?

Good 

Outpatient services were caring.

We saw very caring and compassionate care delivered by all grades and disciplines of staff working at the Hospital. 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 in the reception area and maintained eye contact when conversing.
- Staff were trained and 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. A patient said, "It's really good overall. They are too busy, but the staff are lovely". Another patient said, "I can't fault them".
- Patients also told us that they had been treated with dignity in the department. One patient told us, "I have always been treated with respect".
- Staff knocked on doors and waited for a response before entering.

Patient understanding and involvement

- 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

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felt included in decisions that were made about their care and that their preferences were taken into account. One patient however said that the doctor had talked to the computer screen rather than their face.

- 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.
- Patients received a copy of the letter that was sent to their General Practitioner (GP) this outlined what had been discussed at their appointment and any treatment options.
- We also observed the doctors behaving in a friendly and respectful manner towards the patients in their care.
- The Service provided chaperones where required for patients. We were told that staff were always available for this.

Emotional support

- We observed one person who was in pain and had become distressed. We saw staff deal with the person kindly and discreetly. Staff ensured that the person was moved to a private area where they were able to assist them.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Inadequate 

Out patients services were not responsive to people's needs.

The Trust fell below the national average (performed worse) with the percentage of people seen by specialist within 2 weeks, of an urgent GP referral for a suspected cancer.

The Trust had consistently failed to meet with the operating standard for NHS Consultant-led Referral to Treatment (RTT) waiting times over the past year. Some specialities performed worse. For example. Rheumatology where some patients were waiting 48 -49 weeks for appointment.

Patients were not being seen for follow up appointments within the timescale requested by their clinician. There were no alerting systems in place to warn staff that patients had not been seen for follow up appointments in a timely manner.

The new service redesign had been poorly implemented. As a result patients were waiting in long queues, being sent to the wrong areas, and being lost in the hospital and missing their appointments due to computer systems that were not fit for purpose.

Essential jobs had been missed in the service redesign as staff were not consulted about the job roles that they completed. As a result essential documentation about patient pathways was not being completed.

Clinical staff were consistently being pulled from their clinical duties to find patients who were lost in the hospital, and to check whether patients had booked in at main reception when they did not arrive for clinics.

Mistakes were being made with the dictation and typing of letters following appointments. These letters outlined the diagnosis and treatment of patients and mistakes could potentially put patients at risk of inappropriate treatment.

Service planning and delivery to meet the needs of local people

- Due to the reconfiguration of some clinics to specific sites booking staff were having problems booking patients for appointments as patients were refusing to travel the distance from Eastbourne to Hastings to attend their appointments at the Conquest site. Staff were not aware of any strategy to assist patients when this happened. Staff told us that they had received verbal abuse from patients who felt that they should have outpatient appointments offered to them closer to their home.
- The booking in system had been centralised in a recent review of services. We were told by most of the staff and members of the public that we spoke with that this had not been implemented well by the Trust and that patients had suffered as a consequence. The new system had caused confusion and long queues for patients. Staff said that the changes had been made too fast with no consultation with the staff that worked in the department. As a consequence staff felt that the current system was not fit for purpose.

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- The new design of the booking system meant that regardless of speciality all patients entering OPD were booked at a central desk in the entrance lobby. Patients were then entered into the system as having arrived and sent to the area that their clinic was in.
- The electronic system did not allow staff in the OPD areas to be informed which patients had arrived in clinic. We were told of many examples where patients were being sent in error to the wrong place in clinic. Because staff were not aware that patients had arrived at the hospital. When they didn't arrive in their clinics staff made the assumption that the patient had not arrived for their appointment.
- We were told many stories of the impact this had on patients. We saw documented evidence of a frail patient brought in by hospital transport that staff were not aware of until the transport arrived to take them home.
- The issues with this system had also affected staff who were struggling with their workloads as they routinely had to walk down to the main reception of the hospital to see whether patients that were not in clinics had arrived in the hospital. Staff told us they spent most of their time redirecting patients who were in the wrong place.
- As the Trust had not removed the appointment desks in the different areas of OPD we also saw many patients standing by unmanned desks waiting for staff attention. This was confusing for patients as they assumed that these desks were manned.
- We were told by staff that the new appointment desk in main reception was so busy that the queue there had on many occasions had been so long that it had stretched outside of the hospital entrance. Staff pointed out that many patients being expected to queue that length of time were frail or had issues with their mobility. We were told that queues had become so long that patients had missed their appointment times which had caused them a great deal of stress.
- Although we did not witness queues of this length on either site staff told us that the appointment lists for OPD had been reduced due to our inspection. We asked the Trust for data on the number of patients attending OPD and found that on the two weeks prior to our inspection across both sites OPD had booked 12,207 and 12,142 patients for appointments in total. On the

week of our inspection they had booked 9489 patients, and the week following our inspection they had booked 12,310. Therefore we had not seen the department running at its usual capacity during our inspection.

- Some patients complained to us that they were unable to contact the OPD via the telephone. Some said that the numbers they had no longer worked, others said that the line was either constantly engaged or rung without being answered. Staff acknowledged that this was a problem currently as due to the reconfiguration of services telephone numbers had changed. Appointments clerks told us that they often had patients who were frustrated with them as they had been unable to get through. They said that they always answered the phone as soon as they were able but were struggling under a heavy workload.

Access and flow

- The 'Two Week Wait' for patients with urgent conditions such as cancer and heart disease was implemented to ensure patients requiring rapid treatment are able to see a specialist more quickly. Patients have right to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected (The Handbook of the NHS Constitution Department of Health 2013).
- The Trust fell below the national average (performed worse) with the percentage of people seen by specialist within 2 weeks, of an urgent GP referral for a suspected cancer. The number of patients seen by a specialist within two weeks for the first quarter of 2014 was 93.1% where the average for England was 95%. For the second quarter of 2014 the trust saw 90.3% of patients within 2 weeks where the England average was 93.5%. The Trust consistently fell below the national average for the past year.
- The monthly National Statistics on NHS Consultant-led Referral to Treatment (RTT) waiting times were released on 10th July 2014 according to the arrangements approved by the UK Statistics Authority. During May 2014, 84.1% of admitted patients (The NHS operating standard is 90%) and 94.1% of non-admitted patients (The NHS operating standard is 95%) started treatment within 18 weeks. This meant that the Trust was not meeting with the operating standard for the NHS. From

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April 2013 the Trust had failed to meet with The NHS operating standard for ten months over that period. In the first three months of 2014 the Trust had fallen below 75%.

- We received complaints during the inspection regarding the wait that patients experienced to receive their appointments at the Trust. The majority of these complaints related to Rheumatology. Patients complained that they had to wait for around a year to be seen by the Rheumatology department.
- The monthly National Statistics on NHS Consultant-led Referral to Treatment (RTT) waiting times showed that in Rheumatology the proportion of patients seen within the allocated timeframe in the Out Patients department who did not require admitted treatment to hospital was 48.1%. The national operating standard is 95%. Data provided by the Trust showed that at the time of our inspection 783 patients were waiting to have their first appointment with the Rheumatology department. With 107 of these patients having already waited over 18 weeks for their appointment, 37 of these patients had been waiting over 39 weeks for their appointment. Trust staff told us that they were currently booking Rheumatology patients in for appointments between 48 and 49 weeks after their referral.
- Staff raised concerns about the amount of time that patients were waiting for Ophthalmology follow up and first appointments. Staff showed us folders full of referral letters that they told us they were not able to book within the timeframes required for follow up appointments. Staff had raised this issue with their managers and provided us with evidence of this. Staff also told us that by the time they were able to offer patients their first appointment they had often already gone elsewhere to have their treatment. During May 2014, 84.4% of admitted patients (The NHS operating standard is 90%) and 98% of non-admitted patients (The NHS operating standard is 95%) started treatment within 18 weeks. However it is worth noting that these figures only reflect the number of patients who have completed their pathways and not patients who are still waiting for an appointment.
- Other specialities that were consistently falling below the expected waiting time targets between April 2013 and June 2014 were Trauma and Orthopaedics, General Surgery, Oral surgery, and Gynaecology.
- Prior to the inspection staff informed CQC about a number of practices which the trust used to monitor and manage the flow of patients through the outpatients department. Staff reported that these mechanisms were not fair but apart from one example in relation to an individual patient, we did not find evidence that such practices were in general operation across the outpatients department.
- We found an example in the central booking office where a patient had been recorded incorrectly as having rung to cancel their appointment. A member of staff showed us one patient who was recorded as having rung to say they couldn't attend their appointment due to work commitments (which were very specific). When we asked how the member of staff knew this to be incorrect they told us that the appointment was for someone they knew personally who did not work in the area specified and had not rung to cancel their appointment.
- Since the OP service redesign we found that essential documentation of patient pathways through OPD had not been recorded. Once a patient was seen in clinic they were given a sheet of paper to hand in at reception which detailed the decisions that had been made during their consultation. Since the service redesign this documentation had not been collected and recorded by reception staff consistently. This may have been due to patients not wishing to queue up again at main reception, or misunderstanding the need to return the documentation to staff. Without this paperwork the Trust cannot accurately record patient waiting times for the 18 and two week pathway data.
- The manager responsible for investigating these incidents across both sites told us that before the redesign of the service they found that on average around ten patients a month did not have this documentation completed and that they were easily able to track the patient's journey through the department and rectify the problem. However, since the redesign of the service the manager had received 874 cases of incomplete documentation. They told us that due to the numbers involved, and the difficulty they would have tracking the patients journey through the service that it would be, "virtually impossible", for them to collect the missing documentation. This meant that at the time of our inspection the Trust was unable to

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report accurate data for their 18 week and 2 week waiting times. Additionally, patients may not be getting the next appointment for care or treatment in a timely or appropriate way.

- The Trust had no alert system in place to inform staff when patients follow up appointment dates were required or overdue. This meant that staff could miss dates because they were not alerted to them. Staff responsible for booking these appointments across both sites told us, “We are usually made aware because the patient will ring and tell us that they are overdue on their appointment, we are unaware of this because nothing on our system tells us”.
- Staff responsible for booking follow up appointments across both sites told us that clinic spaces for follow up appointments did not meet with demand. They also told us that they were given mixed messages from managers regarding booking patients for follow up appointments. Many staff members told us that they were repeatedly being asked to cancel patients follow up appointments. They said that they were booking patients far beyond the dates that had been requested by the consultant.
- We sampled four random patient booking records in the central booking office. We found that all four patients had not received follow up appointments within the time that they should have. All four had also had appointments cancelled at least once. For example, one patient who should have had a six month follow up appointment had had two appointments cancelled and was currently booked 18 months after the initial consultation.
- Clinic delays were recorded on essential care round documentation which was completed for each clinic. Staff were told to announce delayed clinics once they got to a one hour delay. We were shown essential care round documentation that had been completed by staff.
- Staff told us that some clinics ran consistently late, they identified some clinics as worse than others with Ophthalmology regularly having a two to three hour waiting time. We asked the matron if they audited the time that patients waited for their appointments they told us that they did not.
- 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 told us that this was inefficient as they could have typed the letters themselves in the time it took to check them.

- They gave us many examples of where incorrect translation of dictation could have been embarrassing to the Trust or a risk to patients in the case of medical terminology being incorrect. For example, One patient who when describing their hearing as ‘symmetrical ears’ was written as the patient having ‘magical ears’. Another where a lady had been recorded as having had a Vasectomy, a third where ‘Brain scan’ was recorded rather than ‘Bone Scan’.
- The Trust rates for patients not showing up for their appointments were consistently higher than the England average. In July 2014 3301 patients had failed to attend their appointments (DNAs) in August 2014 2442 patients had failed to attend. The trust had an ‘opt in’ system for text messages reminders for appointments. Staff we spoke with told us that there were issues around appointment letters being sent. One doctor wrote to us saying, ‘One of the patients was a member of staff, when I asked her she had had no letter from the Trust advising her of an appointment. This has not been an unusual scenario since central booking came in to place’.
- The Maxillofacial unit (MFU) had produced a report investigating DNA rates in evening clinics. They found that in their clinics running 9am-5pm Monday to Friday 11.8% of patients DNA’d. Whereas in clinics running Monday to Friday between 5pm and 8pm the percentage went up to 25%. The results of this survey were fed back at the clinical governance meeting for MFU.
- Post room staff told us that they were ‘not allowed’ a computer in their department which meant that when they received letters that were addressed incorrectly they were unable to redirect them to the right department using the trusts own intranet.

Meeting people’s individual needs

- The OPD was able to access telephone translation services for patients.
- The OPD shared information booklets with the relatives or carers of patients with learning difficulties to help

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them to understand what would happen at their appointment. For example, we were shown a booklet which explained in an easy read format what would happen during a breast examination.

- The audiology department had hearing loops to assist patients with hearing impairment.
- Information leaflets were available in different languages upon request. The department was also able to access information leaflets in easy read formats.

Learning from complaints and concerns

- We discussed complaints with the matron and OPD sisters who all demonstrated a good understanding of the Trusts procedures when dealing with complaints.
- We spoke with The Patient Advice and Liaison Service (PALS) who told us that there had been a sharp rise in the number of complaints about OPD particularly in the booking of appointments since the changes to the service. They had received 37 complaints on the Eastbourne Site relating to OPD booking in August 2014.
- We did not see evidence from staff meeting minutes that complaints were discussed with staff during these meetings. Staff that we spoke with could not tell us how complaints were discussed and service improvement made as a team.
- We were able to see examples on notice boards around the department where the OPD had listened to patients feedback on patient surveys and had improved the service as a result. When we talked about complaints staff referred to these examples.

Are outpatients services well-led?

Inadequate 

We saw that leadership in the outpatients service was inadequate.

Vision, values and strategy had not been developed with staff in the department. Staff felt undervalued. Staff were not invested in the department changes as they felt they had been forced upon them. This had resulted in unhappy staff and a poorer experience for patients.

Strategies were in place to centralise services. The impact of the changes which had been made too fast and without consulting staff about the essential roles in the department had meant that processes were not robust which had affected the delivery of care to patients.

We were unable to see clear leadership within the department. Many issues were raised during our inspection that had not been recognised and raised as problems. Where the Trust was aware of issues such as the 18 week waiting time breaches and lack of appointment slots for follow up appointments. There were no robust systems in place to deal with this.

Many administration staff sought us out during our inspection to tell us how unhappy they were in their roles following the recent changes in the service and their job roles. They told us that they felt undervalued, and not listened to. Many of these staff did not know who their manager was and felt unable to raise their concerns.

Some staff wanted to discuss with us a culture of bullying in the Trust. They told us that when they had raised concerns they had been disadvantaged as a result of this.

Vision and strategy for this service

- Staff we spoke with were aware of the current changes in their department and were aware that the vision and strategy for their department was to centralise services and booking in systems. Staff were feeling concerned about the strategy for the OPD future. Staff were aware that services were being centralised, they also understood that their roles were either changing, had changed or were under review. However, they felt that patients were receiving a poor service from their department currently and felt frustrated. For example one staff member said, "We work hard to give patients the best experience, but we are failing because the department isn't working well at the moment. We are letting patients down and it upsets us".
- Although some staff told us that they understood the reasons behind the changes that had been made to the department they all told us that these changes had been made too fast and without a full understanding of the functions within the department.
- Strategies were in place to centralise services. The impact of the changes which had been made too fast

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and without consulting staff about the essential roles in the department had meant that processes were not robust which had affected the delivery of care to patients.

- Vision, values and strategy had not been developed with staff in the department. Therefore staff felt undervalued. Staff were not invested in the department changes as they felt they had been forced upon them. This had resulted in unhappy staff and a poorer experience for patients.
- Trust wide communications had been displayed in staff areas for staff to read.

Governance, risk management and quality measurement

- 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.
- There were no leadership meetings within the department although these were to be implemented from September 2014. This meant that senior staff missed opportunities to manage a team approach to governance and feedback any learning from governance to staff.
- There was some alignment with what staff perceived as a problem and the issues that were on the departments risk register such as issues with Health records. However, many of the issues raised with us during the inspection had not been identified as a risk within the department. Two examples of this are the recording of patient pathway documentation not being completed, and health records no longer being tracked.

Leadership of service

- We were unable to see clear leadership within the department. Many issues were raised during our inspection that had not been recognised as issues such as the tracking of health records. Without leaders identifying issues robust mechanisms to manage them were not in place.
- Administration managers did not have the capacity to deal with the numbers of problems that had been raised in their department due to the demands of the service and the breakdown of systems following the recent redesign of the services.

- This had left staff dissatisfied with the management arrangements within the trust with many staff unaware of who their direct line manager was.
- Where staff were raising issues they were telling us that managers were ignoring them or impotent to offer them assistance.
- Where the Trust was aware of issues such as the 18 week waiting time breaches and lack of appointment slots for follow up appointments. There were no robust systems in place to deal with this. Staff were showing us conflicting emails with instructions that contradicted themselves from different managers. Staff were unsure of what appointments they should be booking. We were shown emails as evidence of conflicting advice given to staff on booking follow up appointments for patients.
- Communications we were shown indicated a sense of panic and an unstructured approach to sorting out the issues with a lack of appointment slots.
- Many staff told us about a sense of mistrust in the management in the Trust. They talked of data being manipulated, and we were told by a few members of staff that the Trust had decided it was cheaper to pay the fines imposed for breaches in the 18 week pathway than it was to put on the extra clinics required to sort the issue out.
- Staff from all groups told us that they were feeding their concerns regarding the changes to the service and their job roles back to their managers during one to ones and staff meetings but that they felt nothing was being resolved, and their questions were not being answered by the Trust.
- All of the nursing staff that we spoke to told us that they felt supported by the matron and sisters in the OPD. Nurse Managers also told us that they were in turn supported by their manager.
- Most staff told us did not feel engaged with the executive team, and felt that they were not interested in hearing their views.
- The matron and sisters of the OPD had not had a meeting for over 18 months. This had been raised as a concern and as a result a meeting was scheduled to take place in September 2014.
- Estates staff were concerned about cuts being made to their service. They told us that there were not enough staff and that staff were not being developed in their roles. One member of estates staff described the Trusts strategy as, "Oil bought in cheaply to run the engine".

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Culture within the service

- We had some examples brought to us during our inspection from staff who felt that they had been bullied by managers in the Trust these were mostly staff working in administrative roles within the trust. Some of these staff told us that they had raised their concerns formally but had been dissatisfied with the response to their concerns. Two people told us that despite their concerns being formally acknowledged and their complaints of bullying upheld they had been disadvantaged in their career as a result of making the complaint. One of the staff described this as feeling, “persecuted for speaking out”.
- We also had examples brought to us where staff had felt unable to report their concerns for fear of retribution. One manager told us that they had staff crying in their office regularly due to bullying from a senior member of staff, they said “They wear the number of grievances staff have raised against them like a badge of honour, they boasted about staff that had complained about them previously. They said that they had made them leave, and then ensured that they didn’t get jobs elsewhere”.
- Occupational Health staff raised concerns with us about the numbers of staff referrals that were related to stress following the recent changes in the Trust. They told us that they were struggling to cope with the current high demand of referrals. Other staff told us that managers dissuaded staff from writing stress down as their reason for sickness and absence from work. In the Staff survey of 2013 the Trust rated worse than the national average for work pressure felt by staff, and staff suffering from work related stress.
- We saw staff interacting with their managers and saw that they did this in a relaxed and friendly way. The managers were seen supporting more junior members of staff when it was required.

Public and staff engagement

- The Trust had redesigned the service to create a central booking system with administration reallocated to generic roles. Staff were seeking us out during the inspection across both sites to tell us a consistent message about the failings in this process that they felt had been done far too quickly, and without fully consulting staff and understanding their roles. As a consequence essential administration roles had been

missed in the redesign such as the tracking of patient health records and the recording of appointment outcomes. These omissions put patients at risk of missed appointments, and lost health records.

- Staff we spoke to were aware of the issues in the OPD around the new booking system. Staff told us that they were sometimes dealing with the stress that managing sometimes angry patients due to the problems this brought about. One member of staff described this by saying, “We are the face patients see and they are frustrated, it’s not our fault but we bear the brunt of it”.
- Another member of booking staff told us, “most days I will have patients shouting and swearing at me down the phone, I always ask them not to swear at me, but I can understand their frustration”.
- Staff felt that they had been forced to make decisions about their roles without the support that they required to do this. For example administration staff had been told that they needed to make a choice between two job roles. They told us however, that they had not seen the job description for either role and were forced to make a decision without a full understanding of their choices.
- Staff were passionate about wanting to do a good job and wanting to work as advocates for their patients. They felt that their voices were not being heard. We spoke with many Administration staff across both sites who all repeatedly used the same words to describe how they felt – ‘undervalued, overworked, not listened too, deskilled’. They also said that they were open to change but that they wanted it to be done with consideration so that patients were not adversely affected.
- Patient views were gathered through continuous patient surveys. Notice boards in all OPD areas showed visitors and patients how their comments and complaints had been used by the OPD to improve patient’s experience of the service.

Innovation, improvement and sustainability

- Staff told us they felt impotent in making positive changes to the service. They said that where they had raised concerns or issues that their questions were not being answered.
- Staff from administration and nursing roles including department managers all told us that they had not been consulted about the changes that had been made in the

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redesigning of the service. They all gave examples of where a misunderstanding of their job roles and responsibilities had meant that routine jobs were no longer being done. For example, medical records being tracked. Staff told us that these were decisions that were made and influenced outside of their department and did not therefore feel able to make changes.

- In the 2013 Staff Survey the Trust fell below the national average for staff being able to contribute towards improvements at work, and good communication between senior management and staff.
- The department relied on the goodwill of its staff in being flexible with their shifts and taking on extra hours. This meant that, the way that the department was staffed might not be sustainable in the long term.

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.

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing</p> <p>Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:</p> <p>Staffing</p> <p>In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.</p> <p>Why you are failing to comply with this regulation:</p> <ul style="list-style-type: none">• Staffing levels do not always take into account the patient acuity and turnover.• There is inadequate medical cover in many areas within Eastbourne hospital.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff</p> <p>Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:</p> <p>Supporting workers</p> <p>23. (1) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by—</p>

Compliance actions

(a)receiving appropriate training, professional development, supervision and appraisal; and.

(b)being enabled, from time to time, to obtain further qualifications appropriate to the work they perform..

(2) Where the regulated activity carried on involves the provision of health care, the registered person must (as part of a system of clinical governance and audit) ensure that healthcare professionals employed for the purposes of carrying on the regulated activity are enabled to provide evidence to their relevant professional body demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise.

(3) For the purposes of paragraph (2), “system of clinical governance and audit” means a framework through which the registered person endeavours continuously to—

(a)evaluate and improve the quality of the services provided; and.

(b)safeguard high standards of care by creating an environment in which clinical excellence can flourish.

Why you are failing to comply with this regulation:

- Staffing arrangements for the community midwifery service are not compliant with the European Working Time Regulations 1998.

Regulated activity

Maternity and midwifery services Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Care and welfare of service users

9. (1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of—

Compliance actions

(a) the carrying out of an assessment of the needs of the service user; and.

(b) the planning and delivery of care and, where appropriate, treatment in such a way as to—

(i) meet the service user's individual needs,.

(ii) ensure the welfare and safety of the service user,.

(iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment, and.

(iv) avoid unlawful discrimination including, where applicable, by providing for the making of reasonable adjustments in service provision to meet the service user's individual needs..

(2) The registered person must have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services, in order to mitigate the risks arising from such emergencies to service users.

Why you are failing to comply with this regulation:

- Handovers on the labour ward do not ensure that the service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe
 - Multidisciplinary team working at the Conquest Hospital does not ensure that the service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe
- There is not consistent compliance to the management of VTE

Regulated activity

Maternity and midwifery services Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Consent to care and treatment

Compliance actions

18. The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Why you are failing to comply with this regulation:

- Staff do not have a sound understanding of how to obtain and record that informed consent has been sought before any clinical intervention.

Regulated activity

Maternity and midwifery services Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Records

20. (1) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of—

(a)an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and.

(b)such other records as are appropriate in relation to—.

(i)persons employed for the purposes of carrying on the regulated activity, and.

(ii)the management of the regulated activity..

(2) The registered person must ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are—

(a)kept securely and can be located promptly when required;.

(b)retained for an appropriate period of time; and.

(c)securely destroyed when it is appropriate to do so.

Compliance actions

Why you are failing to comply with this regulation:

- The outpatient department was not protecting patient's confidential data. Patient records were left in public accessible areas without staff present and failing to comply with the Data Protection Act 1998.
- 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 January 2009).

Ensure that medical records and other sources of confidential personal information are managed such that the service is compliant with the requirements of the Data Protection Act 2003 and the guidance issued by the professional associations and Royal Colleges.

Regulated activity

Maternity and midwifery services Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Safety, availability and suitability of equipment

16. (1) The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is—

- (a) properly maintained and suitable for its purpose; and
- (b) used correctly..

(2) The registered person must ensure that equipment is available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs.

Compliance actions

(3) Where equipment is provided to support service users in their day to day living, the registered person must ensure that, as far as reasonably practicable, such equipment promotes the independence and comfort of service users.

(4) For the purposes of this regulation—

(a) “equipment” includes a medical device; and

(b) “medical device” has the same meaning as in the Medical Devices Regulations 2002(1).

Why you are failing to comply with this regulation:

Resuscitation equipment in the out patients departments was not all fit for purpose.

Emergency equipment is not regularly checked.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations
2010 Management of medicines

Regulation 13 of the Health and Social Care Act 2008
(Regulated Activities) Regulations 2010, which states:

Management of medicines

13. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Why you are failing to comply with this regulation:

- The management of medicines within the ED, including storage and recording of temperatures, was not being carried out in accordance with national guidelines
- In Outpatients it could not be assured that medicines were stored at the correct temperatures.

Compliance actions

- In Outpatients medicines were not being prescribed and dispensed in line with relevant legislation. The department had not ensured that when medicines were prescribed and dispensed the prescription and dispensing complied with relevant legislation.

Regulated activity

Maternity and midwifery services Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Assessing and monitoring the quality of service provision

10. (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to—

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and.

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity..

(2) For the purposes of paragraph (1), the registered person must—

(a) where appropriate, obtain relevant professional advice;.

(b) have regard to—.

(i) the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19,.

Compliance actions

(ii) any investigation carried out by the registered person in relation to the conduct of a person employed for the purpose of carrying on the regulated activity;.

(iii) the information contained in the records referred to in regulation 20;.

(iv) appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a));.

(v) reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these Regulations, and.

(vi) periodic reviews and special reviews and investigations carried out by the Commission in relation to the provision of health or social care, where such reviews or investigations are relevant to the regulated activity carried on by the service provider;.

(c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to—.

(i) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and.

(ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies;.

(d) establish mechanisms for ensuring that—.

(i) decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person (P), and.

(ii) P is subject to an appropriate obligation to answer for a decision made by P, in relation to the provision of care and treatment for a service user, to the person responsible for supervising or managing P in relation to that decision; and.

(e) regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users..

Compliance actions

(3) The registered person must send to the Commission, when requested to do so, a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (1) are being complied with, together with any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

Why you are failing to comply with this regulation:

- The governance and incident reporting structure and the way information is collected does not ensure that data is accurate and robust in order to be used to inform service improvements.
- Outpatient staff do not report incidents in accordance with Trust policy and statutory requirements.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Respecting and involving service users

17. (1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure—

(a) the dignity, privacy and independence of service users; and.

(b) that service users are enabled to make, or participate in making, decisions relating to their care or treatment..

(2) For the purposes of paragraph (1), the registered person must—

(a) treat service users with consideration and respect;.

(b) provide service users with appropriate information and support in relation to their care or treatment;.

(c) encourage service users, or those acting on their behalf, to—.

Compliance actions

(i) understand the care or treatment choices available to the service user, and discuss with an appropriate health care professional, or other appropriate person, the balance of risks and benefits involved in any particular course of care or treatment, and.

(ii) express their views as to what is important to them in relation to the care or treatment;

(d) where necessary, assist service users, or those acting on their behalf, to express the views referred to in sub-paragraph (c)(ii) and, so far as appropriate and reasonably practicable, accommodate those views;.

(e) where appropriate, provide opportunities for service users to manage their own care or treatment;.

(f) where appropriate, involve service users in decisions relating to the way in which the regulated activity is carried on in so far as it relates to their care or treatment;.

(g) provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement; and.

(h) take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have.

Why you are failing to comply with this regulation:

- The privacy and dignity of patients is not being upheld. There are same sex breaches within the Clinical Decision Unit (CDU).

Regulated activity

Maternity and midwifery services Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA 2008 (Regulated Activities) Regulations
2010 Complaints

Regulation 19 of the Health and Social Care Act 2008
(Regulated Activities) Regulations 2010, which states:

Compliance actions

Complaints

19. (1) For the purposes of assessing, and preventing or reducing the impact of, unsafe or inappropriate care or treatment, the registered person must have an effective system in place (referred to in this regulation as “the complaints system”) for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf, in relation to the carrying on of the regulated activity.

(2) In particular, the registered person must—

(a) bring the complaints system to the attention of service users and persons acting on their behalf in a suitable manner and format;

(b) provide service users and those acting on their behalf with support to bring a complaint or make a comment, where such assistance is necessary;

(c) ensure that any complaint made is fully investigated and, so far as reasonably practicable, resolved to the satisfaction of the service user, or the person acting on the service user’s behalf; and.

(d) take appropriate steps to coordinate a response to a complaint where that complaint relates to care or treatment provided to a service user in circumstances where the provision of such care or treatment has been shared with, or transferred to, others..

(3) The registered person must send to the Commission, when requested to do so, a summary of the—

(a) complaints made pursuant to paragraph (1); and.

(b) responses made by the registered person to such complaints.

Why you are failing to comply with this regulation:

- The complaints handling process does not ensure that the services learns and improves as a result.