East Sussex Healthcare NHS Trust

Conquest Hospital

Quality Report

The Ridge
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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	Requires improvement
Urgent and emergency services	Requires improvement
Surgery	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the Conquest Hospital as part of the East Sussex Healthcare NHS Trust inspection on 4,5 and 6 October 2016. The trust had been previously inspected in September 2014 and March 2015. On both inspections we identified serious concerns and gave the hospital an overall rating of inadequate. The trust was rated inadequate overall because the two location reports and the concerns that we identified across the trust relating to culture and governance. A Quality Summit which included all key stakeholder organisations was held in September 2015 and, following that meeting, I recommended that the trust be placed into 'Special Measures'. This meant that the trust was subject to additional scrutiny and support from the local clinical commissioning groups and NHSI who provided an improvement director to advise and to monitor the implementation of action plans to address the shortcomings identified. The commission also maintained a heightened programme of engagement and monitoring of data and concerns raised directly with us.

This inspection was specifically designed to test the requirement for the continued application of special measures at the trust. Prior to inspection we risk assessed all services provided by the trust using national and local data and intelligence we received from a number of sources. That assessment led us to include six acute hospital services (emergency care, surgery, maternity and gynaecology, children and young people, end of life care and outpatients) in our inspection. The two other acute hospital services (medicine and critical care) and community services were not inspected as they had indicated good performance at previous inspections and our information review suggested that this had been sustained.

We did consider how medical services and the high number of medical patients impacted on patient flow and whether this affected other core services. We also visited medical wards as part of the review of end of life care.

We did not inspect community services as part of this inspection as they were currently rated 'good' overall. We did consider where new initiatives developed by the community services impacted upon the work of the two acute hospitals.

Following this inspection we have re-rated the services inspected. For other services we have maintained ratings from previous inspections. We have aggregated the ratings to provide an overall rating for the trust of requires improvement.Caring was rated as good, whilst safe, effective, responsive and well-led are all rated as requires improvement. This constitutes a significant improvement from the previous rating of inadequate.

.Our key findings were as follows: -

SAFE

- The incident reporting culture had been significantly improved.
- We saw clear evidence of learning from a Never Event with robust investigation and embedded changes to practice across the hospital.
- Staff understanding of duty of candour had improved.
- Infection control oversight had been significantly strengthened and hand hygiene practice was largely compliant.
- We were able to see fledgling improvements in the provision of services trustwide with clear indicators of positive changes from data provided by the trust and from national data we hold at CQC about the trust.
- Daily 'Safety Huddles' were being rolled out across the hospital. These encouraged the wider multidisciplinary team to share concerns and consider ways to improve the care of patients.
- Where compliance with VTE risk assessment and prevention had been a concern in our previous inspection report, there was now evidence of high rates of compliance with 95% of patients having a properly completed VTE risk assessment in July 2016.
- Safeguarding vulnerable adults and children was given sufficient priority.

Summary of findings

- Medicines management processes had been significantly improved.
- The transfer of patients from ambulance to the emergency department was subject to delay and not being monitored.
- There was a significant backlog in the reporting of x-ray examinations.
- Record keeping was not consistent across the trust notably in the documentation of risk assessments within the emergency department and full completion of risk assessments in paediatric services.
- Where electronic recording and escalation of observations had been introduced this had demonstrably improved the outcomes for patients.
- Staff recruitment continued to be problematic with high levels of bank and agency use in some areas. There were departments such as the emergency department where the staffing arrangements were not in line with the national recommendations.

EFFECTIVE

- Pain was managed well with new initiatives in the care of children and young people and better recording of pain scores across the hospital.
- Stroke services had been consolidated at the Eastbourne site. A recent report issued by the Stroke Association in November 2016 showed that the hospital was providing good access to stroke services.
- End of life care and emergency departments were not meeting national audit standards in some areas.
- The assessment of mental capacity by staff remained inconsistent across the trust.
- The wishes of patients about the upper limit of treatment when on an end of life care pathway was not always recorded. Staff had not always discussed the 'ceiling of care with patients or their families.
- There were no services now rated as inadequate
- Policies were largely up to date and referenced by best practice, with the exception of maternity services.
- Surgery services were no longer an outlier for clinical outcomes.
- Auditing programmes were more developed than on previous inspection visits but further work was needed to ensure that the full cycle of data collation being used to drive improvements needed further embedding.

RESPONSIVE

- The emergency department indicated a deteriorating performance against access standards.
- The trust was not maintaining the delivery of treatment to patients within 18 weeks of referral from GP's or within 62 days for patients referred onto a cancer pathway.
- Patient flow through the hospital was challenged leading to patients being cared for in suboptimal clinical areas.
- A Frailty Nurse Specialist team had been set up to work across the acute hospitals and community services to reduce the number of unnecessary admission (particularly from care homes) and to support patients who were best cared for in the community.
- Patients on an end of life care pathway did not have access to a rapid discharge service.
- The outpatients service was no longer rated as inadequate with significant improvements to the call centre.
- The hospital staff tried to ensure that the individual needs and preferences of patients were met. Our previous report from September 2014 talked about staffing shortages and a culture that led to task focussed nursing care and a lack of consideration of individual needs. This was not something we observed on this inspection visit.
- The trust was very responsive to meeting the complex needs of patients notably those living with dementia or learning disabilities.
- Appropriately trained staff were not available to support children who were particularly anxious or in pain through play
- Response times to complaints had improved significantly since April 2016. We saw evidence of appropriate responses to complaints, and learning from complaints and concerns. The trust had improved the way they responded to complaints as well as the response times.

Summary of findings

WELL LED

- No services were rated as inadequate for leadership.
- The senior leadership was now sighted on operational and strategic issues and had clear and well considered plans for service improvement.
- Staff told us that the executive team were much more visible around the hospital than they had been prior to the appointment of the new chair in January 2016 and new chief executive in April 2016.
- Nursing staff also talked to us about the Director of Nursing (DoN) who was felt to be a consistent and steadying influence as the trust went through a period of significant change. Nurses said they trusted the DoN and felt she was ever present, approachable and understood the challenges at ward level.
- The organisational culture had transformed since our last inspection. Staff were largely positive, well engaged and felt valued by the organisation. However, there were areas where staff were still feeling daunted by the changes and where morale was low. This was particularly the case with medical records and some administrative staff where the systems they worked with and, in some cases, their place of work had changed.
- Governance had been significantly strengthened in terms of structure and the quality of board papers and data.This had led to a strong sense of accountability within the trust.
- The senior team remains relatively new in constitution and some elements of governance and performance management have only recently been introduced
- The trust was yet to complete the transition to a new operational structure.
- At service levels our inspection identified some weaknesses in the management of risk and mortality.
- Innovation was now encouraged and we saw several areas where staff had been encouraged and supported to introduce changes to bring about improvements in quality and safety. Staff felt more engaged in developing the service and were allowed more involvement in how services were provided.

We saw several areas of outstanding practice including:

- Following the project lead midwife's maternity review, the trust had introduced a programme of project groups related to maternity. These included the pilot scheme of a new homebirth and triage role for community midwives, and a perinatal mental health specialist midwife role.
- A consultant orthopaedic surgeon had written a national guide for the Royal College of Surgeons on avoiding unconscious bias which was published in August. The guide focused on overcoming the unconscious opinions that everyone forms about people when they first meet them and offered advice to get beyond this. This national guidance referenced the trust's Anti-bullying Policy in the Doctors' Clinical Handbook and highlighted the progress and work made within the trust to address perceptions of bullying and harassment.
- We saw an example of best practice for care provided to dental patients with special needs or learning disabilities.A multidisciplinary planning meeting was conducted in advance of the attendance. The appointment was used to provide one stop care including taking bloods, scans and giving the patient a haircut to minimise distress to the patient. There were a variety of options provided for location; aspects of care could be initiated in different locations such as properly supported sedation in the patient's home and anaesthesia in the car park or in the hospital depending on the need.
- A dedicated multidisciplinary team had established a five-year plan to establish an innovative rehabilitation care plan as part of an out of hospitals services transformation programme. This programme included staff from multiple specialties and enabled ED staff to work with colleagues from across the trust and in the community to develop future services, including an ambulatory rehabilitation unit and a rapid access care service. The programme planned to introduce nurse practitioner roles for frailty, crisis response and proactive care who would provide an integrated rehabilitation service alongside hospital and community-based specialists. This programme would significantly

improve working links between the trust's hospitals and local authority social care services and enable rehabilitation services to be provided more responsively to avoid the need for hospital admissions. There was significant support and infrastructure for staff to develop this programme and they had been invited to present their plans and work so far at a national Health and Social Care Awards ceremony.

- Patients on a cancer pathway had a dedicated booking team in the booking centre. All referrals were received electronically and an email was sent to the GP to indicate it had been received. The booking team escalated concerns about appointments to service managers. Weekly cancer patient tracking list meetings provided clinical oversight of patients on cancer pathways.
- The paediatric team had introduced a 'consultant of the week' system whereby a designated consultant answered enquiries from local GPs about sick children in their care. This recent initiative had reduced the number of admissions because GPs had a specific point of contact and could be supported to care for the child in the community, where practical.
- An entrepreneur programme was being established that focused on the reduction of ambulance handover delays.
- There were good initiatives being developed and encouraged to meet people's individual needs. The hospital's League of Friends team had knitted comfort bands for patients, which helped them stop picking at intravenous lines. A 'distraction box' was also available to help provide stimulation for patients with dementia and reduce their anxiety in an unfamiliar environment. A nurse had developed a number of resources to help provide emotional support to parents who lost a child to sudden infant death syndrome.
- A member of the maintenance team had given up his own time to paint a mural on the wall of the recently decorated ultrasound unit to soften the environment for young patients

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

Importantly, the trust **must** :

- Ensure that consultant cover meets the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine.
- Must develop play services in line with national best practice guidance.

In addition the trust **should**:

- The surgery directorate should ensure completion of anaesthetic machine logbooks
- The surgery directorate should ensure compliance with: inadvertent perioperative hypothermia, NICE guidance clinical guideline CG 65.
- The surgery directorate should ensure accurate record keeping of controlled drugs in theatres.
- The surgery directorate should improve the quality, content and outcomes of mortality and morbidity meetings.
- The surgery directorate should ensure compliance with the guidance contained in venous thromboembolism (VTE) in adults: reducing the risk in hospital QS3.
- The surgery directorate should ensure compliance with National Patient Safety Alerts regarding safer spinal and epidural needles.
- The surgery directorate should ensure a consistent governance structure across the two surgical directorates.
- Review all maternity policies and procedures that are outside their review date and take action to ensure all policies reflect current national and evidence-based guidance.
- The hospital should discuss and record ceilings of care for patients who have a DNACPR.
- The trust should have a defined regular audit programme for the end of life care service.

Summary of findings

- The trust should record evidence of discussion of an end of life care patient's spiritual needs.
- The trust should implement a formal feedback process to capture bereaved relatives views of delivery of care.
- The trust should ensure that all staff received regular mandatory training for end of life care.
- The trust should provide a formal referral criterion for the specialist care team for staff to follow.
- The trust should define and streamline their end of life care service to ensure staff are clear of their roles and who to contact.
- Develop a rapid discharge process for end of life care patients to be discharged to their preferred place of death.

  Extend the Palliative care team service to provide support and advice over the full seven days. As the hospital did not currently have this provision, some patients did not have access to specialist palliative support, for care in the last days of life in all cases.
- Work towards meeting the requirements of the key performance indicators of the National Care of the Dying Audit (NCDAH) 2016.
- Continue to consider ways to improve staff recruitment and retention such that it meets the national recommended levels.
- Play services should be developed and a play specialist employed.
- The trust should ensure incidents occurring in the ED are investigated thoroughly and all staff are included in the dissemination of the outcomes.
- The trust should ensure nurse to patient ratios in the ED are managed in relation to the individual needs of patients based on acuity.
- The trust should ensure that RTT is met in accordance with national standards.
- The trust should ensure that standard for patients receiving their first treatment within 62 days of an urgent GP referral is met.
- The diagnostic department should ensure all policies and procedures are up to date.
- The diagnostic imaging department should ensure they have a recent audit from their Radiation Protection Advisor.
- The diagnostic imaging department should monitor their waiting times and reporting times.
- The diagnostic imaging department should ensure staff attend mandatory training in line with the trusts target.
- The maternity services should ensure medication locks are suitable and do not allow unauthorised patient access.
- The maternity services should ensure there is a clear procedure documented for pool evacuation.
- The trust should consider improving the environment in the Day Assessment Unit waiting area as flooring could be a trip hazard and the room is unwelcoming.
- The maternity services should ensure a robust mechanism is in place to monitor and audit abortion HSA4 notification completion.
- The maternity services should ensure resuscitation trollies are fully stocked with items that are in date, at all times.
- The maternity services should ensure cleaning schedules are adhered to and audit is appropriately used to monitor this in the obstetric theatres.
- The children's service should address the lack of storage space and cramped conditions on the Kipling ward.

Summary of findings

- The children's service should develop transition planning for children with long term conditions approaching adulthood.
- The children's service should improve efficiency of appointment and clinic booking systems to avoid long delays in accessing paediatric review and to improve efficiency.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Overall we rated urgent and emergency services as 'requires improvement' because: • Staff worked in a culture that empowered them to report incidents. However, learning from incidents, including serious incidents, was limited and not all incidents had an investigation. In some cases, where an incident resulted in patient harm or occurred due to a staff mistake, appropriate training and support was provided. • Consultant cover did not meet the minimum requirements of the Royal College of Emergency Medicine and there was a significant shortage of middle grade doctors. Nurse staffing levels were variable and the department regularly operated with less than the number of nurses established, as needed to provide safe care. This increased risks to patients and the risk management and clinical governance systems had not addressed this. • Risk management in patient records was inconsistent and sometimes inaccurate. There was also variable standards in the monitoring of patients who were deteriorating. • There were significant variances in how staff assessed mental capacity and understanding of patients. This included contradictory, incomplete or inaccurate documentation. • Patients often experience lengthy delays while waiting for a mental health assessment, including referrals from the child and adolescent mental health team. There was also limited evidence staff were trained or equipped to provide care and treatment for patients with a learning disability. • Delays to triage and assessment increased patient risk. Although the senior leadership team implemented strategies to address this, there had been little substantive improvement at the time of our inspection. However we also found areas of good practice:

Summary of findings

- There was consistent evidence the duty of candour was used in relation to incidents to maintain transparency and communication with patients and relatives.
- Medicines management was of a high standard and nurse prescribers worked to Patient Group Directions.
- The trust had responded to risks associated with low levels of paediatric nurses by increasing training for existing staff and recruiting new nurses.
- A comprehensive programme of clinical audits was used to benchmark standards and quality of care against the guidance of organisations such as the National Institute for Health and Care Excellence.
- Multidisciplinary working was embedded in the department and a dedicated hospital interventions team provided physiotherapy, occupational therapy and nurse practitioner support during patient admissions and discharges. A crisis response team was available to help avoid unnecessary hospital admissions by organising care at home.
- An education programme was available to staff and included practical competency training from a dedicated practice development nurse as well as training from visiting specialists.
- Patients and their relatives were treated kindly, with dignity and respect and recommendation rates for the department were similar to the national average.
- Staff provided specific services to meet the needs of individual people. This included specialist support for patients living with dementia and translation resources for non-English speakers.
- Although the hospital consistently failed to meet the Department of Health target that 95% of patients be admitted, transferred or discharged within four hours, a programme of significant development was underway to improve all aspects of the service times, including triage, assessment and treatment.
- A frailty pathway service was in development to address the needs of the local population

and this service aimed to reduce the need for hospital attendances and admissions and ensure patients had better access to home or community services.

- A restructure of the clinical unit and management team was due to be completed by November 2016 and staff spoke positively about the increase in support, training and engagement they had experienced as a result of the changes. The department vision and strategy were included in a five year plan to improve access and flow through the department and improve specialist care pathways. A multidisciplinary team was also developing an innovative rehabilitation programme to ensure patients had access to support at home and reduce the need for repeat hospital attendances.

Surgery

Good

Overall, we rated the surgical service at Conquest Hospital as 'Good'. This was because:

- People were being protected from avoidable harm and abuse.
- Openness and transparency about safety was encouraged. Staff understood their responsibilities in relation to incident reporting. Incidents were investigated appropriately by staff with the necessary clinical knowledge and who had received training in leading such investigations. We were given examples of where changes to practice had been made following incidents. The service had experienced a 'never event' at the Conquest hospital which had involved the wrong administration route of a medicine. This had been rigorously investigated and changes had been made in order to ensure it was not repeated.
- The services, wards and departments were clean and staff adhered to infection control policies and protocols. Pragmatic solutions had been found to some of the problems that were identified during previous inspection visits. This included the appointment of staff known colloquially (and with some pride) as "Theatre

Summary of findings

Fairies". These staff kept the theatre environment clear of equipment, waste and other clutter that got in the way of safe and efficient theatre practice.

- Record keeping was comprehensive and audited regularly. Records were now tracked using a barcode tracking system and most patients had their full notes available for consultations. An off-site records storage system was being used and whilst some staff were still unhappy about the need to relocate, the records management was more effective and working in the best interests of patients.
- Decision making about the care and treatment of a patient was clearly documented. The electronic observation recording system had been used to drive improvement in the timely identification of patients at risk of unexpected deterioration. It had allowed for oversight of patients with elevated risk by the critical outreach team and concerns were escalated for review by the medical or surgical emergency teams more swiftly.
- Treatment and care was generally provided in accordance with the National Institute of Health and Care Excellence (NICE) evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. There were examples of effective multidisciplinary working.
- Performance against national audits such as patients with a fractured neck of femur (broken hip) audit showed evidence of good outcomes for patients.
- Leadership was good and staff told us about being supported and enjoyed being part of a team. There was evidence of multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.
- Development opportunities and clinical training was accessible and there was evidence of staff being supported and developed in order to improve services provided to patients.

Summary of findings

- Feedback from patients was continually positive about the way staff treated people. We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff.

However:

- There was not an effective system in place that ensured completion of anaesthetic machine safety logbooks.
- Controlled drug records in theatres were incomplete with some staff block signing for drugs.
- The content and quality of records for mortality and morbidity meetings required improvement.
- There was still a heavy reliance of temporary staff for both medical and nursing staff.

Maternity and gynaecology

Requires improvement

We rated this service as 'requires improvement' because:

- The triage system did not ensure all calls were answered in a timely manner and sometimes led to calls being missed.
- We were told of delays in the day assessment unit out of hours due to staff being moved to the delivery suite. We witnessed this during our un-announced inspection on a Saturday.
- Midwives were not always able to attend the daily risk meetings and feedback was not always ensured.
- Cleaning schedules in theatres were not always completed and we saw high level dust on inspection.
- Sterile equipment on the labour ward resuscitation trolley was not in date and two sterile packages were ripped open and left on the trolley.
- Mandatory training fell below trust targets in many areas across the whole department.
- Several of the maternity policies and procedures were outside their review date. This meant the service might not have worked to all the relevant and current evidence-based guidelines, standards or best practice.

Summary of findings

- There were delays for patients using gynaecology services and referral to treatment times were consistently worse than the 18-week target.
- Mirrlees ward was often taking patients that were not gynaecological patients (medical outliers).

However;

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Daily risk meetings and the sharing of incident learning ensured that staff learned from incidents to prevent recurrences.
- When staff identified issues we saw that they initiated projects to try and understand the causes for this. For example (HIE) cases were further reviewed to look for causes and possible actions to reduce recurrence.
- There was enough equipment to allow staff to safely treat patients. Equipment was regularly checked and maintained to ensure that it worked safely.
- Staff followed infection control procedures and demonstrated a good understanding of these. The use of personal protective equipment (PPE) was audited to ensure staff were following guidelines.
- Staff received mandatory training in safety systems, including responding to childbirth emergencies such as post-partum haemorrhage (and
- Safeguarding vulnerable adults and children was given sufficient priority. Staff received an appropriate level of safeguarding training to allow them to identify safeguarding concerns and knew how to raise these.
- Outcomes for people who used services were generally positive and met expectations.
- Appraisal rates met expected trust targets. Staff we spoke with found senior staff members supportive.
- Staff treated people with dignity, respect and kindness. Patients felt supported and said staff

Summary of findings

cared about them. We saw a rapid disciplinary response from staff members when a patient's dignity was not considered by a colleague who made an inappropriate comment.

- People and staff worked together to plan care and there was shared decision-making about care and treatment. Women's wishes were understood and met if possible with clear explanation if this could not happen.
- The service made reasonable adjustments to remove barriers when people found it hard to use or access services, for example, through provision of interpreters.
- The service had good links to services within the community and outside organisations such as GP surgeries and social services.
- Response times to complaints had improved significantly since April 2016. We saw evidence of appropriate responses to complaints, and learning from complaints and concerns.
- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.
- The service proactively engaged and involved all staff through the maternity service review and other channels and ensured that the voices of all staff were heard and acted on.
- Staff felt respected, valued and supported. All staff we spoke to felt the culture had improved since our last inspection, and gave us examples of positive improvements.
- The trust had a programme of project groups related to maternity, which drove improvements in different areas of the service.
- The culture within the trust was good and staff felt supported and listened too. Staff were proud of the department and their work colleagues.

Services for children and young people **Requires improvement**

We rated this service as requires improvement because:

Summary of findings

- The environment was generally cluttered with equipment stored in the corridor. One bay was crowded with insufficient space for the number of beds. This was rectified during our inspection.
- Feedback and learning from incidents was mixed with some staff saying that they didn't get feedback when they had reported an incident. We also heard that some incidents weren't reported as the process was too long or staff wouldn't report some incidents in case there were repercussions.
- Outpatient waiting times were excessive with 79 of 1106 patients waiting over 18 weeks for their appointment.
- There was no play specialist to lead and develop play services.
- There was no parents room that could be used to have private or difficult conversations
- The outside play area was not able to be used due to the type of flooring. The equipment available had also been left for so long that it was not fit for use.

However:

- Staff understanding of child safeguarding responsibilities, processes and protocols was well embedded. We found there was a strong focus on safeguarding when staff were caring for children.
- Although cluttered, the equipment on the ward and the ward was clean. This was reflected in the cleanliness and hand hygiene audits.
- The trust had appointed a consultant who had dedicated time to review all National Institute for Health and Care Excellence (NICE) guidelines and implement them.
- Internal auditing was comprehensive and each audit was given a priority rating.
- There was an appropriate response when a child's condition deteriorated.
- We observed compassionate care from all staff who had interaction with both children and their families

Summary of findings

- Safety huddles, which started at Eastbourne SSPAU and on the SCBU were introduced on the Kipling ward in August 2016
- We heard how the culture across the ward was supportive, praising and caring which promoted close working relationships across the teams.
- There was a published strategy for Womens and Childrens Services with explicit priorities and measurable performance indicators.
- There was clear leadership of the children's services with Board level representation.

End of life care

Requires improvement

Overall we rated the end of life care service at the Conquest Hospital as 'Requires Improvement'. This was because:

- The service did not have a programme of regular audits for end of life care.
- The trust provided formal training for some staff in end of life care. However, junior staff told us they were not confident at recognising an end of life care patient.
- The trust did not meet the requirements of the key performance indicators of the National Care of the Dying Audit (NCDAH) 2016.
- The trust had not implemented the standards set by the Department of Health and National Institute of Health and Care Excellence's (NICE) guidance.
- There were inconsistencies in the documentation in the recording of spiritual assessments, Mental Capacity Act assessments and recording of ceilings of care for patients with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form completed.
- Patients did not always have access to a specialist palliative support for care in the last days of life, as the trust did not have a service seven days a week
- We found the service did not have clarity in its leadership. It was disjointed without a clear line of objectives that the staff could understand or follow.
- There was no formal referral criterion for the specialist care team for staff to follow.

Summary of findings

- The risk register for the service was insufficient and did not reflect the needs of the service.
- The trust did not collate service user's views with a patients or bereaved relatives' survey.

However:

- The specialist palliative care team were a dedicated team who worked with ward staff and other departments in the hospital to provide holistic care for patients with palliative and end of life care needs in line with national guidance.
- Staff recognised that provision of high quality compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team and end of life care guidelines.
- Staff at the hospital provided focused, dignified and compassionate care for dying and deceased patients and their relatives. Most of the clinical areas in the hospital had an end of life care link staff member.
- Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.
- The hospital had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines.
- Areas we visited were visibly clean, tidy and fit for purpose. The environment was light, airy and comfortable.
- Medical records and care plans were completed, contained individualised end of life care plans and contained discussions with families. The DNACPR forms were all completed in accordance national guidance and the trust policy.
- The hospital had sufficient supplies of appropriate syringe drivers and staff were trained in their use.
- Out of hours telephone support for palliative medicine was provided by the local hospice.

Summary of findings

- A current end of life care policy was available and a steering group met regularly to ensure that a multidisciplinary approach was maintained.

Since the inspection visit in September 2014 there have been a number of improvements to the end of life care provided at the Conquest Hospital. There are still areas where further improvement is needed but greater consideration was being given to identifying and meeting the needs of this group of patients. Some significant changes to the safety of the service that were evident included much better understanding of the rationale for reporting incidents and a more robust investigation process. We saw evidence across the hospital that there was now a commitment to sharing learning when things went wrong. The trust now had a single type of syringe driver for use with patients.
Patients with an end of life care plan were now identified at bed meetings and there was a commitment from senior staff that these patients should be cared for in single rooms, without being moved around, whenever possible. We attended the bed meetings and saw this happened in practice.
Completion of DNACPRs was now good. The records showed that there had been discussion with the patients and/or their relatives. There was consultant review of any decision made by a more junior doctor regarding resuscitation. Work still needed to be done to support staff around 'ceiling of care' discussions but overall there were significant positive changes in practice relating to the identification of people approaching end of life, the use of DNACPRs.

Outpatients and diagnostic imaging

Requires improvement

We found the outpatient and diagnostic imaging services at Conquest Hospital to be requires improvement. This was because:

- There were 22,000 patient x-rays awaiting a report and a diagnosis.
- Staffing numbers in the diagnostic imaging department were 33% below the numbers required to cover all examinations and the on call rota.

Summary of findings

- The trust referral to treatment time (RTT) had fallen below the 92% standard from March 2016 onwards, but had been the same as the England average since July 2015.
- The trust was performing much worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.
- Morale was low in the diagnostic imaging department. Staff felt they were not consulted on changes in the structure of the department and that there was disconnect between staff and managers.
- The outpatient department had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines.
- Areas we visited were visibly clean, tidy and the environment was light, airy and comfortable.
- A wide range of equipment was available for staff to deliver a range of services and examinations.
- Medicines were stored in locked cupboards and administration was in line with relevant legislation.
- Staff kept medical records accurately and securely in line with the Data Protection Act 1998.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- The outpatient services had sufficient numbers of appropriately trained competent staff to provide their services.
- Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- Staff interacted with patients in a kind, caring and considerate manner and respected their dignity. Patients told us they felt relaxed when having their treatment.
- The hospital was responsive to the needs of the local populations. Appointments could be accessed in a timely manner and at a variety of times throughout the day.

Summary of findings

- Staff in the outpatient department felt their managers were visible, approachable and effective.

Conquest Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Surgery; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Conquest Hospital

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

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

East Sussex Healthcare NHS Trust is one of a number of Trusts across England with a longstanding and significant financial challenge. Their aim this year is to reduce the deficit from £48m to £31.2m. It was placed in 'Financial Special Measures' in October 2016 by NHSI. Financial Special Measures were introduced by NHS England and NHS Improvement (NHSI) to improve Trusts' financial and operational performance. As part of these measures, NHSI appoint a Financial Improvement Director who works with them to oversee the development of a robust financial recovery plan. Whilst the financial situation impacts on how the trust provides services, CQC does not report on this aspect of the trust's work. Our remit is to focus on the quality and safety of the services that are being provided.

The Trust serves a population of 525,000 people across East Sussex. It provides a total of 833 beds with 661 beds provided in general and acute services at the two district general hospital and community hospitals. In addition there are 45 Maternity beds at Conquest Hospital, and the midwifery led unit and 19 Critical care beds (11 at Conquest Hospital, 8 at Eastbourne District General Hospital).

At the time of the inspection there was a new Trust Board which included a Chairman, five Non-executive directors, Chief Executive and Executive directors. The Chair was appointed in January 2016for a period of four years. The Chief Executive Officer joined the Trust in April 2016. The Non executive directors have varying lengths of service with the trust with some appointed quite recently and others being more established. Other new appointments since our last inspection include the Chief Operating Officer, the Medical Director and the Finance Director who all started work during 2016. Some stability and continuity were provided by the Human Resources Director, Director of Nursing and Director of Corporate Affairs who had all been in post prior to the previous inspections and were overseeing the implementation of the action plan.

The trust's main Clinical Commissioning Group's (CCG) are Eastbourne, Hailsham and Seaford Commissioning Group, Hastings and Rother Clinical Commissioning Group and High Weald, Lewes and Havens Clinical Commissioning Group.

Detailed findings

We carried out this focussed inspection in October 2016. We held a series of focus groups with staff from across the trust in the week preceding the inspection. Teams, which included CQC inspectors and clinical experts, visited the two acute hospitals. We spoke with staff of all grades, individually and in groups, who worked in acute and community settings. We also carried out an unannounced inspection visits after the announced visit.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop

Head of Hospital Inspection: Alan Thorne, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: The team of 52 that visited across the Trust on4, 5, 6,October 2016 and the team who visited the hospitals on16 October 2016 included senior CQC managers, inspectors, a data analyst, an inspection planner registered general nurses and sick children's nurses, consultant midwives, a theatre specialist, consultants and junior doctors, a pharmacist, therapists, a radiographer and senior NHS managers.

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 six core services across East Sussex Healthcare NHS Trust –

- Accident and emergency services
- Surgery
- 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), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC)and the local Healthwatch.

We received comments from people who contacted us to tell us about their experiences and people who posted written responses in comments boxes that we put in the hospital. We also used information provided by the organisation.

We held a series of focus groups with staff of all grades from across the organisation, to listen to their views and hear about the impact of the changed made since the last inspection.

We made an announced inspection of the Trust services on4, 5, 6, October 2016 and an additional unannounced inspection visit to both acute hospitals on 16 October 2016. 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.

Detailed findings

Facts and data about Conquest Hospital

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

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

In the latest full financial year, the trust had an income of £356,152,000 and costs of £403,911,000. This meant overall it had a normalised deficit of £47,997,000 for the year. The trust predicts that it will have a deficit of £41,700,000 in 2016/17.

As at June 2016, the trust employed 5726.26 staff out of an establishment of 6337.82, meaning the overall vacancy rate at the trust was 9.65%. The highest vacancy rate was amongst medical staff with a rate of 14.46%.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Conquest Hospital has a four-bedded resuscitation bay, five majors beds and five minors beds, a mental health assessment room, two emergency nurse practitioner bays and seven additional bays used for extra capacity. There is a clinical decision unit connected to the ED by a corridor that has seven bed bays and is used to observe patients overnight when they cannot be transferred to a ward. A paediatric resuscitation bay and a designated paediatric treatment cubicle are available. There is an x-ray facility in the ED.

The trust's adult emergency departments saw 131,509 patients between April 2016 and March 2016, of which 23% were admitted. The paediatric emergency department was responsible for seeing and treating 13,668 children during 2015/16.

Patients can arrive into the department on foot, where they are booked in by a receptionist and then triaged by a nurse. Patients who arrive by ambulance are triaged by a nurse and then directed to the appropriate treatment area. They can be admitted directly to the clinical decision unit for overnight observation and pain management. Trauma surgery is available on site and the hospital offers a range of specialist inpatient medical services, including for paediatric patients.

As part of our inspection, we spoke with 29 clinical and non-clinical staff across multiple areas of responsibility. This included nurses, doctors and healthcare assistants at all levels, clerical staff, locum and permanent doctors at all levels, paramedics, therapies and pharmacy staff and a range of managers. Prior to our inspection over 250 members of staff attended focus groups and shared their experiences of working at the trust. We also spoke with five relatives, six patients and spent time observing care being delivered. We reviewed 20 sets of patient notes and looked at 65 other individual items of evidence. After our announced inspection, we returned to the ED on an unannounced basis at a weekend. The evidence we gathered from both visits is included here.

Urgent and emergency services

Summary of findings

Overall we rated urgent and emergency services as 'requires improvement' because:

- Staff worked in a culture that empowered them to report incidents. However, learning from incidents, including serious incidents, was limited and not all incidents had an investigation. In some cases, where an incident resulted in patient harm or occurred due to a staff mistake, appropriate training and support was provided.
- Consultant cover did not meet the minimum requirements of the Royal College of Emergency Medicine and there was a significant shortage of middle grade doctors. Nurse staffing levels were variable and the department regularly operated with less than the number of nurses established, as needed to provide safe care. This increased risks to patients and the risk management and clinical governance systems had not addressed this.
- Risk management in patient records was inconsistent and sometimes inaccurate. There was also variable standards in the monitoring of patients who were deteriorating.
- There were significant variances in how staff assessed mental capacity and understanding of patients. This included contradictory, incomplete or inaccurate documentation.
- Patients often experience lengthy delays while waiting for a mental health assessment, including referrals from the child and adolescent mental health team. There was also limited evidence staff were trained or equipped to provide care and treatment for patients with a learning disability.
- Delays to triage and assessment increased patient risk. Although the senior leadership team implemented strategies to address this, there had been little substantive improvement at the time of our inspection.

However we also found areas of good practice:

- There was consistent evidence the duty of candour was used in relation to incidents to maintain transparency and communication with patients and relatives.
- Medicines management was of a high standard and nurse prescribers worked to Patient Group Directions.
- The trust had responded to risks associated with low levels of paediatric nurses by increasing training for existing staff and recruiting new nurses.
- A comprehensive programme of clinical audits was used to benchmark standards and quality of care against the guidance of organisations such as the National Institute for Health and Care Excellence.
- Multidisciplinary working was embedded in the department and a dedicated hospital interventions team provided physiotherapy, occupational therapy and nurse practitioner support during patient admissions and discharges. A crisis response team was available to help avoid unnecessary hospital admissions by organising care at home.
- An education programme was available to staff and included practical competency training from a dedicated practice development nurse as well as training from visiting specialists.
- Patients and their relatives were treated kindly, with dignity and respect and recommendation rates for the department were similar to the national average.
- Staff provided specific services to meet the needs of individual people. This included specialist support for patients living with dementia and translation resources for non-English speakers.
- Although the hospital consistently failed to meet the Department of Health target that 95% of patients be admitted, transferred or discharged within four hours, a programme of significant development was underway to improve all aspects of the service times, including triage, assessment and treatment.

Urgent and emergency services

- A frailty pathway service was in development to address the needs of the local population and this service aimed to reduce the need for hospital attendances and admissions and ensure patients had better access to home or community services.
- A restructure of the clinical unit and management team was due to be completed by November 2016 and staff spoke positively about the increase in support, training and engagement they had experienced as a result of the changes. The department vision and strategy were included in a five year plan to improve access and flow through the department and improve specialist care pathways. A multidisciplinary team was also developing an innovative rehabilitation programme to ensure patients had access to support at home and reduce the need for repeat hospital attendances.

Are urgent and emergency services safe?

Inadequate

We rated urgent and emergency services 'inadequate' for safe because:

- There was limited evidence of learning from incidents amongst clinical staff and 20% of incidents reported did not have an investigation. There was significant number of unresolved mortality reviews related to the emergency department although a plan was in place to complete these by December 2016.
- The unit did not meet the Royal College of Emergency Medicine minimum requirements for consultant cover and there were sustained, frequent gaps in the cover level for other grades of doctor. A shortage of middle grade doctors was recognised on the unit's risk register and some recruitment had taken place but rotas we saw indicated an on-going lack of cover.
- Nurse to patient ratios frequently fell short of established safe minimum standards and this was reflected in incident reports submitted by staff.
- Although falls were identified as a significant risk to patients in the department, audits of risk assessments indicated broad variances in completion rates. There was also inconsistent completion of integrated care documents to manage patient risks in relation to pressure ulcers and mental capacity and staff did not always use the sepsis screening tool appropriately.
- Rates of mandatory training were variable due to on-going staff shortages and in some cases did not meet the trust's minimum target of 90% completion. This included in child safeguarding and information governance.
- Management of risks to patients was inconsistent and staff did not always accurately document observations of deteriorating patients, use body maps to document injuries or ensure patients were able to call for help when needed.
- Workplace assessments had found health and safety risks to be present for patients in the clinical decision unit (CDU) and for staff in male toilets but there were no documented updates to these.

- A mental health assessment room in the department was poorly equipped and presented a number of safety risks to patients and staff.
- Fire safety assessments indicated a number of gaps in the completion and recording of regular checks and there was no evidence of an improvement plan. The department was not compliant with the trust's fire safety policies as fire drill and evacuation training had lapsed and senior safety staff had been unable to identify if trained fire wardens were in place.

However we also found areas of good practice:

- New processes had been implemented to ensure staff received a formal debrief after critical incidents or child deaths in the department. This ensured they were supported professionally and pastorally and debriefs were used to identify areas for improvement in practice.
- Infection control and hand hygiene audit results consistently exceeded the trust's minimum target although there was room for improvement in staff practice from our observations.
- The electronics and medical engineering department managed a planned programme of maintenance that ensured there were no interruptions to service as a result of unavailable equipment.
- Medicines were managed appropriately, including with temperature monitoring, stock rotation and administration in relation to Patient Group Directions.
- The trust identified a lack of paediatric nurses as a significant risk within the service but had responded appropriately by increasing recruitment and providing existing experienced nurses with paediatric life support training.
- A trauma nurse service coordinator had begun to develop the department's major incident and biohazard decontamination training, including in the practical use of body suits by staff.

Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between August 2015 and July 2016 the trust reported no incidents which were classified as Never Events for urgent and emergency care.
- Staff were offered a debrief after critical incidents and this process had been used to identify areas for improvement in training and knowledge, such as in advanced safeguarding training. A new process had been established to hold a professional meeting following child deaths in the department. This provided pastoral support to staff and enabled them to review how the patient had been cared for and treated.
- Staff used an electronic reporting system to submit incident details to senior staff and staff we spoke with said they felt confident in doing so. Between March 2016 and June 2016, 123 incidents were reported in the emergency department (ED) including the clinical decisions unit and in resuscitation. Eleven incidents related to short staffing, in cases where staff felt the service was unsafe as a result and ten incidents related to falls. The member of staff submitting the report documented action taken in each case and a senior nurse or manager recorded an investigation in 80% of cases. Where investigations took place, appropriate senior staff led these, including senior clinicians where the incident related to a clinical error. However, investigations had not taken place in some situations. For example, where a patient had accidently slipped while moving but was mobile and independent or where an ambulance crew had lacked equipment, but no harm had resulted. One incident involved a patient under a specific order of the Mental Health Act where staff had failed to document the need for continuous supervision of the patient and had sent their escort home. The member of staff who identified this, acted appropriately and in a way that safeguarded the patient and others in the department, but there was no formal investigation of this. Some staff said the findings from incidents were shared in handovers and meetings but others said they did not know how they would find out about incident findings. This meant there was a risk learning was not disseminated to all appropriate staff and risked a recurrence of the problem.

- In accordance with the Serious Incident Framework 2015, urgent and emergency care reported two serious incidents (SIs) which met the reporting criteria set by NHS England between August 2015 and July 2016. One SI related to a failure to act on diagnostic results and one related to the failure to escalate a young person who presented with an attempted suicide. In both cases senior clinical staff conducted investigations with those involved and used reflective exercises to identify where additional training and supervision was needed. At the time of our inspection neither SI had been formally concluded or closed with learning.
- The senior team led a monthly risk meeting to review incidents and identify trends. The clinical services manager told us falls were the highest patient risk in the clinical unit and reflected the demographics of the local population. The outcomes of meetings were disseminated to band seven matrons by e-mail. However, there was limited evidence the processes in place to communicate the outcomes of incident investigations to staff were consistent. For example, two doctors said they were unaware of any serious incidents or any changes in practice as a result of incident investigations. One nurse said they had been praised by managers for submitting an incident report.
- Senior medical staff were proactive in encouraging colleagues to learn from incidents in EDs at other hospitals. For example, they had created a noticeboard that displayed Never Events reported to the Royal College of Emergency Medicine (RCEM) from other hospitals and posed the question 'Could this happen here?'
- In September 2016, the urgent and emergency services had 62 unresolved mortality reviews in place. This meant an appropriate clinician had not reviewed 62 patient deaths, of which 36 were attributed to ED. To address this, a clinical governance support office led a mortality review improvement plan. This was to conclude all mortality reviews by December 2016 through the provision of targeted IT support to doctors and robust monthly monitoring of morbidity and mortality (M & M) meetings. A weekly teaching session between consultants or registrars and junior doctors also acted as a morbidity and mortality meeting. This meant junior staff had the opportunity, in protected time, to review patient cases, including deaths, with a senior clinician.

Cleanliness, infection control and hygiene

- The ED participated in monthly hand hygiene audits that assessed staff on their hand washing and hygiene practices against the trust's infection control policy. Between February 2016 and July 2016, the ED achieved 100% compliance in four months and did not contribute data in two months. In the months where data were available, the standards exceeded the trust's minimum target of 90%.
- An infection control nurse led a monthly compliance audit to assess staff against their use of personal protective equipment and adherence to the 'bare below the elbows' policy. Data were available to us from April 2016 and May 2016 only. In this period 14 staff members were observed, with a compliance rate of 86%. Areas for improvement included a healthcare assistant who did not wash their hands after removing gloves and a non-clinical member of staff who wore long sleeves.
- Most staff we saw practised good hand hygiene in the unit, including using hand gel and washing their hands at appropriate intervals and between patient contact. We observed an exception to this in the CDU where a nurse moved between patients without using hand gel or washing their hands despite touching both patients. Hand gel and hand washing sinks were available at appropriate locations in bed bays and near cubicles. Not all staff adhered to the trust's bare below the elbows policy, including a doctor who moved between several cubicles wearing long sleeves.
- Decontamination products were stored appropriately and securely and were risk assessed using the control of substances hazardous to health (COSHH) guidelines.
- Cleaning contractors used a cleaning management tool to monitor the cleanliness of areas considered to be of significant risk, high risk or very high risk to patients if not properly maintained. Standards were assessed against a minimum target of 95% compliance. The data available to us related to June 2016 and July 2016, when overall compliance was

96%. This related to all staff groups responsible for cleanliness and hygiene practices. Rates of compliance amongst nurses was slightly lower, at 81%.

- There was room for improvement in how the environment was managed to minimise infection control risks. For example, a box of tissues covered in a yellow substance had been discarded on the side of the nurses station in the escalation area but had not been noticed by cleaning staff or nurses. A vial of blood was left unattended on a work bench for over 40 minutes without attention from staff.
- Housekeepers and clinical staff used bright green 'I'm clean' stickers to indicate when an item of equipment was clean and ready for use. We saw this procedure was consistently used in all ED areas.
- Dedicated housekeeper cover was available 24 hours per day Monday to Friday and 23 hours per day Saturday and Sunday.

Environment and equipment

- Refurbishment of some areas of the ED was under way, including to create a new paediatric waiting area and two paediatric cubicles. Planning documents for this showed the works adhered to the Department of Health's health building note 15-01, which relates to the provision of a safe and appropriate accident and emergency environment. In the meantime, security of paediatric areas was limited and staff were not always able to monitor access.
- The electronics and medical engineering (EME) department managed a programme of planned maintenance of ED equipment and provided ad-hoc support to staff 24-hours, seven days a week. A robust monitoring system enabled EME staff to plan equipment maintenance in advance. As of July 2016, EME were 96% compliant with all scheduled maintenance across both of the trust's ED services. Although the standard of service from EME staff was demonstrably consistent, it was not apparent ED staff always understood reporting or escalation procedures for faulty equipment. For example, a macerator in the clinical decision unit (CDU) was out of service and had a handwritten notice that stated this, along with a comment about staff frustration of the extended period over which this had been the case. There was no job or reference number on the equipment and staff on shift were not able to tell us when it had been reported.
- A general workplace risk assessment had taken place in February 2016 to assess environmental risks to patients, staff and visitors. This found the lack of space for manoeuvring patients and some window blinds in the CDU to present risks that needed addressing.
- A health and safety site report had been completed in June 2016 and found staff toilets to be in urgent need of repair. There was not a documented update to this.
- Documented daily safety checks of resuscitation trollies were consistent, including for paediatric equipment. In the three months prior to our inspection there was one missing check on the equipment in the CDU. We saw appropriate equipment was available and all disposable equipment on the trolley was in date.
- There was a lack of confidentiality for patients who arrived in the department on foot and were booked in at the reception window. This was because conversations between the receptionist and patient could be overheard by others in the waiting room. The reception desk was very limited in space and only one receptionist could be at the desk at a time. Staff told us this often led to lengthy delays of booking patients in.
- A designated room was available in the ED for patients with mental health needs or risks. However, this room was poorly equipped and contained risks such as movable furniture and a one-way lock on the door. This meant patients could lock themselves in the room or use loose furniture as a weapon. Senior staff said they recognised the risk and until the room could be refurbished, patients would only be accommodated there if a member of staff was available to stay with them.
- We checked 23 items of electrical equipment and found they had an up to date electrical safety test.

Medicines

- Medicines and controlled drugs (CDs) were stored and dispensed using an electronic system that operated securely on staff thumbprint access. Pharmacy

services monitored this system centrally and were alerted if there was a problem with temperature maintenance or stock discrepancies with CDs. This meant medicines were stored safely and securely in line with legislation.Daily support was provided by a pharmacy technician who supplemented the central monitoring checks with stock taking and stock rotation. Although the CDU had no formal scheduled pharmacy support, nurses worked between the ED and CDU and could get help from the pharmacy technician if needed.

- Between March 2016 and June 2016, 14 incidents of medication errors were reported. All incidents were investigated with support from the pharmacy and dispensary and staff involved were provided with additional training, a chance to be involved in the investigation and checks to ensure they met standards of professional competency.
- Bulky medicines like IV fluids and irrigations were stored securely in a separate room.
- Registered nurses used Patient Group Directions (PGDs) to provide pain relief during triage and to supply medicines to take away within the minor injuries unit. PGDs were within their review dates and had been appropriately approved by the organisation. Individual staff were also appropriately approved to use PGDs.

Records

- In March 2015 an audit of patient records took place to assess compliance with the Records Management NHS Code of Practice. The audit found low levels of compliance with the quality standards of records. For example, clinicians had legibly printed their name and job title in only 33% of records and their writing was legible in only 62% of records. However, compliance with dating records and ensuring they were contemporaneous met the 90% minimum standard, with 92% and 100% compliance, respectively. There had not been a re-audit to assess improvements.
- The CDU admissions protocol required staff to complete a drug chart and management plan before patients could be admitted. We looked at 17 records and both documents were complete in all 17, with clear and legible staff signatures and designations.
- During our weekend unannounced inspection we looked at the records of four patients in the ED and four patients in the CDU. In all but one case patients had risk assessments in place for falls and pressure sores. Staff also completed risk assessments for venous thromboembolism.
- There was inconsistent evidence the sepsis screening tool was always used appropriately. For example, paramedics had completed a sepsis alert for one patient but ED staff had not completed the sepsis screening tool or an appropriate risk assessment. This meant the patient was at risk of delayed treatment and it was not clear that an adequate medical assessment had taken place. Another patient with neutropenic sepsis had been in the ED for over eight hours but staff had not started the sepsis pathway. However, during our weekend unannounced inspection, staff had completed the sepsis screening tool in eight records we looked at.
- Completion of falls risk assessments was audited on a monthly basis. The most recent audit results indicated significant differences in completion, with risk assessments documented in records between 0% and 100% of cases. This indicated risk assessments were completed inconsistently.
- Staff used an integrated patient care document to monitor patients who were admitted to the CDU or waiting in the ED for admission to a ward or a community service. This included a record of mental capacity, resuscitation status and risk assessments, such as falls and pressure ulcers. The document enabled staff to record observations at specific intervals to meet national guidance, such as National Institute of Health and Care Excellence clinical guidance 161, regarding managing the risks of falls. Staff did not always use this tool consistently. For example, one patient had been in the department on a trolley for over 14 hours but staff had not completed the integrated care document and the patient had no risk assessments in place for pressure sores, bed rails or infection control.
- There was evidence staff did not always follow trust information governance policy in relation to patient information. For example, on one day of our inspection we found a printed urine dipstick analysis left on the side of the nurse station in the escalation

area. The analysis did not have a patient name or identification number on it and the nurse in charge of this area did not know who it referred to or which member of staff had requested the analysis.

- Staff completed pressure ulcer risk assessments as part of each patient's admission documentation but this was not always effective or monitored at appropriate intervals. For example, one patient admitted to the CDU had been assessed as having no risk of pressure ulcers. However, within 48 hours they had developed a grade two pressure ulcer.

Safeguarding

- The incident records and investigation log indicated there was room for improvement in staff knowledge and understanding of the principles of safeguarding. For example, a member of staff with level two child safeguarding training had not acted appropriately when a young patient presented in the department after an attempted suicide. This incident was investigated and action taken, including additional training for the member of staff involved including the provision of Nursing and Midwifery Council (NMC) standards of safeguarding. The member of staff reflected on the incident with a written statement and the head of nursing ensured all department staff were aware of the procedure to follow where patients were extremely vulnerable. However, staff acted in the best interests of patients in most incidents. For example, where a patient was found confused and lost away from their care home, ED staff liaised with adult social care services and the care home manager to ensure they remained safe and their disappearance was investigated. In addition, all of the staff we spoke with demonstrated a good understanding of how to raise a safeguarding concern.
- Clinical unit governance meetings had identified a need for improved child safeguarding training for consultants, particularly with regard to the Mental Capacity Act (2005) and recognition of female genital mutilation (FGM). Meeting minutes from July 2016 indicated rates of training were being improved with the introduction of level three child safeguarding training for all consultants and a questionnaire on FGM. A paediatric nurse had begun to deliver FGM training to clinical staff.
- All staff in urgent and emergency services, including therapies staff, had adult and child safeguarding training to level one and higher levels of training were then completed, based on the level of responsibility each member of staff had. For example, all nurses were required to complete adult and child safeguarding to level two and senior nurses and doctors completed the training to level three. This in line with the Safeguarding Children and Young People – Roles and Competencies for Staff Intercollegiate Document updated in September 2010. Of the staff required to complete child safeguarding level two, 88% were up to date and 81% were up to date with child safeguarding level three.
- Detailed and up to date information was readily available to staff with regards to referring patients to out of hours crisis support teams, social workers and child protection duty officers.

Mandatory training

- Senior staff monitored completion rates for mandatory training of staff against the trust's minimum 90% target. Monitoring took place for the urgent care clinical unit as a whole and was not available for individual hospitals. Overall, as of June 2016, staff held an average compliance of 80% with up to date mandatory training across 11 separate topics. More than 85% of staff had a complete induction and up to date training in the Mental Capacity Act and the Deprivation of Liberty Safeguards. Training rates were lowest in information governance (71%) and child safeguarding level three (63%). Training rates in manual handling, infection control, adult safeguarding level two, child safeguarding level two and fire safety were lower than the trust's 90% standard.
- Staff were given protected time on their rota to complete mandatory training to help them keep up to date but the lower rates of training reflected on-going shortages of staff due to sickness.

Assessing and responding to patient risk

- Staff used the national early warning scores (NEWS) system to monitor patient condition and to identify when someone was deteriorating. This was documented inconsistently. In ten sets of patient notes we looked at, four did not have a NEWS score recorded. The paediatric early warning score was used

appropriately in all cases we looked at but the score was not always calculated accurately. In addition not all doctors had completed paediatric life support training. The new deputy head of nursing for the ED had identified a NEWS audit as a priority in the first 90 days of their new role.

- There was evidence staff used escalation procedures appropriately. For example, a patient presented in the department on foot and the receptionist recognised they were very unwell and ensured the triage nurse assessed them immediately. Staff escalated patients with deteriorating NEWS scores to the critical care outreach team (CCOT) who were able to provide clinical support to acutely unwell patients and arrange for their transfer to the intensive care unit. A CCOT nurse also attended to all cardiac arrest calls in the ED.
- Staff had access to body maps to document injuries to patients. This helped with assessment and could be used in cases of unexplained bruising or injuries where there was a safeguarding concern. However, staff used these inconsistently and audit data indicated body maps were completed in only 14% of patients who presented with an injury. We saw this to be the case in practice, including one patient with a leg injury who did not have a completed body map.
- Senior staff had trialled a rapid assessment and treat model for two months to enable them to assess and treat majors patients more quickly. The senior team had not yet identified if the trial results justified introducing the model on a permanent basis.
- Staff legibly recorded allergies in all patient notes we looked at, which formed part of a risk assessment to reduce the risk of medication side effects.
- When patients arrive at the ED by ambulance, the national standard is that paramedics complete a handover with ED staff within 60 minutes of arrival. Between July 2016 and October 2016, an average of 7% of patients experienced a handover delay in excess of 60 minutes.
- All cubicles and bed spaces had call bells fitted that would enable patients to call for assistance. However, staff did not routinely check that call bell cords were within reach of patients. For example, the call bell in four cubicles we checked was out of reach of the patient. This meant comfort rounds, which were used to check items such as this, were not used consistently.
- A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. This hospital did not routinely collect this breach data.

Nursing staffing

- A team of 56 nurses, supported by a team of healthcare assistants (HCAs), led nursing care in the ED, including the CDU and ambulatory care unit. There were four staff nurse vacancies and the senior management team were preparing a review of safe nursing levels using the RCN baseline emergency staffing tool. A deputy head of nursing had recently been appointed to provide greater oversight of the quality of care provided in relation to staffing levels.
- Between 7.30am and 7.30pm, planned nursing staff was, 10 nurses including an emergency nurse practitioner (ENP) and six HCAs. Between 7.30pm and 7.30am, planned nurse staffing was nine nurses, which included a twilight ENP and four HCAs. This included a nurse and HCA for the CDU and a supernumerary nurse coordinator. The unit was frequently understaffed based on this establishment due to sickness and non-availability of bank and agency nurses. In addition, nurses were sometimes reassigned to work in the acute assessment unit to cover staff shortages there. This was done only with oversight of a senior nurse who ensured the most appropriate balance of experience and skills was made between the clinical areas.
- The ED had no permanent paediatric nurses and this was highlighted as a significant risk on the urgent services risk register. The trust had mitigated this by increasing the number of nurses with paediatric intermediate life support and European paediatric advanced life support training. They also improved training in the use of the paediatric streaming pathway. In addition, an on-call paediatrician attended each paediatric crash call to support the clinical team. New paediatric nurses had been recruited as part of the broader improvement of

paediatric services, equivalent to 3.7 whole time equivalent (WTE) staff. To further mitigate the risk, senior staff were recruiting existing nurses into a paediatric rotation. A paediatric waiting room was being refurbished and new staff would help to establish a paediatric pathway to ensure children were triaged and seen away from adult patients. Two new paediatric cubicles were due to be completed and available from late October 2016.

- The unit was funded for 3.8WTE ENPs and had 2.8WTE in post. This team provided an ENP service seven days a week, from 7am to 7.30pm.
- Nurse staffing in the escalation area, bed bays 11 to 18, was often not enough to meet patient needs. On one day of our inspection this area was operating at capacity with one staff nurse and one HCA. Staff told us this was a regular occurrence although they said the service specification for this area required a minimum of two staff nurses at all times.
- Nurse handovers took place twice daily and senior nurses used this time to discuss any safety issues or service pressures with staff. Senior nurses also provided reminders to staff on maintaining the hospital's 'bare below the elbows' policy and checked the experience and skill mix of staff to ensure they were allocated to areas appropriately.

Medical staffing

- The ED did not meet the requirements of RCEM that consultant cover be provided a minimum 16 hours per day. On weekdays, consultants were typically present from 8am to 7pm and on weekends from 8.30am to 2.30pm. This included dedicated consultant cover for a morning handover, ward round and review clinic. However, there were a number of gaps in the consultant rota during our inspection. For example, for three consecutive days there was no consultant cover for the morning handover and for two consecutive days there was no consultant cover for the review clinic. In the same time period there were nine gaps in medical cover in the senior house officer (SHO) and middle grade bands.
- The proportion of consultants reported to be working at the trust was slightly lower than the national average and the proportion of junior doctors was higher than the national average. In the EDs, consultants accounted for 24% of medical staff, 34% were junior doctors, 21% were middle career doctors and 21% were registrars. The figures represent average staffing across both ED sites.
- Where a consultant was not present for a handover, a registrar took the lead. We observed a handover, which included the registrar, junior doctors and nurse in charge. The registrar reviewed medical and nurse staffing in the ED and identified patients with deteriorating or priority needs for immediate review.
- Gaps in medical staffing were reflected in the risk register for urgent care services. This included middle grade doctors and less than five full time consultants in post, which meant there was a risk the service would continue to fall short of RCEM minimum requirements. To mitigate this risk, existing consultants provided additional cover and internal locum, middle grade doctors were appointed. In addition, three new middle grade doctors had been recruited into substantive posts between this ED and the trust's Eastbourne site.
- Six SHOs and three middle grade doctors provided cover on a staggered shift basis; on 24 hour cycles between 8am and 8am, including one SHO, and two registrars overnight between 12am and 4am. There was some degree of flexibility between medical teams at Conquest Hospital and colleagues at the Eastbourne site. For example, during our weekend unannounced inspection, one doctor had called in sick but a consultant was able to secure cover from a colleague at Eastbourne to ensure the service remained safely staffed. Some medical staff told us that overnight cover was sometimes insufficient to safely meet patient needs. For example, one doctor said overnight there was often only one registrar on shift and if the medical team was made up of locum doctors, there was much less support for more junior members of the team.
- We received variable feedback from medical staff about the consultant cover in the unit. One member of staff said they felt unsupported and felt it was difficult to obtain consultant input unless the unit was very busy and others said the support to care for patients with complex needs was "excellent." Doctors also described varying experiences of staffing in the department. For example, one locum doctor said they

felt well supported by consultants and another doctor said the lack of consultant cover after 6pm had a negative impact. For example, they said they were concerned by how exhausted doctors were as they often only had 10 hours between shifts.

- A consultant clinical lead was not formally in post but a senior consultant was typically described by staff as the lead. A new governance and unit structure due in November 2016 would result in an appointment to a clinical lead post.
- There were discrepancies in the understanding of levels of training and professional competency of middle grade doctors. For example, a consultant told us they believed every middle grade doctor had completed a membership or fellowship of the RCEM exam. However, one doctor we spoke with had worked in the unit for over 12 months and said they had not completed this.
- Paediatric and anaesthetic rotation posts for middle grade doctors had been developed to improve the gaps in this team by attracting more doctors to work in the department.

Major incident awareness and training

- A fire management policy was in place that met the requirements of the Department of Health's Health Technical Memorandum 05-01 in relation to managing healthcare fire safety. This required fire wardens to complete weekly fire safety checks and to assume a leadership role in an evacuation. The policy required staff to take part in a fire drill or fire evacuation drill every 12 months. Two fire wardens were in post and assured us weekly checks had taken place and had been documented although the fire folder that contained the records had been misplaced. This meant documented evidence of weekly fire checks was only available for April 2016 and October 2016 in the six months prior to our inspection.
- The checks that were available indicated gaps in regular safety and premises checking. For example, it was noted in April 2016 that three fire extinguishers had not been checked since April 2014. A fire risk assessment for the department in September 2016 found that fire drill and evacuation training was overdue and that several fire doors needed attention. The assessor had also been unable to confirm if fire wardens conducted weekly checks. A workplace risk assessment in March 2016 found no fire drills or fire walkthrough had occurred in the previous 12 months and this was highlighted as an area for attention. However, no updates had been documented.
- The trauma nurse service coordinator had begun to develop the emergency planning and major incident training for staff. Most recently this had included a table-top emergency planning exercise with non-clinical staff in the unit.
- Two security officers were available 24-hours a day; seven days a week and this team had an emergency response vehicle on-site. This meant ED staff had rapid access to security support if needed to help with violent or threatening patients. However, it was not clear that security services provided supervision for patients in the waiting room. For example, two patients provided feedback that they had felt threatened whilst waiting to be seen because of the behaviour of others they considered to be under the influence of alcohol and with no security presence.
- Major incident and decontamination equipment was available on site in line with NHS England guidance on chemical, biological, radiological and nuclear (CBRN) provision. A CBRN link nurse was in post and the trauma nurse service coordinator had begun to conduct practical training with clinical staff on the use of CBRN protection suits and with clerical staff on major incident planning. Hospital porters were trained to put up decontamination tents.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated urgent and emergency services 'requires improvement' for effective because:

- A comprehensive local audit programme was in place that sought to assess care and treatment according to a range of factors, including national guidance and

benchmarks. Local regular audit results were displayed in the unit but were undated and not all staff we spoke with were familiar with the results. This limited their effectiveness.

- Care was provided in accordance with National Institute for Health and Care Excellence guidance on safe staffing in accident and emergency departments.
- Multidisciplinary working was embedded in the department and patients were cared for by an experienced team of professionals. This included a hospitals intervention team that was dedicated to the department and was staffed by physiotherapists, occupational therapists and nurse practitioners. A crisis response team and rapid discharge team also provided specialist support.
- Trauma audit and research network data indicated mortality rates had significantly improved in the department and survival rates from trauma were better than expected. A trauma nurse service coordinator was in post and conducted peer reviews of trauma processes to identify areas for improved practice.
- Clinical staff had access to a range of training opportunities led by a practice development nurse and visiting specialists. In addition, locum doctors and junior doctors gave positive feedback about the department's handbook and new nurses said their induction handbook had helped them settle in quickly.
- Although unplanned reattendance rates did not meet the 5% national target, they were typically better than the national average of similar emergency departments.
- Overall 90% of staff had received an appraisal in the previous 12 months and new staff were positive about their induction programme.
- Staff generally demonstrated a good level of knowledge of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

However we also found areas that required improvement:

- The assessment, recording and monitoring of mental capacity assessments and mental cognitive function was highly variable. Some patient records contained inconsistent information and others indicated an inappropriate response to risks associated with worsening confusion.
- There were significant variances in how well pain was managed, with some patients waiting lengthy periods of time for analgesia.
- Food choices for breakfast were limited in the clinical decision unit and we received variable feedback from patients about how well staff managed their fluid intake.
- The department performed worse than the national average in the Royal College of Emergency Medicine (RCEM) 2013/14 audit for severe sepsis and septic shock.
- Between April 2014 to May 2015 the department performed variably in the RCEM audit for assessing cognitive impairment in older people, including in the completion of cognitive assessments.
- In the same period in the RCEM audit for mental health in the ED, the trust did not meet the fundamental standard of completing a documented risk assessment in all cases.

Evidence-based care and treatment

- A local audit programme was shared with the Eastbourne urgent care clinical unit and included 27 individual audits used to benchmark and assess care and patient outcomes against a range of targets and standards. This included those set by the National Clinical Audit and Patient Outcomes Programme, the regional Commissioning for Quality and Innovation priorities, the Department of Health statutory requirements, the National Institute for Health and Care Excellence(NICE) and the Society for Acute Medicines. The audit schedule included six clinical audits relating to clinician's own interests, such as the development of an eye proforma to be used in ED and an audit ofcompliance with the Royal College of Emergency Medicine (RCEM) Guidelines for the use of medicines to prevent blood clots, in walking trauma patients.
- Local audit information was displayed for staff and was used to highlight areas of good practice and areas where improvement was needed. Staff told us this was

a useful tool for them but the audit data was undated, which meant it was not immediately clear how up to date they were. Not all staff were aware of the audits or findings from them. This included a doctor who had worked in the unit for over 12 months.

- A trauma nurse service coordinator had been appointed to enable the unit to contribute to the national trauma review programme, which would help to benchmark standards against other units nationally. The member of staff worked with the director of rehabilitation to peer review trauma processes and support nurses with trauma education and care supervision. The trauma nurse also conducted a daily check of patient admission records to ensure staff had correctly identified trauma.
- Emergency nurse practitioners (ENPs) worked in accordance with national best practice guidance issued by NICE, including for safe staffing in accident and emergency and in the treatment of head injuries. This guidance was readily available to ENPs in the department.
- Staff working in the paediatric resuscitation bay followed the South Thames Retrieval guidelines for the management of critically ill children. This meant they had access to a specialist retrieval team who could transfer children to an intensive care unit with the capability to provide appropriate care and treatment.
- The clinical service manager audited patients who presented with an unplanned readmission. This aimed to review their original notes and identify if care or treatment could have been provided differently if their return was for a related problem.

Pain relief

- In the CQC A&E Survey, the trust scored 5.5 for the question "How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.
- The trust scored 7.36 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as than other trusts.
- The clinical decision unit (CDU) provided patients with overnight pain management delivered by a multidisciplinary team.
- A clinician was due to conduct an audit of pain relief in the ED between September 2016 and December 2016.
- There was an inconsistent approach to the management of pain. In ten sets of patient notes we looked at, four did not have a pain score documented. One patient with the maximum pain score waited 60 minutes for analgesia. We spoke with four patients about pain management. One patient said they had been in a cubicle for 40 minutes without being administered analgesia. Staff had recorded a high pain score for this patient and we were not able to confirm why there was a delay in them receiving pain relief. However, we also observed staff asking patients about their levels of pain during examinations and at regular intervals.
- The recording of initial pain scores was audited on a monthly basis. The most recent audit results indicated significant differences in standards, with pain scores documented in records between 17% and 100% of cases. In 20 sets of paediatric records we looked at, pain scores were documented in over 50% of cases.

Nutrition and hydration

- In the CQC A&E Survey, the trust scored 7.00 for the question "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as other trusts.
- One patient had been in a cubicle for three hours and had not been offered a drink. Another had been in a cubicle for four hours and said they had seen one member of staff who was so busy they felt uncomfortable asking them for a drink. One patient had been in a cubicle for six hours and 45 minutes. They said, "No-one has asked if I'm thirsty but a nurse did ask if I want a sandwich. I don't know when it's coming though, I don't know if it was a food order for tonight."
- We observed a breakfast round in the CDU and found choice was very limited and patients were not able to

make special requests. For example, there was only enough porridge for two patients and when more patients wanted this, they had to have cereal or bread instead.

Patient outcomes

- The trust contributed to the Trauma Audit and Research Network (TARN), which aims to reduce unnecessary mortality through effective management and treatment of patient injuries following trauma. In the reporting period from April 2015 to May 2016, 120 patient cases were considered in the TARN audit, which included eight trauma deaths. This audit identified a trajectory of improvement in the mortality rate in the ED, from 11% of trauma patients in 2015 to 6% in 2016. In the reporting period from April 2015 to May 2016, the number of patients who survived a trauma as a result of treatment was better than the expected rate of survival. For example, 88% of patients were expected to survive and an average of 92% actually survived.
- The ED performance varied in the time to CT scans for patients admitted with a trauma such as 31 minutes in July 2015, 70 minutes in January 2016 and 42 minutes in July 2016.
- In the reporting period from April 2013 to May 2014 RCEM audit for asthma in children, the trust was in lower quartile compared to other trusts for five of the ten audit measures and was in the upper quartile for one of the ten measures. This meant the trust typically performed worse than other similar departments. The measures for which the trust performed in the lower quartile related to initial observations and treatment. This included a respiration rate recorded in 46% of patients, oxygen saturation recorded in 49% of patients, a pulse recorded in 49% of patients and a temperature recorded in 49% of patients. In addition, appropriate treatment was given in 57% of patients. The trust performed better in the provision of an airway management nebuliser within 10 minutes of arrival in 14% of patients.
- In the reporting period from April 2013 to May 2014 audit for paracetamol overdose, 88% of patients were treated according to Medicines and Healthcare products Regulatory Agency guidelines.
- In the reporting period from April 2013 to May 2014
  - Capillary blood glucose was measured and recorded on arrival in 60% of cases
  - There was evidence that serum lactate measurement was obtained in the ED in 68% of cases
- In the reporting period from April 2014 to May 2015 RCEM audit for assessing cognitive impairment in older people, the trust performed variably. A cognitive assessment took place in 56% of eligible patients although a structured assessment tool was used in 97% of these cases. The hospital did not meet the fundamental standard of having an early warning score documented for every patient.
- In the reporting period from April 2014 to May 2015 RCEM audit for initial management of the fitting child the trust did not meet the fundamental standard of checking and documenting blood glucose. This was documented in only 50% of cases.
- In the reporting period from April 2014 to May 2015 RCEM audit for mental health in the ED, the trust did not meet the fundamental standard of completing a documented risk assessment in all cases. The audit reported this occurred in 94% of eligible patients. A history of the patient's previous mental health issues was taken and recorded in 96% of cases, a mental state examination was taken and recorded in 94% of cases and a provisional diagnosis was documented in 92% of cases. This meant the department was amongst the better performing hospitals nationally. However, no patients were assessed by a mental health professional within one hour.
- Between May 2015 and April 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average. In the latest period, trust performance was 7.1 % compared to an England average of 8.7 %. In the three months prior to our inspection, there were 236 unplanned readmissions to the ED.

Competent staff

- Overall, in the urgent care clinical unit, 90% of staff had received an appraisal in the previous 12 months. This was better than the trust target of 75%.

- New staff were given an ED welcome pack that had been created by a practice development nurse (PDN). This included the types of responsibilities ED staff had as well as useful contact information for others in the trust, such as human resources.
- Nurses and healthcare assistants undertook additional training to work in link roles in areas they had a special interest. This included keeping up to date with new policies and procedures in this area, assisting with audits and attending training sessions so they could brief their colleagues in the ED. Link nurses were in post for 47 areas that covered medical treatment and care as well as the department itself, including neutropenic sepsis, infection control, learning disabilities and major incidents. The new deputy head of nursing was reviewing the link nurse roles, as they had not been updated for some time due to staff turnover and sickness.
- In-house education sessions were regularly offered on plastering and trauma management and dementia 'champions' attended training courses offered by a specialist community team. This enabled them to provide support to colleagues in the unit who cared for patients with dementia.
- The PDN had recently been promoted into another role. In response, a band seven matron had been recruited into the PDN role and was planning an overhaul of the staff education process and to increase the number of nurses who took the post-registration qualification in accident and emergency nursing.
- Junior doctors spoke positively about teaching and learning opportunities in the ED. They had access to scheduled teaching sessions twice weekly and the senior registrar offered regular bedside teaching. Junior doctors also described the department handbook they were given on joining as very helpful in learning about minor conditions. This was not replicated for locum doctors, including those who had worked in the department for over 12 months who told us they had not been offered any training or teaching opportunities.
- The trauma nurse service coordinator was leading a programme of major trauma nursing competencies amongst nursing staff to improve skills and knowledge. This included assessing senior nurses in airway management to ensure they could lead more junior staff in this area of competency.
- Two clinical fellows had been recruited to work between both of the trust's EDs in education roles to provide teaching and learning support to the medical team.
- We observed excellent standards of preparation in the resuscitation area, including the use of safety checklists and preparation of equipment according to best practice guidance and infection control principles.

Multidisciplinary working

- A hospital intervention team (HIT) was dedicated to the ED and consisted of physiotherapists, occupational therapists, nurse practitioners and social workers. This team provided support to patients who had limited mobility and who needed a community package of care in place before they could be safely discharged.
- A team of six nurse practitioners, occupational therapists and physiotherapists formed the HIT team and were dedicated to the ED. This team had one vacancy and which was filled with a locum member of staff to minimise disruption to the service.
- A team of nutrition and dietetics staff were available and covered all clinical services. This team was significantly short staffed and between March 2016 and June 2016, a total of 5093 hours across three grades of staff were uncovered. This meant patients did not always have access to timely, expert input from a nutritionist or dietician.
- Staff had access to support from two speech and language therapists in the hospital.
- Communication between teams was not always consistent or well-coordinated. For example, during our weekend unannounced inspection, the HIT team had noted a patient had a community package of care and was due for imminent discharge. However staff on duty said this was an error and they didn't know who had written it. They also stated this patient would be in the CDU for another week.

- A dedicated pharmacist worked in the ED who provided oversight of medicines management and support for staff who experienced a medication error.
- ENPs, staff nurses and HCAs worked together to pool their skills in response to the demands of the department and to enable them to develop their professional skills. For example, an HCA worked with the triage nurse on each shift and another HCA worked with the ENP to help with dressings and plastering.
- A trauma nurse service coordinator, was in post and provided specialised training to band seven matrons in the management of trauma patients. This member of staff helped to plan complex repatriations. ensured practice in the department met the national guidance of the National Major Trauma Nursing Group.
- A cardiac nurse practitioner was available in the hospital seven days a week from 7am to 7.30pm. The practitioner assisted with triage, could review diagnostics and take bloods. They could also liaise directly with consultants and stream patients to the catheterization laboratory for diagnostic imagining.
- Mental health liaison nurses were available 24-hours, seven days a week. The nurses were provided by another organisation and were permanently based in the hospital and overnight a doctor provided additional support for patients with mental health needs.
- A paediatric liaison service saw all children under the age of 16 and adolescents with mental health needs. A child and adolescent mental health (CAMHS) nurse was available in the ED between 9am and 5pm Monday to Friday and helped support staff in the use of the CAMHS pathway. This ensured patients aged 16 to 18 were seen in the CDU, which was a more suitable environment for staff to provide care.
- Non-clinical support teams in the department were not always well equipped to provide support to each other or to patients. For example, housekeeping staff also provided patients with a breakfast service but had problems with stock levels and workload.
- A consultant led a review clinic for one hour three days per week alongside ENPs.
- A palliative care audit in 2016 found a need for improvement in how ED doctors engaged with the palliative care specialist team or with external providers overnight and at weekends. For example, in 25 ED patients with palliative care needs, clinicians sought specialists advice in only one case. The audit team were due to present the results and their recommendations to the clinical unit board in December 2016.

Seven-day services

- Consultants were available seven days a week although the cover provided did not meet the minimum 16 hours per day required by RCEM.
- Physiotherapists, occupational therapists, a crisis response team and rapid discharge team were available seven days a week and pharmacy support was available on-call at all times. This met clinical services seven day standard 3, 2016. This requires all emergency inpatients to be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant.
- Other services were not available at weekends or out of hours, including dietetics and speech and language therapy.

Access to information

- Staff had access to the local authority safeguarding system that highlighted children on the child protection register and those who had an active safeguarding alert. Staff worked with the paediatric liaison service and school nurses to ensure they had access to information on child protection and this information was discussed at a weekly multidisciplinary meeting between all agencies involved in the care of vulnerable children and those with mental health needs.
- Clinicians had electronic access to patient histories and an alert system identified any patients known to be at risk or to be living with a condition such as dementia.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In March 2015, a hospital records audit identified that in a sample of 15 patient records there was no

documented evidence staff had completed a Mental Capacity Act (2005) (MCA) assessment. The same audit indicated staff obtained consent for treatment in only 13% of patients.

- There was inconsistent evidence that staff used mental capacity assessments and screening tools appropriately in the CDU. For example, in one person's integrated care document the mental capacity tool was not completed although they had been in the unit for two days. There were conflicting comments from different staff in the same document. For example, a doctor had written the patient was "confused and wandering" but a member of the MDT team had noted they "had capacity." A relative had raised a concern the person was becoming more confused and staff had conducted tests for delirium. However, there was no authoritative overarching decision or note about the patient's mental capacity or state. As a default approach to ensuring their safety a nurse told us they were treated on the assumption they were living with dementia.
- Staff used a monthly audit to monitor the consistency of recording consent in patient records. The most recent audit results indicated significant differences in documentation, with consent documented in records between 33% and 100% of cases. However, during our observations staff obtained consent routinely for examinations and treatment.
- Senior staff said they felt there had been improvements in the training and understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards and 90% of staff had up to date training.
- Staff used a dementia screening tool and the Glasgow coma scale to document cognitive function. However, assessments were completed inconsistently and were not always checked for accuracy. For example, one patient had two different cognitive function scores for the same tool listed by the same doctor during the same assessment. There were also contradictions in nursing documentation that related to mental capacity. For example, in one patient's notes staff had written they had reduced awareness but they understood where they were and what was happening. However, another nurse had documented the patient was aggressive and lacked capacity to understand why they needed to take their medication. This meant it was not clear staff always completed cognitive assessments correctly or that patients received care appropriate to their mental health state.

Are urgent and emergency services caring?

Good

We rated urgent and emergency services as 'good' for caring because:

- All of the patients and relatives we spoke with gave us positive feedback about the kindness and compassion staff had shown them in the department.
- The hospital performed similarly to the national average in the Friends and Family Test results in regards to the percentage of respondents who would recommend the department.
- We observed staff routinely ensured the dignity and privacy of patients when conducting examinations and giving treatment. This included ensuring patients who were vulnerable or confused were given time and patience to understand what was happening.
- Emotional support services were available for patients and their relatives.

However, we also found areas for improvement:

- Relatives and patients gave us variable feedback about how well informed they were in their care and treatment plan.
- Staff were not always able to provide appropriate care to patients with a learning disability, which resulted in frustration and anxiety for relatives.

Compassionate care

- The trust's Urgent and Emergency Care Friends and Family Test performance was generally about the same as the England average between July 2015 and June 2016 for the percentage of respondents who would recommend the department. The latest

available results were from August 2016 when 86% of patients said they would recommend this emergency department (ED) which was worse than the England average of 87%.

- Staff told us they often received positive feedback about their approach to different elements of care. For example one nurse said, "It's nice to get good feedback when you're giving your best. Little things like when a patient thanks you for being gentle taking blood, is really important to me."
- All six patients we spoke with said they felt treated with respect and kindness by staff but said they felt waiting times were lengthy. One patient said, "The nurses have been very kind and friendly but they seem to be working in very difficult circumstances."
- We observed staff treating patients with dignity and respect. For example, a nurse took the time to speak calmly with a patient who was disorientated and confused and asked them if they knew how they arrived in the ED without causing them anxiety or embarrassment. The general manager was proactive in supporting patients and helped to calm down one person who was anxious and upset. During another observation, a doctor spoke very gently with a patient and their relative about a distressing test result, took the time to answer their questions and offered them a drink afterwards while they waited to see another clinician. This had a demonstrably calming effect on both people.

Understanding and involvement of patients and those close to them

- The results of the CQC A&E survey, 2014 showed that the trust scored about the same as other trusts in 23 of the 24 questions relevant to caring. The response to the question 'If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?' was worse than the other trusts.
- Patients and relatives we spoke with did not always feel involved in care planning or treatment. One relative said, "[My relative] came in here three weeks ago but they were so full they were put in a chair in [AAU] and then discharged the same night. Two days later we were back and [my relative] was readmitted in a more serious condition." Another patient had been in the ED for six hours and 45 minutes without being spoken to by a doctor. They said, "I don't know what I'm waiting for, no-one has told me anything."
- During our observations all staff routinely involved patients in plans and decisions about their care and treatment. For example, one nurse explained in simple terms to one patient why they needed a blood transfusion and took the time to answer their questions.
- There was a lack of evidence staff were equipped to provide care or support to patients with a learning disability, including to their relatives. For example, one relative attended the department with a family member and said a doctor told them there was no-one in the department qualified to care for an adolescent patient with mental health needs. They told us, "I can't say anyone was caring because I saw so few staff. I got the impression that mental health is not a priority but no-one asked me for information about [relative] and they just didn't seem interested in what I had to say." The consultant in charge was unaware of the patient and we found they were in the ED for 17 hours, with a 14 hour wait to be seen by a child and adolescent mental health nurse.
- The hospital intervention team worked closely with family members to ensure discharge packages were appropriate, including what would make them and their family member feel safe.
- In March 2015, a hospital records audit identified that in a sample of 15 patient records there was no documented evidence patients had been involved in their care planning or that clinical staff had checked they understood their condition. There was also no evidence clinicians had checked the patients' relatives had been involved in a discussion.

Emotional support

- Over 30 recent thank you cards were displayed addressed to staff or the ED as a whole and included comments such as, "…care was second to none" and, "I don't know what I would've done without you all."

Urgent and emergency services

- Staff provided immediate signposting to support services, including emergency counselling services, for the relatives of babies who died from sudden infant death syndrome.
- Bereavement and multi-faith chaplaincy services were available on site to provide emotional support to families and there carers.
- The trust published patient, relative and public feedback using their social media-based '#ourmarvellousteams' programme. The ED and ambulatory care unit had recently received positive feedback. For example, one patient commented "…a service well in excess of anything I had expected" and another patient wrote, "The nurse…was kind, caring and thoroughly professional, a real asset to the Conquest and the NHS."
- Staff took steps to ensure patients were given privacy and dignity at all times. For example, when a doctor undertook an intimate procedure for a patient, they assigned another clinician to the cubicle to ensure no-one disturbed them. The patient tracking and information system also ensured patient privacy was protected. For example, if a patient was admitted with an alert, such as a safeguarding or child protection alert, a discreet symbol was marked on the information board. This prompted staff to check electronic records for the detailed information about the patient's situation.
- Doctors told us they felt the care provided by nurses and healthcare assistants was of a very high standard. One doctor said, "Every member of the team is very compassionate." The shortage of nursing staff sometimes meant there was a risk care-based tasks would not be completed. However, most doctors said they stepped in and completed these where they could, including offering drinks and providing emotional support.
- During our inspection a patient who had been treated in the department in the previous week came back to personally thank a doctor for the "kind and reassuring care" they had received.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated urgent and emergency services as 'requires improvement' for responsive because:

- A new frailty pathway had been launched to help the department provide appropriate care and a care pathway for the significant number of patients with related needs.
- The team had developed a number of resources to help them communicate with and care for patients living with dementia and two healthcare assistants had undertaken additional training to help them support colleagues with communication techniques.
- Although the department consistently failed to meet the Department of Health's target of 95% of patients admitted, transferred or discharged within four hours, a significant improvement plan was in place to address this. This included the introduction of new staff coordination roles, the use of hospital ambulance liaison officers and improved triage and pathways to reduce waiting times. This was part of a five-year urgent care flow project and senior staff contributed to the planned improvements by leading regular bed, flow and multidisciplinary meetings to ensure patients were being seen in the most appropriate place.
- Staff had completed audits to identify how they could further meet the needs of vulnerable groups, including those with alcohol dependency.
- Comfort rounds were used, which meant that staff ensured patients were safe, had a call bell in reach and to ensure their care needs were met.
- Senior nurses had undertaken more extensive training to help them manage complaints. The complaints process ensured patients or relatives were involved in the resolution and this information used to help staff improve services.

However, we also found areas for improvement:

- Care pathways and procedures were in place to ensure paediatric patients with a learning disability were seen immediately by a specialist. However, this

was not always followed in practice and young people were not always cared for with appropriate risk assessments or specialist input. In addition, an agreement between the department and paediatric inpatient services did not always work in the best interests of the patient.

- Discharge processes were not always consistent, did not always work well and delays could occur because of a lack of clarity over roles and responsibilities amongst the staff team.

Service planning and delivery to meet the needs of local people

- The emergency department (ED) saw a significant number of patients with needs relating to frailty. To ensure they received appropriate care, a frailty lead and team of frailty practitioners were in post to support discharge packages and reduce the risk of readmission. This team also conducted virtual ward rounds with a geriatric consultant to ensure care pathways were appropriate.
- A multidisciplinary crisis response team had been launched as part of a regional programme to prevent unnecessary hospital admissions. Staff could refer patients to the team with a single telephone call who could escort patients home and provide support such as staying overnight with patients to ensure they were safe. This enabled patients with limited support from relatives at home to be discharged safely. The crisis response team typically prioritised frail patients in response to the increasing numbers of patients seen in the ED with needs relating to this. During our weekend unannounced inspection we saw this team were proactive in conducting a board round review of patients in the clinical decision unit (CDU) to identify who could be supported in their discharge.
- An agreement was in place that allowed paediatric patients with a learning disability to be fast-tracked to specialist paediatric in-patient areas. This reduced the distress that could be caused to them in the ED.
- A standard operating procedure was in place between the air ambulance service and the ED to provide rapid transfer of trauma and severely medically unwell patients by helicopter.

Meeting people's individual needs

- Clinical staff had completed an audit of the care and treatment received by patients based on the individual needs of those who presented in ED with end of life care needs. An audit was also underway to establish how well the ED cared for patients who presented with alcohol withdrawal symptoms against National Institute for Health and Care Excellence guidance.
- Staff documented comfort rounds for patients to ensure they could reach their call bell and had food and drink when needed.
- Staff had a number of resources to help them care for patients living with dementia. A rummage box was available with pictures of old film stars, which staff used as a conversation starter and distraction technique when patients were anxious. The hospital's league of friends team had knitted comfort bands for patients, which helped them stop picking at intravenous lines. Patients were able to take these home with them. Staff also used a document that enabled them to get to know patients by finding out about their likes and dislikes, including what made them worried about being in hospital. A butterfly symbol was added to patient records and to their wristband that helped clinical staff identify immediately if they had dementia. The unit planned to develop the resources available and was scoping the use of digital reminiscence therapy software. This is software available on a tablet that provides digital content that can be tailored to a specific period of time in a patient's life and adheres to the good practice guidance of the Institute for Research and Innovation in Social Services.
- Healthcare assistants had created a dementia resource and information board for colleagues. This included information on recognising the condition and best practice guidance for effective and compassionate communication.
- The CDU had two patient showers and kept a stock of basic personal care items. One patient asked staff if they could brush their teeth but staff did not think they had any toothbrushes, although they promised to find out.
- There was a lack of evidence clinical staff always acted appropriately to monitor young people with mental

health needs. For example, a teenager who was identified as being at risk of self-harm was in the ED for over 13 hours with only one set of observation notes completed. Staff had not completed a mental health risk assessment and the patient was admitted to the CDU without clear oversight of their mental health status. The nurse in charge told us this was a frequent occurrence because it was so difficult to obtain support from the community adolescent mental health service. They also told us the paediatric inpatient ward had refused to admit the patient for observation but this was not documented in their notes and it was not possible to clearly trace the decision-making applied in this case. A doctor told us this was a common occurrence and it was much easier to obtain mental health support for adults than children due to the presence of mental health nurses in the hospital.

- A relatives room was available for private conversations and relatives also had access to separate toilet facilities.
- Two HCAs had taken the lead on developing care provision for patients living with dementia. They had completed specialised training that enabled them to provide support to other staff who struggled to reduce the anxiety levels of patients. For example, one patient in the CDU had awoken in the night disorientated and confused and staff in that unit did not have the knowledge from training that would help them to use calming techniques. One of the HCAs had been able to spend time with the patient and use techniques such as a gently stroking the back of their hand to effectively reduce their level of distress. This had enabled staff to complete their observations and help the patient to fall asleep. Staff who had undertaken the training said they felt much better prepared in such circumstances.
- Although there was room for improvement in the documentation of risk assessments and observations, staff demonstrated a proactive approach to managing patient's physical needs in relation to avoiding pressure ulcers. For example, when it became clear one patient could not be discharged from the CDU, staff ordered a profile bed and ensured the patient was turned every two hours.
- Staff did not routinely ensure patients had a call bell within reach, despite this forming part of two hourly comfort rounds. Out of 19 patients we checked during our inspection, 14 did not have their call bell within reach. Staff monitored this more consistently in the CDU, where all patients had a call bell within reach.
- A nurse had developed a number of resources to help provide emotional support to parents who lost a child. This included enlisting a graphic designer to produce a keepsake booklet that included a poem, a page to attach a lock of hair and a page to insert a hand and footprint. A keepsake box had been developed by a family who lost a child. This included a soft toy for the parents and the same soft toy to be kept with the child and a number of other personal remembrance items such as a glass angel and a 'sweet dreams' candle. A digital camera card was also included to ensure parents could store digital photographs of their child.

Access and flow

- The RCEM recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust was similar to the 60 minute time to treatment standard between May 2015 and April 2016. In June 2015 the median time from arrival to treatment was 54 minutes and in April 2016 it was 68 minutes. Between February 2016 and April 2016 performance against this standard showed a trend of decline, and the trust has not met the target since February 2016.
- The Department of Health's standard for EDs is to admit, transfer or discharge patients within four hours of arrival. The trust was worse than the England average for the four hour waiting time target of 95% of patients between July 2015 and June 2016
- Between July 2015 and June 2016 the trust did not meet the 95% target. The trust's performance had steadily declined during this period. Between April 2016 and July 2016, the trust met the four hour target with 84% of patients.
- The risk of failing to meet the four hour target for 95% of patients was identified on the urgent care service's risk register as a result of short staffing and lack of capacity. To mitigate this risk, senior staff implemented bed meetings four times daily, daily board rounds and recruited additional locum staff,

nurse practitioners and a quality improvement lead. As a result the severity of the risk had been decreased and senior staff continued to monitor this on a three monthly basis.

- New streaming protocols to the paediatric assessment unit and the ambulatory care unit had been introduced to try and help the ED meet the 95% target.
- The majority of patients who were not seen, treated and discharged within four hours were 85 years or over and accounted for 2600 individual time breaches between July 2015 and July 2016. Clinical unit staff identified discharges late in the day, a lack of timely access to diagnostics and a failure to utilise the discharge lounge as key contributing factors to the breaches.
- The Academic Health Science Network had reviewed ED services and identified slow cubicle turnover, variations in triage processes and a lack of capacity in medical specialties as contributing to waiting times and a lack of flow in the ED.
- The Department of Health's standard for emergency departments is to admit patients to a specialty ward, unit or service within 12 hours of being assessed by a specialist and the decision to admit being made. When a patient waits longer than this in ED, this is called a breach. Urgent care matrons, the clinical service manager and a consultant led daily breach meetings to try and avoid this situation and to review patients who had breached the four hour standard of being admitted transferred or discharged. We observed one meeting and saw breaches were due to deterioration in medical condition, delayed blood results and a delay in receiving a mental health assessment as the patient was under the influence of alcohol. Senior staff used this meeting to identify how patients could have been managed more efficiently and the learning from this discussed with the wider team. For example, patients with simple complaints and no historical risk factors could be discharged after a clear blood result and some patients could be safely seen in out of hours GP clinics.
- Between July 2015 and June 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was similar to the England average. Between July 2015 and March 2016 performance against this metric showed a trend of decline.
- Between May 2015 and April 2016 the trust's monthly median percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was similar to the England average. Between June 2015 and April 2016 the trust's performance against this standard showed an overall trend of decline.
- Between May 2015 and April 2016 the trust's monthly median total time in ED for admitted patients was consistently higher than the England average. Performance against this standard showed an overall trend of decline between June 2015 and March 2016.
- Between April 2015 and April 2016 the number of ambulance handovers delayed over 30 minutes for this trust was zero.. This indicated very good performance.
- Between July 2015 and June 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In July 2015 54% of ambulance journeys had turnaround times over 30 minutes; in June 2016 the figure was 67%.
- Staff used an admission protocol to ensure patients were only admitted overnight to the CDU when it was clinically safe and appropriate. The protocol identified five conditions that could be safely observed in patients overnight, such as a mechanical fall in elderly patients, minor head injuries and drug overdoses that did not need further medical treatment. We saw the admissions protocol was adhered to in practice but the maximum 24 hour stay stipulated was not always achieved due to a lack of capacity elsewhere in the hospital or in the community.
- An urgent care flow project was part of a wider five year plan of service improvement. This included planned recruitment of ambulance handover nurses, advanced physiotherapists, non-clinical flow navigators and general practitioners to ensure the trust was in a position to assess and treat patients more quickly.

- Patients spent extended periods of time in the ED due to a lack of capacity in inpatient wards and in community adult social care services. This was made worse at weekends due to lower levels of medical staffing and fewer social care resources. For example, during our unannounced inspection at a weekend, six patients had been in the ED for more than 14 hours, including one patient who had been there for over 17 hours. However, we saw staff found all patients a bed out of the ED within 12 hours of the decision to admit, which avoided breaching Department of Health requirements.
- There was not always clinically robust oversight of discharge planning. For example, one patient who had been in the CDU for two days had a rapid discharge assessment in place and the crisis response team visited them as they were able to free up a bed elsewhere in the hospital. However, the HIT team felt this would be unsafe because social input was needed and they did not think this could be available as readily elsewhere in the hospital. This meant the patient spent another day in the CDU.
- A hospital ambulance liaison officer was sometimes deployed to the ED by the local ambulance provider during times of high demand. This member of staff liaised between incoming crews and ED staff to reduce the amount of time ambulances needed to spend at the department. This was not a substantive post and was provided on an ad-hoc basis. However, an ambulance coordinator post was being recruited to in the ED and this would enable existing nurses to work in a dedicated post to manage ambulance handovers and reduce initial waiting times.
- The service manager attended bed meetings four times per day to coordinate discharges and admissions with hospital bed managers.
- We observed ambulance crews waiting in the corridor outside of ED with patients for extended periods of time. We spoke with two paramedics who had handed over a patient to a nurse and then waited 50 minutes for the patient to be moved into a majors cubicle.
- There were discrepancies between the time patients spent in the ED and the waiting times presented in the bed meeting. For example, on one day of our inspection, a manager in the bed meeting reported a waiting time of two hours and eight minutes to see a doctor but we found one patient had waited two hours and 55 minutes without being seen. This meant the efficacy of the bed meeting was not robust because it was not based on accurate information.
- There were contradictions in how staff approached discharge and admission processes. For example, we found one patient had waited unnecessarily in a cubicle to be told their blood results were as expected and they could go home but a locum registrar told us they felt it was the nurse's responsibility to organise this.
- We observed a bed meeting attended by six service managers, four matrons, two clinical service managers and the chief operating officer. The meeting was used to identify the number of patients in both ED sites, waiting times and any staffing shortages. This meeting was also used to identify any imminent discharges from wards and intensive care.
- Doctors, the nurse in charge and therapies staff attended a combined board round and safety huddle each morning. This was used to review each patient in the department and identify opportunities for safe transfer and discharge.
- A daily cross-site multidisciplinary hospital bed meeting took place that included input from hospital directors, matrons, clinical managers, service manager, general managers, heads of nursing, the infection control lead, the site manager and duty manager for transport services. This meeting was facilitated using video conferencing, which reduced the need for staff to travel between sites and disrupt service and included a review of staffing levels, capacity and flow problems at both sites. Staff also identified any medical outliers who were being cared for in surgical wards and planned how to transfer them into more appropriate medical areas. Intermediate care community beds were also identified and a plan made to discharge any appropriate patients to these.
- The numbers of reception staff on duty at one time were often insufficient to meet demand. For example, only one receptionist was on shift to book in patients who arrived by ambulance and on foot before 11am each morning.

Learning from complaints and concerns

Urgent and emergency services

- Between August 2015 and July 2016, urgent and emergency services received 55 formal complaints. This represented 8% of all complaints received for all departments in the trust, including the Conquest Hospital. In October 2016, five of the complaints remained unresolved and under investigation. Of the total complaints, 33 related to aspects of clinical treatment and five related to patient dissatisfaction with communication from staff. There was evidence in each case a senior member of staff contacted the complainant, offered an apology and discussed the contributing factors to what happened. The clinical service manager offered to meet the complainant where a face-to-face meeting was more appropriate.
- Heads and deputy heads of nursing led weekly complaints meetings with the personal assistants to consultants and the hospital complaints lead. The senior team had improved training for band seven matrons to help them handle minor complaints from patients and relatives during the course of a shift. A patient who had previously submitted a complaint attended a band seven staff training day to help them understand the cause of the complaint and what could have been done to avoid it.
- Staff nurses had a good working knowledge of hospital complaints procedures and were able to address minor issues at the time they were raised. Where this happened they apologised to the patient and made sure the nurse in charge spoke with them out of courtesy.

Are urgent and emergency services well-led?

Requires improvement

We rated urgent and emergency services as 'requires improvement' for well-led because:

- The senior team, who worked across trust sites, had not fully addressed deteriorating performance in access and flow, including triage, handover and assessment although a programme of improvements was underway.
- Risks to patient safety due to short staffing and incomplete mortality reviews were ongoing and the existing clinical governance structure had not enabled staff to resolve them.
- An overarching local strategy plan was in place and was shared with the trust's Eastbourne site. This was led by an emergency care programme board and set out a structure of ambitious improvements to streamline working practices, introduce innovative new staff roles and ensure existing teams were supported and motivated to continue developing and improving the service. Although the strategy laid out improvement plans and new initiatives to address risk, these had not been fully implemented or realised at the time of our inspection.

However, we also found areas of good practice:

- An overarching local strategy plan was in place and was shared with the trust's Eastbourne site. This was led by an emergency care programme board and set out a structure of ambitious improvements to streamline working practices, introduce innovative new staff roles and ensure existing teams were supported and motivated to continue developing and improving the service.
- Significant risks to the service were well managed by a senior team who reviewed them regularly and proactively sought new practices to reduce or resolve long-standing risks.
- Staff spoke positively about the improvements in leadership and working culture that had experienced, including developmental opportunities and a more visible presence from the trust's senior team. A restructure of the local management team had been well-received by staff who told us they felt more supported as a result. New senior posts involved staff in decisions regarding the unit and used their feedback in planning.
- Staff and the department demonstrated a number of areas of innovation, including in the planning to diversify staff roles and increase recruitment to improve quality of care and reduce waiting times.

Leadership of service

- The leadership of the trust's EDs had recently been restructured to help manage the five year plan and

improve quality and performance. A nurse director and deputy nurse director provided senior leadership within the clinical unit and a head of nursing a newly-appointed deputy head of nursing and a service manager were responsible for the ED and CDU. The service manager was responsible for the flow of patients and the head and deputy head of nursing led patient care and quality. Shifts were led by band seven matrons.

- Senior staff had fostered an environment with a 'flat hierarchy'. This meant any member of staff could approach each other for support or guidance without the need to wait for a specific person because of the management structure. Staff were very positive about this and the deputy head of nursing said it had resulted in improved working relationships. They said, "It's led to a working environment where HCAs can approach consultants for advice and they get this straight away, there's no need for them to wait for a certain individual just because of their job title."

Vision and strategy for this service

- The trust had an overarching vision and strategy titled 'Outstanding by 2020' that related to a broad programme of improvement and restructuring.
- The emergency department (ED) had a local strategy plan, which was shared with the Eastbourne District General Hospital ED and aimed to improve partnership working with clinical commissioning groups and clinical units. The plan was supported by an emergency care programme board and enabled the units to work collaboratively with specialist advising organisations, including the Academic Health Science Network and NHS Improvement. Improved patient care was a key planned outcome of the plan, which was due to be achieved through the enhancement of skills and competencies of staff across professional roles, including nurses and physiotherapists.
- The clinical unit that included the ED also included specialist ward services, such as a frailty pathway. There was a plan in place to begin a staged realignment of specialist services that would move wards out of the urgent care remit and into that of specialist medicine. This would enable greater focus to be placed on improving performance and quality in the respective areas because managers would have a more targeted scope of responsibility.
- An emergency care project group had been formed to look at how the ED worked in partnership with other departments and how this could be improved to reduce treatment delays and ensure the ED met the 95% target. The clinical service manager represented the ED in this group.
- The trauma nurse service coordinator was working with the rehabilitation lead to develop working relationships with other regional trauma services, including the air ambulance service, and multidisciplinary allied health professionals to work towards a future 24-hours, seven days a week trauma service.

Governance, risk management and quality measurement

- The ED was part of the urgent care clinical unit, which included the clinical decision unit (CDU) at Conquest Hospital and the medical assessment unit (MAU) at Eastbourne District General Hospital as well as the acute admissions units (AAUs) and ambulatory care units at both sites. Clinical unit leads led the governance and risk management structure. This included the use of a risk register to assess and monitor risks to the service, its users and staff. Two risks were in place at the time of our inspection that related to Conquest Hospital and a further 11 risks were shared with the Eastbourne site. One risk at the Conquest site related to the lack of AAU space and the potential for inappropriate admissions as a result. The head of nursing was in the process of reviewing this risk and had mitigated severity in the meantime by improving collaboration between staff in the AAU and the ambulatory care unit. The second risk related to the geographic separation of the CDU from the main ED and that the emergency communication systems were not connected. This meant in an emergency staff in the CDU could not easily seek help from the ED. In place of a long-term solution, staff had been provided with an emergency two-way radio system to enable them to get help urgently. Staff were trained in its use

and we saw permanent staff trained agency staff how to use the system. The head of nursing had reviewed both risks in August 2016 and updated the strategy to resolve them.

- Seven of the risks the Conquest ED shared with the Eastbourne site related to short staffing in medical and nursing teams, including the inability to provide minimal medical cover at specific grades. Other risks related to the lack of segregation for children, delays in transferring care due to hospitals operating at capacity and lengthy delays in obtaining specialist mental health referrals. All risks had an accountable senior person assigned to them and all had been reviewed with an update to mitigating strategies in August 2016.
- The senior clinical unit team used six quality performance indicators to measure patient experience and pressures on the service, including treatment time delays and care for patients who frequently attended both ED sites. The meetings took place monthly and were attended by clinical service managers, at least on consultant, a general manager and a head of nursing although consultant presence from the ED or frailty team was inconsistent. We looked at the minutes of meetings from May 2016 to July 2016 and found improvements in the governance of the unit. For example, through the development of a more robust management and accountability system, the number of unresolved incident reports was reduced and the unit achieved the trust's minimum requirement of 90% of staff with an up to date appraisal.
- A review by the Academic Health Science Network identified poor processes and lack of oversight of how staff used policies and procedures as contributing to the significant capacity, access and flow problems in the ED. In response, senior staff developed an urgent care action plan that aimed to establish an emergency care programme board, review all clinical protocols by August 2016 and introduce a new medical model of working. The team also planned to introduce a rapid access and treatment (RAT) stream within ED to see and treat non-complex patients. This was due to be in place by August 2016 but had not been established by our inspection in October 2016. A multi-agency discharge improvement group commenced in June 2016 to work with the urgent care board to reduce discharge delays and ensure patients awaiting specialty beds or discharge to adult social care services received faster attention.

Culture within the service

- Following several months of exceptionally high numbers of patients, senior staff expressed the need to make sure staff felt valued and were recognised for good work. This included the reintroduction of regular staff meetings and shift leaders made sure they thanked each nurse personally at the end of every shift. All of the senior staff in the unit worked with an 'open door' policy and staff told us they had no shortage of people to go to if they had an issue or concern. The concerns of staff we spoke with related most often to short staffing and the workload. One member of staff said, "Staff are stressed and tired. It hasn't let up [the workload] for months and there are never enough of us. I'm very worried about what will happen in the winter."
- The trust had appointed a speak up guardian who attended meetings with senior ED staff. This individual was also available to any staff working in the department for advice.
- Staff were very positive about their relationships with and the visibility of the senior executive team. One member of staff described the chief executive officer as "massively approachable" and said senior staff often visited the unit to thank everyone for their hard work.
- Staff who had recently joined the department described it as a supportive place to work. One member of staff said, "This was a totally new role for me but there are always lots of people to ask for help. I got a mentor to start with and the whole team has been very welcoming. We're able to influence our rota a little bit so I can get the time off that's important to me." Another member of staff said, "I had some time away and came back and there are lots of new staff but it's the same great atmosphere and a really supportive place to work."

Public engagement

- Visitors were encouraged to submit suggestions and feedback to the department through comment cards and social media.
- Reception staff proactively engaged with people visiting the department by giving out a feedback form on arrival and encouraging them to give this to staff during their stay.

Staff engagement

- Staff had been engaged by senior staff during the recent structure changes in the unit and with the management team. The deputy head of nursing was a new post and the member of staff had initially met with each band seven matron to get to know them and find out what they needed to continue leading shifts in the department. As part of their strategy to increase engagement with staff, a band seven away day had been organised with their colleagues from the Eastbourne ED. As a result of this, band seven matrons had agreed to spend some time working cross-site to help them establish more standardised working practices and to learn from the good practice that occurred in the thrust's other ED.
- Senior administration staff introduced a monthly newsletter for the clerical team to improve how involved the team were in the department. This included details of upcoming training, including for major incidents as well as positive feedback from colleagues such as how smart their new uniforms were.

Innovation, improvement and sustainability

- Urgent care services had a monthly staff sickness rate higher than the trust average. In June 2016 the annual sickness rate was 5% compared to the trust average of 4%. Staff turnover between June 2015 and June 2016 was 10%, equivalent to 44.75 whole time equivalent members of staff. To address this, the clinical unit management team had recruited a new deputy head of nursing for each ED and organised a band seven nurse away day in August 2016 to promote team cohesion and morale.
- The ED had recently been funded to recruit an ambulance handover nurse. This member of staff would manage incoming patient handovers from ambulance crews and reduce the need for them to wait in the unit to be seen.
- The deputy head of nursing post was created alongside a similar post in the ED at Eastbourne. The two members of staff planned to work together to standardise processes between both sites to improve safety and performance, such as when staff moved between sites and for quality monitoring. This included the introduction of a standardised streaming pathway for patients who needed an urgent gynaecology referral.
- The trauma nurse service coordinator had coordinated a complex international repatriation with an acquired brain injury (ABI) specialist nurse from the clinical commissioning group, a general practitioner and an ABI non-profit organisation. The trauma nurse acted as a single point of contact for the patient's family and in the process identified the need for an ABI pathway that included scope for international collaboration and repatriation. As an interim measure, information for international patients and relatives was made available on the trust's website and the trauma nurse planned to develop this pathway as part of their work to improve rehabilitation services.
- The trauma nurse service coordinator and PDN were working together to offer staff nurses the opportunity to undertake a specialised trauma course in early 2017. This was to ensure the ED could offer a service to patients with catastrophic airway collapse or another trauma that would otherwise result in a transfer to another site.
- In November 2016 there was due to be a significant change to the structure of the clinical unit. A new medical division would be created and acute medicine would leave the urgent care clinical unit, leaving the emergency department as the sole department. This was led by an urgent programme board and immediate plans included a consultation to introduce a senior nurse enhanced coordinator role to improve access and flow and a consultant emergency medicine lead. The programme board also planned to

continue developing the frailty service by introducing a frailty model to the department that meant patients would be seen by specialists immediately on arrival in the department.

- The ENP service continued to be developed, with 30% of all ED patients seen by this team. This included supplementing the team with a trained HCA and increasing the range of minor injuries they could treat.
- The paediatric area was under development works to build dedicated paediatric evaluation and treatment cubicles.
- A dedicated multidisciplinary team had established a five year plan to establish an innovative rehabilitation care plan as part of an out of hospitals services transformation programme. This programme included staff from multiple specialties and enabled ED staff to work with colleagues from across the trust and in the community to develop future services, including an ambulatory rehabilitation unit and a rapid access care service. The programme planned to introduce nurse practitioner roles for frailty, crisis response and proactive care who would provide an integrated rehabilitation service alongside hospital and community-based specialists. This programme would significantly improve working links between the trust's hospitals and local authority social care services and enable rehabilitation services to be provided more responsively to avoid the need for hospital admissions. There was significant support and infrastructure for staff to develop this programme and they had been invited to present their plans and work so far at a national health and social care awards ceremony.

Surgery

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

Information about the service

The surgical services (the service) at East Sussex Healthcare NHS Trust provide care for a population of 525, 000 people. The surgical department offers multiple speciality services across multiple sites, including Conquest, Eastbourne District General, Lewes Victoria and Bexhill hospitals. During this inspection, the CQC inspected Conquest Hospital (CH) and Eastbourne District General Hospital (EDGH).

This report is focused upon the Conquest Hospital however; both hospitals follow the same guidelines and policies. The Conquest Hospital is a district general hospital, located in St. Leonards-on-Sea, on the outskirts of Hastings.

Surgical services across both sites are made up of two directorates; Theatres and Clinical Support and Surgery.

The service has nine main operating theatres covering general surgery, trauma and orthopaedics, gynaecology, ear nose and throat (ENT), urology and ophthalmology (eyes) across the two sites. Both sites undertake emergency, elective inpatient and day case surgery. There are 170 surgical beds on the Conquest site across eight wards and a 26 bay surgical assessment unit (SAU).

Between April 2015 and March 2016 at Conquest Hospital there was a total of 11,183 surgical spells (a spell refers to a continuous stay of a patient using a hospital bed). Emergency spells accounted for 43%, 39% were day case spells, and the remaining 18% were elective.

We visited all surgical services as part of this inspection, and spoke with 51 staff including staff on the wards and in theatres, nurses, health care assistants, doctors, consultants, therapists, ward managers, porters and other health care professionals. We spoke with 12 patients, and examined 25 patient records, including medical and nursing notes and medication charts.

Following two inspections in September 2014 and March 2015, surgical services at the Conquest Hospital were rated inadequate. Our inspection teams found serious shortcomings in the quality of care and treatment being provided both in the operating theatres and on surgical wards. Issues identified included low staffing levels, a culture where bullying was tolerated, limited learning from serious incidents and delays in patients being treated.

Surgery

Summary of findings

Overall, we rated the surgical service at Conquest Hospital as 'Good'. This was because:

People were being protected from avoidable harm and abuse.

- Openness and transparency about safety was encouraged. Staff understood their responsibilities in relation to incident reporting. Incidents were investigated appropriately by staff with the necessary clinical knowledge and who had received training in leading such investigations. We were given examples of where changes to practice had been made following incidents. The service had experienced a 'never event' at the Conquest hospital which had involved the wrong administration route of a medicine. This had been rigorously investigated and changes had been made in order to ensure it was not repeated.
- The services, wards and departments were clean and staff adhered to infection control policies and protocols. Pragmatic solutions had been found to some of the problems that were identified during previous inspection visits. This included the appointment of staff known colloquially (and with some pride) as "Theatre Fairies". These staff kept the theatre environment clear of equipment, waste and other clutter that got in the way of safe and efficient theatre practice.
- Record keeping was comprehensive and audited regularly. Records were now tracked using a barcode tracking system and most patients had their full notes available for consultations. An off-site records storage system was being used and whilst some staff were still unhappy about the need to relocate, the records management was more effective and working in the best interests of patients.
- Decision making about the care and treatment of a patient was clearly documented. The electronic observation recording system had been used to drive improvement in the timely identification of patients at risk of unexpected deterioration. It had allowed for oversight of patients with elevated risk by the critical outreach team and concerns were escalated for review by the medical or surgical emergency teams more swiftly.
- Treatment and care was generally provided in accordance with the National Institute of Health and Care Excellence (NICE) evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. There were examples of effective multidisciplinary working.
- Performance against national audits such as patients with a fractured neck of femur (broken hip) audit showed evidence of good outcomes for patients.
- Leadership was good and staff told us about being supported and enjoyed being part of a team. There was evidence of multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.
- Development opportunities and clinical training was accessible and there was evidence of staff being supported and developed in order to improve services provided to patients.
- Feedback from patients was continually positive about the way staff treated people. We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff.

However:

- There was not an effective system in place that ensured completion of anaesthetic machine safety logbooks.
- Controlled drug records in theatres were incomplete with some staff block signing for drugs.
- The content and quality of records for mortality and morbidity meetings required improvement.
- There was still a heavy reliance of temporary staff for both medical and nursing staff.

Surgery

Are surgery services safe?

Good

Overall we rated the service as 'Good' for safe

This was because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. We were given examples where learning had taken place and had changed practice. All incidents were analysed and reported to the monthly departmental meetings for further discussion and action. The culture of reporting and the feedback received had improved since our last inspection.
- There were systems, processes and standard operating procedures for example in infection control that were reliable and kept patients safe. We saw greater adherence to the trust infection prevention and control polices when compared to our inspection in September 2014.There was a better use of local audit to drive improved standards in cleanliness.
- The service had effective systems to assess and respond to patient risk. We observed staff recognised and responded appropriately to any deterioration in the condition of patients. The electronic observation system was being used to monitor patients more closely than on our previous inspection visits and there was consistent identification, escalation and oversight when a patient's condition deteriorated.
- Handovers and safety briefings were effective and ensured staff managed risks to people who used the service. Information was shared and staff felt more able to challenge and voice concerns.
- Appropriate safeguarding arrangements were in place to identify and protect people from the risk of abuse.The trust worked within the wider East Sussex multi-agency policies and had strong relationships with other agencies. Shared policies were known and understood by staff.
- Individual patient records were now in a much better condition. Records were generally available for consultation (there were occasional delays in obtaining records reported by pre-assessment staff) and the trust was monitoring record availability. A bar code tracker system had negated the previous problem of notes missing completely.Records seen were legible, in good condition and completed fully. Storage was now secure with coded access to notes storage trollies on wards.
- Staffing was much better but still continued to pose a challenge to the surgical division. The trust had introduced several recruitment strategies, including successful recruitment from overseas.The level of concern around staffing had reduced and most wards and theatres met planned staffing levels most of the time, albeit with the use of agency and bank staff.
- Systems for the safe handling of administration of drugs were in place. Pharmacy input and audit processes had significantly improved since our last inspection.

However

- Controlled drug records in theatres were incomplete.
- Mortality and morbidity meetings required improvement. They were happening regularly now, where they weren't previously but the records showed a lack of depth in the discussions.
- There was still a heavy reliance of temporary staff for both medical and nursing staff.

Incidents

- The trust reported three never events between August 2015 and July 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The never events were two medicine incidents and one surgical/invasive procedure. One never event happened at Conquest hospital and it involved the wrong route administration of medicine. A medicine that was meant to given via an epidural (anaesthetic injection in back) was given into a vein, when the patient was in the post anaesthetic care unit (PACU).
- There had been a number of changes made as a result of learning from the never event investigation. For example, further drug administration training and assessment for all recovery staff, a review of stock

ordering of specific yellow epidural catheters. During our inspection, we saw the specific yellow epidural catheters were available and used at all times. We saw there was posters displayed which reminded staff to use the yellow lines with epidurals. In addition, the pain team had undertaken additional training with PACU staff. This demonstrated good learning from incidents and changed to practice as a result.

- In accordance with the Serious Incident Framework 2015, the Conquest Hospital reported eight serious incidents (SIs) which met the reporting criteria set by NHS England between August 2015 and July 2016 of these, the most common type of serious incident reported was slips, trips and falls with 50% of total incidents.
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents both at junior and senior level. The hospital told us that incident reporting training was part of the trust induction programme; this ensured all staff received training prior to starting working in the hospital. The form was accessible for all staff via an electronic online system.
- Between July 2015 and June 2016, a total of 1,359 surgical care incidents were reported at Conquest hospital.
- The service used the trust's internal safety alerts when a serious incident had occurred to share the incident with all staff and to ensure staff were updated in the actions taken from the incident. There was also a 'Patients First' monthly bulletin which told the story of specific patient incidents
- Staff told us that reporting of incidents had improved since our last inspection, and staff were encouraged to report incidents regardless of severity and had time to do so. Staff told us they had confidence in reporting incidents and gave examples including feedback from the investigation. The number of incidents being reported had increased over time but the number of SIs remained fairly constant. This suggested an improved reporting culture.
- Meeting minutes of the trust August 2016 Quality Report showed that incident reporting across the trust had increased. The trust viewed this as a positive improvement in reporting culture.
- Learning was now shared at the morning theatres meetings, at clinical governance sessions and at unit meetings. Staff felt this was an embedded practice and this was an improvement since our last inspection.
- We saw 'monthly bulletins', which told the story of specific patient incidents, which highlighted the learning from incidents and never events. This ensured all staff in the hospital were informed of incidents and any changes to practice as a result of them.
- There were weekly patient safety summit's (WPSS) which were attended by the director of nursing, the medical director, the associate director of governance, the clinical unit clinical leads and heads of nursing, the patient safety lead and the trust risk lead. The WPSS reviewed all severity three and above patient safety incidents and discussed, confirmed and recorded the; decision on grading and whether serious incident (red), internal incident (amber) or downgraded to severity level or two. The investigation lead was identified, immediate action or learning was taken, the lead then ensured learning was shared throughout the trust and closed the incident. Incidents of lower severity but of concern were also discussed.
- There was a monthly Scrutiny Group meeting where SI's and incidents which resulted in medium harm and above were reviewed prior to closure. This ensured there was a thorough investigation into these incidents and the recommended actions had been undertaken.
- Action points were challenged by the group if it was felt that they did not provide adequate assurances. For example, we saw from the August 2016 meeting minutes that further assurances were requested before the group agreed to close the incident.
- There was a governance lead for theatres and clinical support who had undertaken RCA training. Staff told us that there were plans to ensure more senior staff undertook RCA training.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw evidence that the processes for the duty of candour were in place and documented within the incident reporting system.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents'andprovide reasonable support to that person. Staff understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.
- We reviewed two RCA's and saw evidence that the duty of candour regulation had been applied. Confirmation and evidence of application of the DOC regulation was discussed when incidents were discussed at WPSS.
- Staff described working in an environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives. Staff were able to give examples of when the duty of candour regulation had been applied.

Patient Safety Thermometer

- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harm including new pressure ulcers, catheter urinary tract infections (C.UTIs) and falls.
- The NHS Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. We saw this information was displayed on the wards, such as number of falls and pressure ulcers. For example, Egerton ward displayed the last time a patient had fallen was two days ago and the last pressure ulcers (developed on the ward) was 45 days ago. We saw staff levels for each shift were also displayed on the entrance to each ward.
- Trust level data demonstrated (data was not available at site level) there were 38 pressure ulcers, six falls with harm and were 12 C.UTIs between July 2015 and July 2016. The highest number of pressure ulcers was in April 2016 (9) and the lowest amount was none in November and December 2015. The highest amount of C.UTIs was in July 205 and May 2016 (3), in the same time period there was seven months when there were no C.UTIs. This was a significant improvement from our previous inspection when rates of pressure damage and number of falls were much higher.
- The hospital data provided demonstrated between March 2016 and June 2016 overall the trust VTE risk assessment and management compliance in surgery was 95 % this is equal to the national target. The target was missed in both March and June 2016. The surgery division was still not able to demonstrate consistent and sustained compliance with VTE assessments.
- We saw 25 completed VTE risk assessments documented in patient records and appropriate prescribing of anticoagulation (medication to prevent blood clots) on prescription charts. The practice around VTE prevention had improved significantly since our previous inspection visits when a lack of risk assessment was identified as a serious concern.

Cleanliness, infection control and hygiene

- The trust participated in surgical site infection (SSI) surveillance data collection that was submitted to Public Health England (PHE). Data collected and submitted included every patient who had undergone hip and knee prosthetic (an artificial body part) surgery including resurfacing and revision but excluding first stage revision where cement spacer was used.
- According to the most recent PHE 2015 data for hip and knee prosthetic surgery, the SSI rates were lower than the national average at the Conquest Hospital.
- The only more recent SSI data available demonstrated between 01 January and 31 March 2016, 50 patients underwent hip and knee prosthesis surgery and there was no reported SSI's.
- Between July 2015 and June 2016, the trust reported two cases of methicillin resistant staphylococcus (MRSA) and 58 cases of clostridium difficille (C. Diff) infections at the trust. This was worse than the objective case rate set by NHS England of 44 cases. This data was not broken down by service.
- Wards we visited had boards, which indicated the date of the last MRSA and C. Diff infection on the ward for patients and members of the public to see. For example, we saw on Egerton ward the last time a patient had a C.Diff infection was 10 months ago.
- We saw staff complying with infection prevention and control policies. For example, we saw eight members of

staff wash their hands and seven members of staff use alcohol hand sanitiser in accordance with the World Health Organisation (WHO) 'Five moments for hand hygiene'.

- We saw hand sanitiser bottles readily available throughout clinical areas in theatres and on the wards. The hand hygiene audit for July 2016 showed an average compliance of 99% across the wards and 100% in theatres. The score had been above 97% for each month since February 2016.This audit demonstrated that staff were cleaning their hands in accordance with national guidance.
- All members of staff we saw in clinical areas were bare below the elbows (BBE) to prevent the spread of infections in accordance with national guidance. An audit undertaken by the trust across seven surgical wards in April 2016 demonstrated that out of 36 staff members audited only one staff member was non-compliant with BBE. This audit showed that the majority of staff were BBE in accordance with national guidelines. This demonstrated an improvement in BBE compliance since our last inspection.
- The ward areas and theatres had cleaning schedules available for cleaning all the equipment. This was in line with the Department of Health 2014 document 'Specification for the planning application, measurement and review cleanliness services in hospitals'.
- A cleaning audit undertaken by the trust in July demonstrated that the surgical ward average cleanliness score was 96% and theatres was 98%.This data showed that there was high levels of cleanliness on the wards and theatres.
- Staff told us they cleaned equipment as they used it. We saw 'I'm clean' sticker on some equipment but not all. Therefore, we were not assured that all equipment was cleaned and safe to use.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2015 scored 95% for cleanliness at Conquest hospital, which was slightly worse than the national average of 98%. We were not provided with scores for all areas but noted that Egerton ward scored 87%, which is worse than the national average of 98%, Gardner ward (99%) and the Richard Ticehurst Unit (100%) scored better than the national average.
- We saw personal protective equipment (PPE), such as gloves and aprons were used appropriately and were available in sufficient quantities. An audit was undertaken in July 2016 on the use of PPE across the surgical wards. This audit demonstrated out of 66 members of staff only one staff member was non-compliant with the correct use of PPE .This audit showed the majority of staff were using PPE correctly to protect themselves and patients.
- Operating theatres had separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for re-processing by the trusts decontamination service.
- We saw records of a deep cleaning and filter change schedule of the theatres, this showed that there was a system in place to regularly undertake deep cleaning of theatres and replace filters to ensure theatres were clean.
- If maintenance work was undertaken in theatres, a "deep clean" would be undertaken before the theatres were used again.
- Storage of contaminated waste outside operating theatres had been highlighted as a concern during our last inspection. Since our last inspection, theatres had employed domestic support staff, it was their job to ensure all contaminated waste was removed from the theatre environment. We saw theatres were visibly clean with all contaminated waste disposed of correctly. This showed an improvement since our last inspection, we spoke to one of the "Theatre Fairies" who took pride in ensuring theatres were clean and tidy.
- We observed that the National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: Staff in the theatre environment followed prevention and treatment of surgical site infections (2008) was followed. This included skin preparation and management of the post-operative wound.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we witnessed staff using these.

- Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations.
- Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked 19 sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability. We saw posters displayed which outlined what action must be taken if a member of staff sustained a sharp injury.
- We observed that sharp safe cannulas (a thin tube inserted into a vein) and sharp safe hypodermic needles (hollow needle) were being used. These devices reduced the risk of a member of staff receiving a sharps injury.
- Decontamination and sterilisation of instruments was managed at EDGH, which was compliant with the Medical Devices Directive. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, ward and clinics.
- Theatre staff wore the appropriate theatre attire, such as theatre blues, hats and masks. We saw that staff put on a protective coat over their theatre blues, and removed hats when leaving theatres. This was in line with the trust uniform policy.
- We saw signage on side room doors indicating when a patient had an infection and equipment to support barrier nursing.
- Ward staff described to us using aseptic techniques when changing a dressing using a non-touch technique to avoid any cross infection. This was in line with NICE guidance (QS49).
- We saw in theatres that skin cleaner, which contained antimicrobial ingredients, was used prior to insertion a cannula (a thin tube inserted into a vein).This reduced the amount of germs on the skin and reduced the risk of infection.
- We saw there were daily checklists, which ensured all water outlets were run for a minimum of two minutes at full velocity. This ensured compliance with the Health and safety Executive: The control of legionella bacteria in hot and cold water systems HSG274 (2014).

Environment and equipment

- There were nine operating theatres and a recovery area with 10 bays and one high dependency bay. The theatre department also included anaesthetic rooms, scrub facilities, clean preparation rooms and dirty utility.
- We saw there were an adequate number of portable oxygen cylinders for the transfer of patients or for use in an emergency. We checked ten cylinders, which were in date and labelled.
- Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut. There was a hospital generator that was tested monthly; this ensured there was a backup supply of electricity if the main electricity supply failed. We saw records of the generator testing and records of when the generator had been used to supply power to the hospital.
- We saw that electrical safety checking labels were attached to electrical items showing that it had been tested and was safe to use .We checked 38 pieces of electrical equipment and all had been tested within the last 12 months.
- Theatres had a difficult intubation (placing a breathing tube in the windpipe) trolley, which met the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society standard. We saw daily checking records, which were fully, completed which gave assurance that the equipment was ready to use in the event of an emergency.
- There was a clinical anaesthetic kit evaluation (CAKE) group, which met every month and was made up of anaesthetists. The purpose of this group was to review current anaesthetic equipment and highlight the need for replacements and additional training.
- We saw Health and Safety Control of Substances Hazardous to Health substances were stored in line with Health and Safety Executive guideline SR24.This ensured safe storage of substances, which could cause harm to staff and prevented unauthorised access.

Surgery

- We checked over 30 consumable (disposable equipment) items and all were within their expiry date, which showed they were safe to use.
- The wards and theatres had portable resuscitation trolleys. The trolleys contained medication and equipment for use in the event of a cardiac arrest. We saw daily check sheets completed for all trolleys to ensure equipment was available and in date. The resuscitation trolleys all had tamper evident tags to alert staff to any potential removal of equipment.
- The inconsistency of checking emergency equipment had been highlighted as a concern during our last inspection. We saw there was a robust system in place to ensure emergency equipment was checked daily. Staff were allocated to check emergency equipment on a daily basis on the wards and theatres. This was highlighted on the staff allocation, which ensured all staff knew who was responsible for checking it. We saw how changes had been made since our last inspection to the equipment checking process. For example, in theatres emergency trollies are now standardised with checklist and tamper evident tags, there was also a resource folder, which details the contents of each trolley for staff to refer to.
- We saw in theatres that there was a robust system in place to ensure the recording of medical implants used. This was in accordance with the Medical Devices Regulations 2002. A medical implant is a device intended to be either totally introduced into the body or to be partially introduced into the body through surgery and to remain there for at least 30 days.
- We saw the trust had a five-year equipment replacement programme, which included 51 pieces of theatre equipment for example operating tables and video cameras. This demonstrated that there was a process in place to replace equipment as it became old and no longer safe to use.
- In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients' operations. This ensured no items were left behind during surgery and was in line with the Association for Perioperative Practice (AfPP) guidelines.
- The staff we spoke with confirmed they had access to the equipment they required to meet peoples' care needs.
- Cleaning and sterilisation of instruments was undertaken at EDGH, there were two instrument coordinators who liaised with staff in theatres and staff in the sterilisation unit at EDGH. This ensured effective communication between the two departments and equipment needs were planned to avoid delays to surgery due to unavailability of instruments.
- We saw quarterly environment and equipment audits were undertaken, with actions taken if non-compliance was noted. For example, an audit undertaken in April 2016 identified the vinyl edging and flooring in an area in theatres needed attention. The audit showed that an action had been taken to replace the flooring.

However:

- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) was not consistently adhered to. This guideline stated that records must be kept of each safety check of all anaesthetic machines in a logbook, which is kept with the machine. We identified in six log books we examined not all were complete with daily signatures to confirm the safety checks had been undertaken. For example, in theatre eight between 19 April and 19 September there was 12 occasions when the safety checks were not recorded or marked as the theatre was closed. This meant there was not a robust process in place, which ensured these safety checks had always been documented.
- The National Patient Safety Agency (NPSA) alert PSA001 issued 31January 2011 states: All NHS healthcare organisations are asked to ensure that: From 1 April 2012 all spinal intrathecal (injection into the spinal canal) bolus doses (medication administered rapidly) and lumbar puncture samples(procedure to collect and look at the cerebrospinal fluid) are performed using syringes, needles and other devices with connectors that cannot connect with intravenous Luer connectors. (standardized system fluid fittings used for making leak-free connections between medical and laboratory instruments, including hypodermic syringe tips and needles or stopcocks and needles) (Part A). From 1 April 2013 all epidural (injection into the back which produces loss of sensation below the waist), spinal intrathecal (injection into the spinal canal) and regional

infusions and boluses are performed with devices that use safer connectors that cannot connect with intravenous Luer connectors or intravenous infusion spikes (Part B)

- The trust is non-compliant with this alert but it was highlighted on the surgical risk register. The risk was last reviewed in August 2016 and was given an increased risk rating from high to extreme. This was due to the never event that occurred which involved non-compliant spinal and epidural equipment. The service had put measures into place in order to mitigate the risk for example; all epidural lines and pumps colour coded yellow ,all epidural pumps connected where possible in theatre and if nursing staff were required to connect epidural lines, a two person check was required. This demonstrated that the service had reviewed the risk following the never event and had put further measures in place to mitigate the risk. Staff told us that they were in the process via the CAKE group of trials of equipment to ensure compliance with this alert.

Medicines

- The trust had a medicine policy, which was in date and referenced national guidance for example General Medical Council (2013), Good practice in prescribing and managing medical devices, and Nurse & Midwifery Council (2006), Standards for proficiency for nurse and midwife prescribers.
- The Duthie report contains extensive recommendations for NHS care providers to support and develop policy and good practice on the handling and security of medicines to improve clinical governance and patient safety. The trust completed quarterly audits against these recommendations. The March 2016 audit demonstrated theatres had a compliance of 85% and surgery 80% compliance both were worse than the trust target of 90%.
- We checked temperature monitoring charts for the medicine fridges in both wards and theatres. The records showed staff had monitored the temperature of both fridges daily in the last month. This showed an improvement since our last inspection when fridge temperature monitoring was sporadic. This provided assurance the unit stored refrigerated medicines within the correct temperature range to maintain their function and safety. We asked two members of staff what the safe temperature ranges were and both were able to describe these and in addition what action to take if the temperature fell outside of the safe range.
- There was a completed daily checklist for monitoring the ambient temperature on the wards and theatres. This ensured that medicines stored at room temperature remained within the manufacturer's indicated temperature range.
- An audit undertaken in March 2016 demonstrated that 76% of areas kept medicines for return to pharmacy securely. During our inspection, we saw there were dedicated secure containers to place medicines, which were for return to pharmacy. This meant any medicines for return to pharmacy were kept secure and isolated from other medicines.
- We saw medicines on the wards and theatres were stored safely and securely in line with relevant legislation for the safe storage of medicines. We observed nursing staff locking medicines trolleys when they administered medicines to patients.
- An audit undertaken in March 2016 showed 59 % of patient medication lockers were in good condition/ undamaged. In all the areas we inspected patient medication lockers were in a good condition and undamaged. This meant patient medications were kept securely.
- We checked the controlled medicines (CD) cupboards. Controlled Drugs are medicines liable for misuse that required special management. We saw the CD cupboards were locked, and we checked a random sample of stock levels. We saw the correct quantities in stock according to the stock list, and that all were in-date. However, all the CD books demonstrated incomplete records of the CD's. This was because staff block-signed for the medicines rather than signing individually at each stage of the dispensary process. This contravened The Department of Health guideline, safer management of CDs: a guide to good practice in secondary care states that each entry should be signed and witnessed. This was also highlighted in our previous inspection and still required improvement.
- On our previous inspection, other aspects of poor medicine management were highlighted. For example, pre prepared medications left unattended in theatres,

lack of daily CD checks in theatres and the preparation of intravenous fluids by the bedside on the wards. During this inspection, we did not identify these issues occurring but saw much improved medicines management across the service.

- There were a total of 94 medication errors across the service between July 2015 and July 2016. Of these errors 75 were graded as a severity of level one harm (low harm), 18 were medium harm and one was high harm.
- We looked at six medication charts which were completed comprehensively, dated, signed and had no missing doses. The sample of medication charts we reviewed showed interventions from a pharmacist. This demonstrated that pharmacists were regularly reviewing medication charts to ensure medicines were correctly prescribed.
- A trust drug chart audit undertaken between June 2015 and March 2016 found that although medication reconciliation (MR) was completed for all patients on average only 59% of patients had the MR completed within the time frame. The trusts policy and the National Institute for Health and Care Excellence (NICE) guideline NG5 states it should be undertaken within 24 hours of the patients admission. Medication reconciliation is matching the medicines the patient should be prescribed to those they are actually prescribed. We noted that MR had been completed on all drug charts we reviewed however we did not assess the timeliness of the MR.
- Staff reported having good access to pharmacists when advice was required and adequate access to medicines. Pharmacy technicians undertook weekly reviews of stock levels and ordered replenishments. This was an improvement on our previous inspection findings when, due to staff shortages, there was difficulty in accessing pharmacy advice.
- Theatre recovery had an automated dispensing machine (ADM) which was used for the supply and storage of medicines in theatres and recovery. An ADM is a decentralized medicine distribution systems that provides computer controlled storage, dispensing, and tracking of medications. Staff in theatres and recovery spoke very positively about the system and there were plans to install further machines in individual theatres.
- We saw a hand held computer was used to order specific patient medicines, this meant the drug chart did not have to leave the ward when it might be needed in order to give medication.
- Patient allergies had been clearly noted on their paper notes, medication chart and on their identity band, which alerted staff to their allergy.
- We noted that the trust had plans to undertake six medicine audits in 2016/17; four of these were to monitor compliance with National Institute for Health and Care Excellence (NICE) guidelines. For example, there was a planned audit to monitor compliance with the recording and accuracy of penicillin drug allergy status for adult patients admitted to acute care wards. This showed that adherence to NICE guidelines was monitored to ensure patients received the correct medicines for their condition.
- Pharmacy input and audit processes had significantly improved since our last inspection.
- We check ten oxygen cylinders all were secured to a wall labelled and within date. This meant cylinders were kept securely, were clearly labelled as to their contents and were safe to use.

Records

- We looked at 25 sets of patient's records. These were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with the patient and families.
- Medical records were stored securely in trolleys, which had a numeric combination lock. Only authorised staff knew the access code to these locks this maintained the security and prevent unauthorised access of patient records.

Safeguarding

- The trust had safeguarding adults and children policies, which were in date. The trust policy states that in addition to other reporting requirements for safeguarding it must also be reported on the trusts electronic reporting system. Between July 2015 and June 2016 there was 11 incidents reported which related to surgery that were categorised as safeguarding.

- The trust was part of the development of and signed up to the Sussex Multi Agency Policies for Adults and Children.
- The safeguarding team within the trust was led by the assistant director of nursing for safeguarding. There was one designated adult safeguarding manager (DASM) which included the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- There were flow charts in each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.
- The trust produced a monthly safeguarding newsletter for staff, which highlighted any new guidance and ensured staff were aware of what action to take if they had any safeguarding concerns. We saw a copy of the September 2016 newsletter displayed in ward areas for staff to read and retain for reference.
- All trust staff received level one safeguarding children training, clinical staff received level two training and all staff who worked directly with children received level three training. All clinical staff received level two adult safeguarding training.
- As at March 2016, trust data showed 100% compliance for level one safeguarding children training, this was complaint with the trust target of 90%.
- Within the surgical directorate at Conquest Hospital, 89.2% of nursing staff had completed the appropriate level of child safeguarding training and 87.3% had completed adult safeguarding. Medical staff had lower completion rates with 69% having completed adult safeguarding and 71.2% having completed child safeguarding training.The trust target was 90%.
- The safeguarding training also included female genital mutilation training which was undertaken every three years.
- Staff were required to complete an exam after they had received their safeguarding training, which was sent to the safeguarding team for marking. We saw completed examples of these, they showed that staff had retained knowledge from the training and were able to pass the exam. If staff did not pass the exam, they were offered additional training.

Mandatory training

- The trust had a trust wide induction programme for permanent and temporary staff and a mandatory and statutory training plan. There was a combination of on line learning and face-to-face learning. Within surgery 92.3% of staff had completed all mandatory training and for medical staff the figure was 71%.
- We saw the training records for staff, which were included within their appraisal. If staff were non-compliant with their training, it would be highlighted at their appraisal.
- Managers were able to show us up to date training records of all their staff, from these it was easy to identify who was not compliant with their training. Staff received emails from their managers or the practice educators when their training was due to expire. This meant staff had enough time to book the required training before it expired.
- Staff confirmed they were given enough time and support to complete their mandatory training. This was an improvement since out last inspection when staff said they did not receive training because of financial constraints.
- **Assessing and responding to patient risk**
- Elective surgery patients' risks were assessed and monitored at pre-assessment, and checked again before treatment. These included risks about mobility, medical history and skin damage. This ensured they were medically fit to undergo their operation and their condition had not changed since pre assessment.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'Five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment.
- We reviewed six completed WHO checklists and all were fully completed. This meant there was assurance that the safety checks had been completed. We observed staff using specific WHO checklists for different procedures, for example endoscopy. This ensured staff checked the most important safety factors relating to a specific procedure.

Surgery

- Staff met for a 'team briefing' at the start of each operating list in accordance with the World Health Organisation 'Five steps to safer surgery'. We observed three team briefings, which were comprehensive and discussed each patient to minimise any potential risk to patients. Pre-existing medical conditions and allergies were discussed to ensure the team was informed. Equipment requirements were also discussed and we witnessed surgeons checking the equipment available. The briefings demonstrated that risks were discussed and any potential issues were highlighted.
- The trust undertook a WHO audit in July 2016, which showed for the whole of the audit period April 2015 – March 2016. There was no month where the trust was 100 % compliant for the WHO checklist. The highest rate of compliance was 99% in December 2015 and the lowest was 86% in April 2016. At CH, trauma and orthopaedics had an overall compliance of 73%, ear nose and throat had an overall compliance of 100% and general surgery had an overall compliance of 80%. During the audit period not all data was submitted which meant a lower level of compliance was achieved.
- We reviewed the audit findings and found that where non-compliance was identified action had been taken. For example on one WHO checklist the procedure performed had not been documented, the member of staff who was meant to of recorded it was identified and spoken to.
- WHO audit finding were shared during theatre staff meetings, so learning could be shared and improvements made. In our last inspection, it was identified that the "debriefing step" of the 'five steps' was not documented; we saw this stage was now formally documented. This gave assurances that lessons could be learnt from what went well and what did not go so well during the operating list.
- We saw in patients' records that patients had a weekly falls risk assessment this was in line with NICE guideline CG16.
- Patients' observations were inputted into an electronic database via a handheld computer, this system was introduced two years ago at the trust. The inputted observations also calculated National Early Warning System (NEWS) scores in line with NICE clinical guidance CG50 and sepsis (infection) recognition.
- NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support.
- If a patient had a NEWS score of between three and five then the nurse in charge was informed, if a patient had a NEWS score of more than five a doctor and the critical care outreach team were informed.
- If a patient had a NEWS score of more than nine then a surgical emergency team (SET) emergency call was placed. This meant a team of surgeons, anaesthetists, intensive care staff and the critical care outreach team received an emergency bleep to attend the ward. We witnessed this during our inspection on one of the surgical wards. We observed the intensive care consultant rapidly reviewed the patient's condition and then allocated tasks to be undertaken to specific team members. For example, one member of staff was allocated to undertake blood tests and another to look up the patients x-rays. This meant each staff member was allocated a task to undertake and knew what their responsibility was. We observed the intensive care consultant discussing the patient with the team reviewing the results of various test results and highlighting potential causes for the patient's condition. We saw the patient received review and treatment rapidly and a treatment plan was put in place. This demonstrated that staff had recognised the deterioration of a patient's condition and had taken quick action to address it.
- There was no track and trigger automated escalation incorporated into the electronic observation system. It was the responsibility of the ward staff to make contact and follow the escalation plan for the individual patient; however, the critical care outreach team had oversight of all NEWS scores for all admitted patients in the hospital. This meant there was a robust system in place to ensure deteriorating patients were recognised and received rapid treatment.
- In weeks three and four of July 2016 across the surgical wards at Conquest Hospital 85% of observations were taken on time, this was categorised as requires improvement by the trust. We saw data that showed an improvement of the timeliness of observations over time.

- Senior nurses used data from the electronic database during regular monthly meetings with ward managers as a basis for discussion about the observation and escalation of deteriorating patients on individual wards. This meant any areas where failings occurred the reasons were highlighted and solutions considered.
- All agency staff were offered a session on the use of the electronic observation system and managing deteriorating patients.
- The Post Anaesthetic Care unit (PACU) did not calculate a NEWS score on discharge, this meant that ward staff did not have a baseline NEWS score in order to identify any increase in NEWS score.
- The electronic observation systems were also used to record nutritional risk assessments, cannula management and a new module for infection prevention and control was being introduced.
- The critical care outreach team had provided training across the trust in recognising and managing deteriorating patients including sepsis pathways and peri-arrest.
- Staff had access to the trust's critical care and outreach team for patients that had deteriorated or required additional medical input. Staff told us they were very supportive to staff on the ward and visited the patients on the wards and in the recovery areas when required.
- During our inspection, we observed several occasions when patients had triggered a review based on their NEWS score. On all occasions, we saw that the patients were responded to appropriately.
- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified. We saw evidence of this from the records we reviewed during our inspection.
- There were daily handovers, one at the beginning of the day and the other towards the end of the day. We observed a nursing handover, which was well organised and comprehensive. At the end of handover a safety briefing checklist was used which identified :patients with infections, medication, sick patients, patients at risk of falls, patients identified as potential absconders, same name patients, patients not for resuscitation, hand hygiene, pressure areas, cannula care, documentation assessments and care plans. This meant that staff were informed of patients who might be at an increased risk of harm.
- The service used a communication tool called Situation Background Assessment Recommendations (SBAR) (a technique that can be used to facilitate prompt and appropriate communication) for both medical and nursing staff to use when escalating concerns about a patient's condition.
- Staff told us they checked the pregnancy status of female patients of potential childbearing age on the morning of planned surgery by undertaking a pregnancy test. We saw the results of the test were documented on pre-operation checklist.
- The service used a visual phlebitis-scoring tool for monitoring infusion sites and is recommended by the Royal College of Nursing (RCN). We saw Visual Infusion Phlebitis (VIP) scores had been undertaken and correct action taken in the patient records we reviewed. This meant the need for intravenous (administered into a vein or veins) devices, signs of infection and comfort of the devices were reviewed on a regular basis.

Nurse staffing

- Staffing levels on the surgical wards were planned and monitored in line with the safer staffing tool. This is a decision support toolkit for establishing nursing staff levels endorsed by the National Institute for Health and Care Excellence (NICE).
- Surgical wards we visited were staffed to their agreed establishment during the inspection. Planned vs actual staffing levels were displayed on the wards for patients and members of the public to see.
- Staffing on the wards was highlighted as a concern during our last inspection. Staff told us that generally staffing and skill mix was better now, however, there was still a reliance on bank and agency staff.
- On the day of our visit, we saw staffing levels met the AfPP guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating

staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. We reviewed previous rosters, which demonstrated that this guideline was adhered to.

- The high substantive vacancy rate and reliance of temporary workforce in theatres and surgery was identified as a risk and reflected on the surgical risk register. The service had put measures in place to mitigate the risk for example, staffing of theatre sessions was micromanaged on a daily basis to ensure the best match and balance of skills. This risk was last reviewed in August 2016, this showed that the risk was regularly reviewed and discussed.
- There were 93 clinical incident reported that related to staff shortages between 01 April 2016 and 30 September 2016 within surgical services on both hospital sites. This was approximately 15 per month, it is not possible to determine from the data provided which wards or departments reported these.
- The surgical departments had 440.18 whole time equivalent (WTE) staffing establishment.
- In July 2016, the service reported a vacancy rate of 5% in theatres and clinical support and 17% in surgery. This was a significant improvement since September 2014 when there were 25WTE vacancies in theatres with a weekly shortfall of 10 WTE staff after agency and locum cover was included.
- Theatre staff told us that they had a number of recruitment initiatives in place for example encouraging student nurses to undertake placements in theatres and to make it a positive experience, to encourage newly qualified nurses to work in theatres. In addition, there were plans to expand the recruitment process overseas from where the trust had already recruited successfully.
- We reviewed the planned staffing hours on the surgical wards compared to actual staffing. For example the June 2016 rota demonstrated that on average 94% of shifts for nurses were filled during the day and night shifts were overfilled (108%). Health care assistant shifts were overfilled on both day shifts (104%) and night shifts (141%). This demonstrated that the shifts on the surgical wards were always filled for health care assistant and the majority were filled for nurses.
- Surgical services across both hospital sites had an average of 19% bank and agency use between September 2015 and August 2016.The bank and agency use varied the highest rate (31%) was in December 2015 and the lowest (14%) was in June 2016.
- The trust had an in depth induction pack for bank and agency registered nurses and HCAs. We saw completed copies, which included various competency assessments including drug administration, NEWS score and pressure ulcer prevention. This showed an improvement since our last inspection, when there was no induction process for bank and agency staff.

Medical staffing

- The proportions of consultants and junior doctors reported to be working at the trust were about the same as their respective England averages.
- For the emergency and trauma services there was a consultant of the week, they were the on call consultant for the week. All patients admitted were admitted under the care of a consultant. This meant there was continuity of care for these patients.
- There were two consultant anaesthetists on call twenty-four hours a day seven days a week. There was a “starred” consultant anaesthetist during the day who could supply additional help if clinically required.
- Consultant surgeon cover was available twenty-four hours a day seven days a week.
- There was resident emergency and trauma medical cover twenty-four hours a day seven days a week.
- Junior doctors told us that they felt well supported and that they had enough teaching and supervision. However, in the most recent General Medical Council survey junior doctor’s workload was identified as an outlier.
- Surgical services across both hospital sites had an average of 13% medical locumuse between September 2015 and August 2016.The highest (16%) locum use was in November 2016 and the lowest (10%) was in May 2016.This showed a heavy reliance on medical locum use, which was consistent with our last inspection.
- The availability of locum medical cover for general surgery was reflected on the surgery risk register. For example, the register detailed one incident in April 2016

where a registrar from EDGH was transferred to Conquest Hospital to cover night duty. Medical staffing for ENT and middle grade doctor vacancies for general surgery were also on the risk register.

Major incident awareness and training

- A trust Emergency Preparedness Resilience Response Policy (EPRRP) was in development and the scheduled launch date was October 2016.
- There was a CH major incident response plan for receiving casualties during a major incident (August 2016).This plan set out an established framework for the trust's response in the event of any major emergency, regardless of cause, which produces, or is expected to produce, significant numbers of casualties. The plan reflected the NHS Commissioning Board Emergency Preparedness Framework 2013, the NHS Commissioning Board Command and Control Framework and the Civil Contingencies Act 2004. We saw it triggers and alerting, defined roles and responsibilities, operational responses and action cards. Key members of staff were allocated action cards, which set out what their role, and responsibilities were.
- Major incident training was part of mandatory training.
- Staff were able to describe what action to take if a major incident was declared. In theatres, staff were able to describe what action to take in the prioritisation of theatre lists and escalation processes.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms. This meant that patients were having their individual needs assessed. Records were legible, accurate and up to date.
- We saw the theatre records section of care plans were clear and safety checks documented to ensure safe surgery and treatment was undertaken.
- The service used a number of patient pathway documents, which followed the path the patient took through a specific surgical episode such as a fractured neck of femur and knee and hip replacements. This meant specific risks associated with these procedures were assessed. In addition, it meant all relevant information was in one place together which made finding relevant information easier.
- Between July 2015 and June 2016 there was over 69 incidents which related to missing or incorrectly, managed notes reported on the trusts electronic reporting system within the surgical division, 39 of these occurred at CH. For example, incidents reported included cancelled appointments and procedures due to unavailability of notes, suitability for theatre assessed in absence of patient record and loose notes transported with patient when the main patient record was not available.
- The lack of patient records was reflected on the surgery risk register since November 2015 and was categorised as a high risk. It stated that consultants had agreed that patients will not be seen in clinic and surgery would not be undertaken without the records available. However, the risk had not been reviewed since December 2015. Staff told us that the availability of records had improved. Data provided by the trust showed a real improvement in the availability of records with the trust routinely meeting their target.

Are surgery services effective?

Good

Overall we rated the service as good for effective, this was because:

- Staff and teams were committed to working collaboratively and found ways to deliver more joined-up care to patients. There was a range of examples of working collaboratively and the service used efficient ways to deliver more joined-up care to people who used services. There was a holistic approach to planning people's discharge and transfer to other services.
- Policies and procedures were in line with national guidance and were easily accessible.
- Patients' pain was managed and national nutritional tools were used to monitor those patients who may be at risk of malnutrition.
- Patients had comprehensive assessments of their needs and their care and treatment was regularly reviewed and updated.

- Staff were qualified and had the skills they needed to carry out their roles. Staff were supported to maintain and further develop their professional skills and experience.
- Staff discussed pain relief with patients and provided information on the type of pain relief they could expect to receive as part of their procedure.
- Staff had completed training about the Mental Capacity Act; they could demonstrate a clearunderstanding of the procedures to follow for patients who lacked capacity.

However we found;

- In theatres, patient's temperatures were not being monitored throughout the operation.
- Ear, nose and throat had double the expected rates of readmission for both elective and non-elective readmissions.

Evidence-based care and treatment

- Generally, care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines
- In theatres, and in the patient notes, we saw evidence of providing care and treatment in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic liquid.
- We reviewed 25 patient records, which all showed, evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient's health post-surgery. This was in line with NICE guideline CG50: Acutely ill patients in unit- recognising and responding to deterioration.
- The national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was also in line with NICE clinical guideline CG50.
- We saw in the patient records we reviewed completed venous thromboembolism (VTE) assessments in accordance with NICE clinical guideline 92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to surgery. However, the trust was unable to provide data, which gave assurances of consistent compliance with this guideline.
- There were specialist clinical pathways and protocols for the care of patients undergoing different surgical procedures. For example fracture neck of femur (NOF); these were designed to specifically assess risks associated with these operations.
- We saw that patients with fractured hips were treated in line with Hip fracture: management CG124 for example their surgery was scheduled on a planned trauma list.
- Theatres performed World Health Organization (WHO) 'five steps to safer surgery' checklist audits. This meant there were adequate assurances that the WHO checklist was undertaken consistently and in line with national guidance.
- Policies were up to date and followed guidance from NICE and other professional associations for example, the Association of Perioperative Practice (AfPP). Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- Surgical services had an audit programme there was currently 102 audits being undertaken across both hospital sites.
- There was a Governance Support Officer (GSO) whose focus was workings with the clinical leads to review outstanding NICE Quality Standards and action plans. In addition, the GSO monitored audits and ensured they were up to date and findings shared with relevant groups.
- The service participated in the National Hip Fracture Database (NHFD), which is part of the national falls and fragility fracture audit programme.
- The service took part in other national audits, such as the elective surgery PROMS programme, the National Joint Registry and National Bowel Cancer Audit 2014.
- In the National Emergency Laparotomy Audit (NELA) 2014, the service was non-compliant with 15 of the 32 elements. For example there was not an operating theatre reserved for emergency general surgery(EGS) patients twenty-four hours a day seven days a week and there was not a single patient pathway for EGS patients.
- NICE guideline compliance was discussed at a meeting trust wide every three months and within surgery monthly. In August 2016, surgical services as a whole

were 95% compliant with NICE guidelines; theatres and clinical support were 88% compliant. This meant that there was a system in place to ensure compliance with NICE guidelines.
- We saw meeting minutes, which confirmed monthly meetings with theatres and support staff, were NICE guidelines and compliance was discussed. In addition there was ward staff meetings but we noted these only occurred every three months.

However:

- We saw in theatres patients' temperatures was not measured and documented in accordance with inadvertent perioperative hypothermia, NICE guidance clinical guideline CG 65.This meant patients could become too hot or too cold and this would not be identified in a timely manner. We raised this issue with the theatre management team who took immediate action. We saw that each theatre had been equipped with a handheld thermometer, and email had been sent to all clinical staff within theatres and posters had been displayed. This showed that the management team had taken prompt action to ensure patients temperatures were monitored during their operation to ensure they were neither too hot nor too cold, which potentially could have an adverse effect on their health.

Pain relief

- We observed that consideration was given to the different methods of managing patient's pain, including patient controlled analgesia (PCAs) pumps. PCA is a method of allowing a person in pain to administer their own pain relief. Nurses on the medication rounds would ask each patent if they were in any pain and would give prescribed analgesia if necessary.
- Patients we spoke to told us that they were offered pain relief and felt that their pain had been managed appropriately. The service had a nurse led acute pain team (APT) which had named consultants to support the team and covered both sites. Staff told us they received good support from the APT.
- The APT was available Monday to Friday and did not provide cover out of hours and at weekends due to the lack of staff. This did not comply with the Faculty of Pain Medicines core standards. Trainee anaesthetists covered the out of hour's provision.
- A member of the theatre management team had undergone additional pain management training and offered advice and support regarding pain management.
- The service was currently undertaking four different audits in relation to pain management for example pain relief for patients with learning difficulties and dementia. The trust did not provide details of any of these audit findings.
- Staff told us that some nurses were undergoing additional training to administer fascia iliaca nerve blocks for patients with fractured hips, this was in line with Hip fracture: management CG124. A fascia iliaca nerve block is an injection of local anaesthetic into the nerves that supply the hip, which provides pain relief.
- We saw patients' records which showed that pain had been risk assessed using the scale 0 – 3 (zero being no pain and three being extreme pain at rest) found within the NEWS chart and medication was given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner and staff returned to ask if their pain had been relieved.
- We saw potent pain relief was prescribed for the immediate post-operative period when the patient was in recovery. This meant if a patient woke up from the anaesthetic and experienced pain it could be administered to the patient quickly rather than it having to be prescribed.
- The hospital reported one never event which involved the wrong route administration of pain relief medicine, this has been previously described within this report.
- The trusts 2015 inpatient survey showed that the trust scored higher than the national average in the response to the question: Do you think staff did all they could to help control pain? This demonstrated that patients felt that there pain was well controlled.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition and if a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician. Ward staff were able to make referrals to dieticians for review when required.

- The dietitians attended the wards daily where patients were receiving parental nutrition. Parental nutrition is a method of getting nutrition into the body though the veins.
- Staff said they were able to make referrals to the speech and language team (SALT) should they have concerns regarding a patient's ability to swallow.
- We saw food was delivered to the patient's bedside and patients told us the food was hot.
- Pureed food was available for patients who were unable to take solid food.
- The patient-led assessment of the care environment (PLACE) survey showed the trust was equal to (88%) the England average (88%) for the quality of food.
- There was a robust process in place to ensure patients were appropriately starved prior to undergoing a general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, this was in line with best practice.
- We reviewed the patient menu, which had a wide variety of food options available including vegetarian and vegan.
- On wards, we observed staff assisting patients who were unable to feed themselves.
- We saw on the patient boards special diets were highlighted for example low salt. This meant staff were aware if patients were on a restricted or special diet.

Patient outcomes

- Between March 2015 and February 2016, patients at Conquest Hospital had the same observed readmission rates as would be expected for both non-elective and elective readmissions. Ear, nose and throat could be considered an outlier as it had double the expected rates of readmission for both elective and non-elective readmissions.
- Mortality and morbidity meetings occurred monthly across the surgical specialities and we saw minutes from these meetings. However, we noted that the documentation and learning was brief.
- We saw that it was acknowledged that these meetings required improvement in the minutes of the surgical divisional performance report to the board. The information from mortality and morbidity meetings was reported through the governance structure to ensure early intervention.
- There was a dedicated work stream, which covered mortality and a detailed Project Initiation Document (PID), which set out the scope of the project. For example, this work stream undertook clinical engagement summits and grand rounds on mortality were held on both sites. This showed that the trust was trying to improve the quality of mortality and morbidity discussions.
- The trust had made steady improvement in their performance in the hip fracture audit 2015 against their 2014 results.
- The risk-adjusted 30-day mortality rate was 9%, which was higher than expected. This was better than the 2014 figure (10%).
- The proportion of patients having surgery on the day of or day after admission was 86%, which met the national standard of 85%. This was better than the 2014 figure (84 %.)
- The perioperative medical assessment rate was 97%, which did not meet the national standard of 100%. This was much better than the 2014 figure (73%).
- The proportion of patients not developing pressure ulcers was 96%, which fell in the middle 50% when compared to other trusts.
- The length of hospital stay was 18.5 days, which fell in the middle 50% of trusts. This was better than the 2014 figure (18.7).
- In the 2015 Bowel Cancer Audit, 70 % of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. This was about the same as the 2014 figure (69%).
- The risk-adjusted 90-day post-operative mortality rate was 5%, which was within the expected range. This was better than the 2014 figure (8%).
- The risk-adjusted 2-year post-operative mortality rate was 21%, which was within the expected range. This was better than the 2014 figure (26%).
- The risk-adjusted 90-day unplanned readmission rate was 15%, which was within the expected range. This was worse than the 2014 figure was (10%).

- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 51%, which was higher than expected. This was about the same as the 2014 figure (50%).
- Conquest Hospital (CH) took part in the 2015 National Emergency Laparotomy Audit. Of nine key questions, seven were rated as green (80% or above), one was yellow (50 to 79%) and one was red (less than 50%).
- PROMs data was collected. PROMS are a series of questions or a questionnaire that seeks the views of patient on their health, or the impact that any received healthcare has had on their health.
- The trust results from the Patient Outcomes Reporting Measures (PROMS) from April 2015 to March 2016 were as follows: Percentage of patients improved were better than the England average in three measures (2 Groin and 1 Varicose vein measure), worse in five measures (4 hip and 1 knee replacement measure) and the same in two measures (1 Knee and 1 Varicose vein measure).
- For the percentage of patients that had worsened, results were as follows: two were better than the England average (1 Groin and 1 Varicose vein measure) and the rest of the measures were either in line or slightly worse than the England average.

Competent staff

- Ward and theatre staff confirmed that appraisals took place and staff told us they had received an annual appraisal, we saw completed examples, which were thorough and identified objectives.
- Overall compliance with appraisal rates for surgery and clinical services was 93% which was better than the trust target of 90%. The person in charge of areas we visited had an up to date matrix and could identify which staff had an appraisal and when their next appraisal was due.
- Nursing staff told us that appraisals were useful and they felt they had the appropriate skills and training to do their jobs.
- The trust medical appraisal compliance status for 2015-2016 was 99% of all doctors having their medical appraisal within the required timescales. For surgery the appraisal rate was 96%.
- Of the 132 medical staff revalidation, recommendations 108 had revalidated and 24 were deferred and the service had monitoring processes in place to ensure consultants were supported through their revalidation period.
- The trust undertook regular checks of Nursing and Midwifery Council (NMC) revalidation and checked pin numbers. The Director of Nursing undertook regular checks of NMC registration of agency nurses. Agency nurses were supplied via NHS approved agencies, who undertook all the relevant checks for example ensured mandatory training and NMC status was current.
- If concerns regarding staff were identified the trust reported appropriately to the relevant governing boards for example General Medical Council (GMC) NMC and the Health Care Professionals Council.
- Junior doctors within surgery all reported good surgical supervision, they each had a specific personal development plan, which they felt, enhanced their training opportunities.
- Junior medical staff told us they felt supported and had access to their consultants when needed.
- All new staff underwent an induction, which included a departmental orientation programme. As part of this process, staff were allocated a mentor who was a senior member of staff. New staff were given competency documents, which set out skills, and knowledge they must acquire before being able to practice independently. We saw examples of these completed competency documents within theatres. Staff spoke positively of them saying it was a useful framework and gave clear goals and objectives.
- We spoke with a health care assistant who had undergone additional training and worked within the enhanced recovery team. They spoke positively of their role and felt supported during their training and within their role.
- We spoke with a newly appointed nurse who was happy with the support they received by their mentors. They told us their mentors were easily accessible, spent time with them explaining each patient with them and what plans there were to care for each patient. They felt confident they could go to their mentor if they were unsure about what they had to do.
- The service had practice development educators; they were responsible for coordinating new starters and students as well as working with staff to help them develop their skills and knowledge**.**
- Bank staff had an induction to their area prior to starting work on the ward. We spoke with one bank nurse who told us she had been given an orientation to the ward.

Multidisciplinary working

Surgery

- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required. We observed a good working relationship between ward staff, doctors, physiotherapists and the pain team.
- There were a number of multi- disciplinary meetings (MDT) taking place across the service for example weekly trauma discharge team which included; surgeons, nurses, physiotherapists and occupational therapists.
- There were daily trauma meetings and we attended one of these. These were established to review the unscheduled care admissions admitted over a twenty-four hour period and to plan the day's activity. These were attended by the trauma and orthopaedic (T&O) T&O registrars, T&O junior doctors and theatre staff.
- Wards had daily MDT meetings with medical and nursing staff, stoma nurses, a discharge coordinator, physiotherapist, occupational therapist and dietitians. Each patient was discussed in detail with those with more complex conditions preparing for discharge and agreeing care packages and funding arrangements for care when in the community.
- Staff could access the learning disability lead, critical care team, pain management team, intravenous infusion team, social workers, and safeguarding teams who were able to provide advice and support to the surgical teams.
- We observed 'team briefings' in theatres that were held prior to the start of operating lists. Surgeons, anaesthetists, and theatre staff attended these. These 'briefings' allowed the team to review the operating list together and highlight any particular issues.

Seven-day services

- Theatres had a staffed NCEPOD (national confidential enquiry into perioperative deaths) list twenty-four hours a day, seven days a week. Trauma had one staffed list every Saturday and Sunday. Currently there were no permanent elective lists at weekends but occasional lists were undertaken.
- There was theatre staff twenty-four hours a day, seven days a week to cover emergency operations.
- The service had access to the physiotherapy service twenty-four hours a day and seven days a week.
- The pharmacy opening hours at CH were Monday to Friday 9am - 5:30pm, Saturdays and bank holidays 9am – 12pm.
- Outside of these hours, an on-call pharmacist was available via switchboard for urgent supply of medication and medicine information. Out of hours, pharmacy cover was highlighted as a risk during our last inspection. However, a project group had been established and was currently working to develop plans for a seven-day pharmacy service.
- There were consultants in intensive care medicine available twenty-four hours a day, seven days a week and an enhanced critical care outreach service, which provided support to surgery.
- There was twenty-four hours a day, seven days a week consultant surgeons and anaesthetists cover to manage emergency surgery.
- To ensure the delivery of twenty-four hour, seven days a week cover, the trust had established two working groups .The Hospital at night reorganisation meeting and the seven-day service working group.

Access to information

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Staff had good access to patient-related information and records whenever required. We saw staff using the services electronic theatre system where staff could see where their patients were in the surgical process. Agency and bank staff were informed as part of their induction where they could access policies.
- Medical staff used the Patient Archive and Communication System (PACS) system to download and view images of patients x-rays and tests. The PAC is a central system for radiology and medical images.
- Staff had access to an electronic system for requesting and receiving blood tests.
- All patients we spoke with felt staff had given them sufficient information about their procedure, and were able to discuss it with their doctor and nursing staff.
- Ward staff gave patients a discharge pack with specific post-operative instructions. Discharge summaries were given to the patient and sent to their GP when they were discharged from the ward.

- There was a variety of information leaflets available for patients, which gave information about their specific condition and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a Guidance for Staff on the Implementation of the Deprivation of Liberty Safeguards (DoL's) policy, which was in date. The policy was in line with Department of Health (DoL's Code of Practice 2009)
- We spoke to staff on the wards who told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- We saw one DoLS in place, which was completed correctly, and the patient's family had been informed and were involved in the patient's care.
- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- The policy also included guidance on patients with an advance decision (AD), an AD is a decision a patient can make in advance to refuse specific treatment in the future. This meant patients' individual needs or wishes were incorporated into the consent policy. During our inspection, we saw consent forms were fully completed. There was an anaesthetist who was a consent lead and provided training to staff on consent.
- We reviewed ten consent forms for surgery. Patients and staff had fully completed, signed and dated the consents to ensure they were valid. The consent forms did not contain any abbreviations that a patient may not have understood.
- We saw one patient was detained under section three of the Mental Capacity Act: Admission for Treatment 1983.We saw the associated paperwork had been completed correctly. In addition, a multidisciplinary meeting had been arranged by a psychiatrist, which involved surgeons, patient's relatives, nursing staff and a mental health advocate. The purpose of this meeting what to discuss the best interests of the patient and ensure there was a treatment plan in place.

Are surgery services caring?

Good

Overall we rated the service as good for caring

- Patients were treated courteously and their privacy was maintained. Patients were able to make informed decisions about the treatment they received.
- Staff anticipated patients' needs and their privacy and confidentiality were respected at all times.
- Patients understood their care, treatment and condition. Patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- Patients told us they felt safe, supported and cared for.
- The hospital had a number of specialist nurses who were able assess patients and make referrals to external services for support if necessary.
- Trust data from the friends and family test demonstrated that the percentage of patients who would recommend the hospital was higher than the England average.

Compassionate care

- Patients were treated with respect and dignity when receiving care and support from staff.
- Patients told us they felt supported and well cared for. Staff treated them compassionately, and we saw staff responding to them in a timely and appropriate manner.
- Patients told us they thought staff were excellent and they would go out of their way to make sure they felt as comfortable as possible.
- We saw staff took time talking to patients and explaining things to them and those people close to them.
- The most recent NHS Friends and Family Test (FFT) data provided to us was July 2015 and June 2016 and the trust was better than the England average during this time. In latest period, July 2016 the results indicated that 98% or more patients attending the trust would recommend it. This was better than the England

average of 95% and better than the scores in 2014 when wards have averaged 90%. The data was not broken down by site or core service; therefore, results were for all patients attending the trust.

- The Friends and Family Test (FFT) response rate for Surgery at Conquest Hospital was 27%, which was worse than the England average of 30% between July 2015 and June 2016. It was, however, higher than in 2014 when the response rate was around 20% for most wards.
- Survey results from the inpatient 2015 survey showed that the trust scored higher than the national average in six questions for example; during your time in hospital did you feel well looked after by hospital staff? Overall, were you treated with dignity and respect? In the same survey, the trust scored lower than the national average seven questions for example; when admitted, was it a mixed-sex bay or room? The trust identified that improvement was required and were undertaking a full analysis and action plan, which was going to be presented to the Quality and Safety Committee.
- We saw in theatres consideration was given to preserving patients' dignity, for example not opening theatre doors until patients were covered.
- We received positive comments from all of patients we spoke with about their care. Examples of their comments included "The staff are marvellous", and "I can't find anything to complain about".
- We saw thank you cards with plaudits for staff displayed on wards. Ward areas had 'you said we did' boards; displaying actions taken following patient feedback.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2015 scored 85% for privacy, dignity and wellbeing at Conquest hospital, which was broadly in line with the national average of 86%. However, during all of our observations during inspection we found patients' privacy and dignity was maintained.

Understanding and involvement of patients and those close to them

- We spoke with 12 patients, who all told us they had been kept well informed at every stage of their care.
- The service involved patients' relatives and people close to them in their care. They told us they received full explanations of all procedures and the care they would need following their operation.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place. This also reflected patient centred care and that patients' individual needs were taken into consideration.
- We saw a health care assistant discussing a patient's discharge, and that they were awaiting a discussion with their wife to ensure everything was in place for their discharge. This demonstrated involvement of the patient's relative to ensure the arrangements were in place for a safe discharge.
- We observed nurses, doctors and other professionals introducing themselves to patients at all times and explaining to patients and their relatives about their care and treatment options.
- There were a variety of information leaflets on display about different types of conditions and treatments. Staff told us that they were available in different languages on request.
- We saw cards and leaflets on the wards with information for patients on how to leave feedback. In addition, the trust's website had the facility for patients to leave feedback.

Emotional support

- The service used the Butterfly scheme on its wards. This scheme supports patients with dementia and memory impairment. It aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment. Butterfly symbols are put by the patient's bed and remind staff to follow a special response plan.
- There was a variety of specialist nurses available that provided support and advice for patients. For example, there was specialist stoma nurses, who supported patients who had a stoma, they were able to give advice on how to care for it and provide support and contact numbers of support groups for after their discharge.
- There was information displayed regarding a variety of support groups for example smoking cessation, alcohol misuse and counselling services.

Surgery

- There was multi faith chaplaincy support cover between 9am- 5pm seven days a week and an on call chaplain out of hours. There was a multi faith prayer room, which was a calm and quiet place. In addition, there was a photo board with details of representatives of all different faiths and contact details.
- We saw that patients and staff with different religions were supported, for example, Muslim prayers were held every Friday between 1pm and 2pm.This showed that the different religious and spiritual needs of patients and staff were supported.
- The hospital had a group of volunteers that were available to provide support and guidance. There was a volunteer's newsletter that provided information and guidance for patients.

Are surgery services responsive?

Requires improvement

Overall, we rated the service as requiring improvement.

- The admitted referral to treatment time (RTT) trust wide for admitted pathways for surgical pathways was consistently below the national average since July 2015.The latest figures for June 2016, showed 60.2% of this group of patients were treated within 18 weeks.
- Trust wide oral Surgery was the only specialty with an RTT better than the England average. Trauma and Orthopaedics (40%) and ear nose and throat (ENT) (49%) were particularly worse when compared to their England averages of 69.9% and 73.4% respectively.
- Bed occupancy levels across the service were high and the lack of available beds was resulting in patients spending longer periods in the theatre recovery areas. There was a lack of appropriate facilities in the theatre recovery area for patients. There were no refreshment facilities, showers or toilets.
- There was 3485 medical outlier on surgical wards and Conquest hospital between April 2015 and September 2016; this was an average of 19 per day. This had an impact of the availability of beds for surgical patients and the flow through the hospital.

However we also found:

- The individual needs and preferences of patients were taken into account throughout the surgical services. We saw good adaptation of the provision to meet the needs of certain groups. There was particularly support for people living with a learning disability and a variety of specialist nurses and practitioners to care for those patients with complex diseases.
- The service had responded to continual high demand and adapted the way services were delivered to minimise the effects of this. There were dedicated Saturday and Sunday trauma lists, which met the needs of patients. A "Golden Patient system had been introduced to ensure that lists started on time. Theatre utilisation was good it ranged from 83% to 101% and averaged 94% between May 2015 and June 2016.
- There was an improvement in discharge planning since our last inspection.
- The management of complaints and quality of responses to complaints had improved since our last inspection.

Service planning and delivery to meet the needs of local people

- During our last inspection, concerns were raised regarding the lack of discharge planning. There were now discharge coordinators who worked with ward staff and community services to ensure there was appropriate support in place for patients when they were discharged. Multidisciplinary meetings were held for patients with anticipated additional needs for discharge. Ward staff told us that discharge planning now received more focus from the time the patient was admitted or for planned admissions from the time of pre assessment.
- There was telephone and hospital based pre-assessment available for patients having surgery. This meant patients who were considered low risk for an operation could have their pre-assessment done over the phone, which avoided a visit to the hospital.
- In order to improve the patient experience and meet the needs of local people the service had opened a surgical assessment unit (SAU) since our last inspection. The SAU was opened to reduce unnecessary surgical admissions to the surgical wards by providing quicker access to a review by the surgical team and improve the flow of patients through the surgical pathway.

- There were weekly theatre planning meetings, this meant that theatre staff and managers met to review and discuss the operations for the forthcoming two weeks. This meant that any additional equipment could be organised and the operating lists reviewed to ensure they were achievable in the time frame. Extra staffing could be organised if there was an anticipated over run of the operating list to minimise the risk of on the day cancellations.
- Trauma lists had a "Golden patient" at the first of each operating list. A "golden patient" was selected to go first on the start of the operating list, this meant all the preparation for the patient for example blood tests and consent was undertaken the day before. The patient was then fully prepared for their operation, which then minimised any delays, and the trauma list could start on time, and the rest of the trauma list could be organised on the day.
- Staff told us that patients with broken hips that required surgery where possible went first on the operating list. This meant patients who may be quite unwell, and who are generally quite elderly, had minimal time to be nil by mouth and had their operation as soon as possible which reduced the risk of complications.

Access and flow

- The admitted referral to treatment time (RTT) trust wide for admitted pathways for surgical pathways was consistently below the national average since July 2015.The latest figures for June 2016, showed 60.2% of this group of patients were treated within 18 weeks.
- Trust wide oral Surgery was the only specialty with an RTT better than the England average. Trauma and Orthopaedics (40%) and ear nose and throat (ENT) (49%) were worse when compared to their England averages of 69.9% and 73.4% respectively.
- Bed occupancy levels across the service were high and the lack of available beds was resulting in patients spending longer periods in the theatre recovery areas. There was a lack of appropriate facilities in the theatre recovery area for patients. There were no refreshment facilities, showers or toilets.
- There was 3485 medical outliers on surgical wards and Conquest hospital between April 2015 and September 2016; this was an average of 19 per day. This had an impact of the availability of beds for surgical patients and the flow through the hospital.
- Planned surgical admissions attended either in the morning or at lunchtime depending on where they were on the operating list. Staggered arrival times meant waiting and nil by mouth time was kept to a minimum. All patients if they were a day case or staying overnight attended the pre admission ward. Pre- admission checks and assessments were undertaken, when completed the patient changed and waited for their procedure. Staff then escorted patients to the theatre, the majority of patients walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for patients in the recovery room.
- Once patients were stable and pain-free, staff took them back to the day surgery ward area or surgical ward to continue recovering. Patients who were a day case had a responsible adult to collect, escort and stay with them for 24 hours. We saw in the patients care plan there was a section that must be completed with the nominated adult's name and contact details. This ensured staff were aware who to contact when the patient was fit for discharge and who would stay with them for twenty-four hours.
- Theatre staff told us they would stop elective lists to ensure emergencies were treated in the event of unexpected demands on the service. Service managers and the theatre management team worked closely to monitor surges in demand and prioritised which operating lists should be undertaken.
- We saw the theatre orthopaedic lead went to the daily trauma meeting; this meant there were informed of the amount of trauma cases that were waiting and could escalate to the relevant managers.
- During our last inspection, the check in/waiting area in theatres were highlighted as a concern as there was a limited number bays. During this inspection, we saw considerable changes had been made which included additional bays. In addition, there was a reception area, which was always staffed in order to coordinate the requesting of patients and supervise patients whilst they were waiting.
- In our last inspection, it was highlighted that there was only one porter to collect patients and take them to theatre. We saw during this inspection that there was one porter and a health care assistant. During our inspection, we did not see any delays occur due to the unavailability of a member of staff to collect patient.
- During our inspection, we saw a number of medical outliers across the service. Medical outliers are where

patients are receiving care on a different speciality ward. We saw there were systems in place to monitor medical outliers throughout the trust. Nursing staff on these wards told us these patients were reviewed on a daily basis by the ward doctors and had access to specialist consultants when required.

- This did mean that surgical beds were blocked by medical outliers, which affected the flow through the surgical wards. It also had an adverse effect on patients requiring surgery, as there was not always a bed available when their surgery had been undertaken. Staff told us that patients were sometimes kept in recovery for extended periods of time whilst waiting for a bed to become available. There was a lack of appropriate facilities in the theatre recovery area for patients. There were no refreshment facilities or toilets. In addition, the recovery area could become full with patients awaiting beds, which left no capacity for other patients undergoing operations. This then had an adverse flow of patients through the operating department and could result in cancellations. Staff told us that patients did not stay in recovery overnight and were always found an inpatient bed.
- Bed planning meetings happened at least twice a day and more often when the hospital was exceptionally busy. Site managers met with departmental managers to review the flow of patients through the hospital. Discharges were expedited, with a co-ordinated effort to get as many patients home or back into community care as quickly as possible. Consideration was given to patients in the emergency department needing beds and patients booked for surgery. Cancellation of operations was one of the last options taken to manage the number of patients in the hospital and was only done when all other possibilities had been considered.
- If a patient required an intensive care bed after their surgery, this would be highlighted at the theatre team briefing before the start of the operating list. The anaesthetist would check to ensure there was one available. If the patient was a planned admission then an intensive care unit would be notified in advance. This ensured there was a bed available after a patient had undergone surgery.
- We attended two bed meetings; these were multidisciplinary and occurred several times a day. We saw that the surgical activity for the day was reviewed and that the allocation of beds, any staffing issue, which may of affected flow were also discussed. At the afternoon bed meeting the surgical activity for the following day was reviewed, this meant any potential problems with access and flow could be identified and addressed in advance.
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently better than the England average, between July 2015 and September 2016. Quarter one in 2016 was the only month the percentage of cancelled operations was higher than the England average (7%).
- The overall percentage of total operations cancelled was better than the national average between July 2015 and September 2016 except for quarter two in 2015/16.
- At Conquest Hospital, theatre utilisation ranged from 83% to 101% and averaged 94% between May 2015 and June 2016.
- The theatre management team had “safety huddles” three times a day; this was an opportunity to review the activity and demand within theatres and identify any issues.
- We saw there was an East Sussex Surge and Capacity Plan September 2015. This document described the way in which East Sussex Health and Social Care Economy would respond to the additional demands of winter and peak pressures throughout the year.

Meeting people’s individual needs

- The service used the trusts butterfly scheme where a butterfly symbol was placed by the patient’s name to identify those patients living with dementia or memory-impairment. Its purpose was to improve patient safety and well-being in hospital. Patients with a diagnosis of dementia had a blue butterfly sticker in their patient records and by their bedside. Patients with confusion or awaiting a diagnosis had a white butterfly. We saw these being used during our inspection.
- There were “dementia champions” who had undertaken additional training to ensure patients living with dementia needs were met. Dementia champions acted as a resource for help and advice for other staff.
- We saw there was information regarding a campaign “this is me” tool, which was supported by the Alzheimer’s society. The tool was designed to give patients suffering with dementia the opportunity to tell staff about their needs. The tool enabled to see patients

as individuals and deliver care, which is specific to the patient's needs. For example, it might include details on how patient's best communicate, or details of their medical history.

- There was a Trust Dementia Care Strategy 2014 – 2016. "Dementia (care) is everyone's business" was the approach taken by the trust to dementia care. This ensured that staff and services were engaged in supporting people with dementia and memory impairment.
- The most recent patient led assessment of the care environment (PLACE) score, undertaken in 2015 scored 62 for dementia care at Conquest Hospital, which was worse than the national average of 75%. We were not provided with scores for all areas but noted that surgical wards Decham scored 72% and the SAU scored 56%.
- The PLACE assessment scores did not reflect what we found during our inspection. Staff we spoke to had a good awareness of the needs of dementia and memory impairment patients.
- Staff on Benson ward knitted single use items, which provided comfort and distraction to patients with dementia.
- There were link practitioners for patients with learning disability; they were available to give advice and guidance and ensure this patient group needs were met. For example, if a patient with a learning disability was a planned admission for a procedure, planning would start at pre-assessment. The link practitioner was involvement in the process and made the necessary arrangements .For example, ensuring the patient was first on the operating list to ensure waiting time was minimised.
- In addition, the trust had an inpatient learning disabilities specialist nurse team who provided support to patients, their carer's and staff.
- We saw guidance on managing patients with special needs available for staff to use as a resource in theatres
- There was a portable DVD player available in the theatre check in/waiting area this could be used to occupy and distract children or adults. Staff told us that for children they would normally send the DVD player to the ward with a choice of DVD's. This meant that patients' could choose a DVD and start watching it prior to coming to theatre.
- In the check in/waiting area in theatres and recovery there were "Magic ears." These were designed to monitor environmental noise; they displayed a green ear when the noise level was low, and amber ear when the noise was medium and a red ear when the noise was too loud. This meant consideration was given to the amount of noise that patients experienced which could be upsetting or interfere with them resting.
- The trust had a service level agreement in place for provision of translation services. This included sign language, lip speakers and translation to braille. The service was available face to face, via telephone or written and audio services.
- Within 48 hours of admission to hospital, all newly admitted patients on the regular wards covered by Chaplaincy were visited and patients asked if they wanted regular visits. Information about a patient's religious needs, such as bedside sacraments were met by members of the Chaplaincy team, but if this was not possible arrangements were made to contact a faith leader for any faith not represented in the Chaplaincy team. Devotional literature was provided as required. Additional support was offered to patients who we are aware are approaching the end of their lives, this was also extended to their families
- Bariatric patients were assessed at pre assessment and any specialist equipment would be organised prior to the patient's admission.
- There was a variety of equipment available to meet the needs of patients with a high body mass index (BMI). For example all operating tables were able to withstand a weight of 450kg and there was a specific bariatric wheelchair, which was larger and designed to withstand increased weight. Bariatrics is a branch of medicine that deals with the causes, prevention, and treatment of obesity.

Learning from complaints and concerns

- The trust had a policy, which related to the recording, investigation and management of complaints, comments, concerns and compliments however, we note that it was due for review in November 2015.
- The management of complaints and response to complaints had been a concern in our last inspection. The management of complaints was disorganised, inefficient and failed to drive service improvement. In addition, managers did not receive complaints that related to their individual departments and did not receive feedback from them. The complaints we reviewed during our last inspection were dismissive to the complainant and did not facilitate learning.

Surgery

- The work had undertaken some work with Healthwatch regarding the management of complaints. In March 2016, Healthwatch East Sussex carried out a volunteer led, independent review of the trust's complaints process. Healthwatch reviewed 66 individual complaints cases the review highlighted areas of good practice and made recommendations for improvement. We reviewed five complaints, which all demonstrated the trust had implemented the Healthwatch's recommendations.
- Between April 2014 and March 2015, the trust received 653 complaints. Complaints data was not broken down by core service, however trauma, orthopaedics, and general surgery were two of the four most complained about services at the trust.
- The Chief Executive had personal responsibility for the complaints procedure and for the review and sign off of complaint responses. The complaints and Patient Advice and Liaison Service (PALS) manager was responsible for the day-to-day running of the complaints team. In the complaints team there were two Customer Liaison Support staff that were responsible for administrative duties and logging all complaints on the database. There were four full time Customer Liaison Leads who were responsible for triaging new complaints, acted as contact for complainants and liaison with the investigating Clinical Unit (CU). They also collated the outcome of the investigation from the relevant CU and drafted the response for the Chief Executive to review. There was also a patient experience lead.
- The Board and Non-Executive led Quality and Safety Committee received a patient experience report or a quality report that included patient experience at each main board meeting.
- There was also an annual complaints report for the trust. The Clinical Units received information on their complaints as part of the Governance Report that was reviewed on a monthly or bi-monthly basis depending on the Clinical Unit and they were responsible for monitoring their complaint actions.
- The committee meeting structure had changed to enhance the reporting and sharing of complaints at a trust wide level. This new group called the Patient Safety and Quality Group was in place from August 2016 and will triangulate incidents complaints and claims.
- Recent changes have been made to the electronic risk management system to record the identified actions from the complaints in order for them to be tracked centrally through the Patient Safety and Quality Group. This will provide the assurance process on completion of complaint actions.
- This showed that the trust had undertaken work in the management of complaints to improve the backlog and the quality of the complaint responses.
- Patients and/or relatives were encouraged to raise any concerns at the time to the staff providing their treatment, as often concerns can be resolved locally without the need for escalation.
- Patient information that advised patients how to make a complaint or raise a concern with PALS was available on the trust website. There was an easy to read leaflet, which was available throughout the trust and was available in other languages upon request.
- The trust aimed to respond to complaints within 30 working days or for complex complaint (multi Clinical Unit or external agencies involved) within 45 working days. The Patient Experience Lead was implementing a clear escalation process to improve timeliness with responding to complaints. For In July 2016 47% of complaints were responded to within the agreed timeframe .There was a historic backlog of complaints with a high number overdue the response period. The trust told us they were working hard to reduce the backlog and the trend was moving in the right direction with less overdue the response period. Weekly monitoring was in place.
- We saw minutes of ward and theatre meetings where complaints had been discussed and learning shared.
- Staff were able to give us examples of changes as a result of a complaint. For example, a patient in recovery complained that they could hear their medical history being discussed on the phone by staff. Their concern was that if they could hear it so could the other patients in recovery and this was a breach of confidentiality. As a result of this complaint, the telephone was moved further away from the area where patients were so conversations could not be overheard.

Are surgery services well-led?

Good

Overall, we rated the service as 'Good' for well led. This was because:

Surgery

- Leadership at a local level was good and staff told us about being supported and enjoyed being part of a team. There was evidence of excellent innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.
- A triumvirate management structure had been put in place with three managers having overall leadership of the Surgical Directorate (a head of nursing, a general manager and a clinical lead). Each had a specific area of responsibility and clear lines of reporting and accountability.Staff now understood who their line manager was and who to seek advice or raise concerns with.
- Nursing leadership at the trust was good and staff said they were able to approach nursing leaders with any concerns and felt they would be listened to and that they were confident the issue would be addressed. Across the hospital staff told us that the DoN was, "Always around and not really part of the Board but just someone who they trusted and who wanted to do right by the staff and the patients".
- Heads of Nursing and ward matrons told us they felt a change in the culture of the organisation. When asked what they felt was good about their work they all replied "My team". They talked positively and with pride about the camaraderie, the willingness to support each other, the commitment to kindness towards the patients and the support they received from each other.
- When we visited wards we saw warmth that was missing on both our previous inspections in September 2014 and March 2015.Where before we saw task centred care and a reluctance to engage with the inspection team, we now felt welcomed and were introduced to all the staff on the wards. The staff were smiling and laughing with each other and with patients. This was a real change in culture since our last inspection when staff felt too afraid to speak up.
- Staff told us that trust wide leadership had improved since the new Chief Executive (CE) was appointed. Staff he was visible and they felt supported and had already seen positive changes since the new CE was appointed.
- The trust board demonstrated a clear vision and strategy for the surgical services, which was absent at our last inspection. Staff knew about the "Outstanding by 2020" strategy and were able to explain their part in it. There was a clear vision and strategy for surgical services which staff were able to describe.
- Staff were able to identify what their biggest risks were on the risk registrar and how they planned to mitigate risks.
- Staff responded quickly to the issues we raised during the inspection, to ensure they were addressed and took action.
- Staff were proud of the service they provided to patients and their families. They spoke positively about the changes made since the last inspection.

However we also found:

- The quality of mortality and morbidity meetings required improvement.

Governance, risk management and quality measurement

- There was a management structure with three managers having overall leadership of the Surgical Directorate (a head of nursing, a general manager and a clinical lead). Each had a specific area of responsibility and clear lines of reporting and accountability.
- There was a surgery risk management strategy, the Integrated Performance Committee (IPC) had overarching responsibility. This committee met monthly and provided assurances to the executive team of the effective delivery of five areas within the governance framework :Quality and safety, leadership and culture, clinical strategy, access and operational delivery, financial control and capital development. The IPC fed into the Divisional Quality Clinical Governance Committee (DQCGC), who met monthly. The DQCGC reviewed, monitored and responded to six risk sub groups for example the surgical directorate and the Health and radiology. The six risk sub groups fed into departmental/ward meetings, the World Health Organisation steering group and the Health and Safety group. There was a two way sharing of information between the groups within the overall strategy.

- The lack of mortality and morbidity meetings was highlighted as a concern in our last inspection. Improvements had been made since our last inspection however, improvement was still required and this was acknowledged by the trust.
- Compliance with VTE assessment and numbers of patients developing a VTE or PE was a concern during our last two inspections. The surgery division was still not able to demonstrate consistent and sustained compliance with VTE assessments.
- The potential risk to patient safety caused by insufficient assessment of VTE in patients within twenty-four hours of admission and leading to potential patient death and non-compliance with national guidance was highlighted on the hospital risk register. It was categorised as an extreme risk and was last reviewed in August 2016.There was measures in place to mitigate the risk for example; VTE assessment at pre assessment, VTE policy which states doctors must complete VTE assessment as part of clerking process and a VTE group had been created to drive improvement in relation to hospital related VTE prevention. This showed that the hospital had highlighted a potential risk but were unable to demonstrate compliance.
- We saw minutes of the various surgical division meetings and quality governance meetings .We saw trends in incidents and complaints were identified, in addition serious incidents, safeguarding, patient feedback and metrics were discussed.
- Staff said they generally received information regarding incidents and were involved in making changes as a result of incident investigations. Staff understood and felt in governance processes.
- The service had completed local as well as national audits. For example, a regular audit had been completed to ensure that compliance with the consent process and an audit was undertaken on the quality of operative notes
- There was a comprehensive risk register for all surgical areas, which included all known areas of risk identified in surgical services. These risks were documented, and a record of the action being taken to reduce the level of risk was maintained. We saw there was a total of 32 risks on the surgical risk register, one hundred percent of these risks had been reviewed within the last 12 months. The oldest risk on the registrar was failure to provide timely diabetic retinopathy screening within recommended time scales, this was added to the registrar in February 2012.
- The register was up to date, identified the risk, the impact to the patient, the controls in place, with a nominated lead for each risk. The risk register was discussed at each departmental clinical governance meetings and we saw evidence of this in meeting minutes.
- Matrons and ward sisters also had daily meetings to discuss staffing levels, patients' safety concerns and bed occupancy.

Vision and strategy for this service

- There were two different priorities 2016/7 for surgical services one for theatres and clinical support and one for surgery. Both showed the top three achievements in the last 12 months and the top three objectives for the next 12 months and how they were going to achieve them.
- Examples of what they had achieved included mandatory training compliance, engagement sessions with staff, and improvements in referral to treatment times. Examples of what they wanted to achieve in the next 12 months included; 100% appraisal compliance and development of sustainable and proactive orthopaedic strategy.
- The trust had launched a new risk and quality delivery strategy in September 2016. It outlined the trust governance structure to support the delivery for three domains of quality (patient safety, patient experience and clinical effectiveness) and outlines the systems in place to manage them. This strategy included the meeting schedule for risk and governance meetings for the surgery, anaesthetics and diagnostics division. This meant that the overall trust and risk and quality strategy linked into the directorate strategy and there was sharing of information between the two.
- Staff we spoke to were aware of the overarching "Outstanding by 2020" strategy and felt confident they could achieve it.
- Staff we spoke to were aware of the vision "Outstanding by 2020" which had been circulated to staff as a pocket

booklet. The booklet and vision had been created from an idea that members of the executive team saw in the physiotherapy department. The physio's idea was adapted and rolled out trust wide.

Leadership of service

- Each speciality had a clinical lead, for example anaesthetics, general surgery and orthopaedic surgery. This provided medical leadership within each speciality.
- We saw strong leadership, commitment and support from the senior team at department level within the service. The senior staff were often responsive, accessible and available to support staff during challenging situations.
- Managers we spoke with appeared knowledgeable about their patient's needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities. This was an improvement since our last inspection when managers lacked insight into their service.
- Staff told us that members of the directorate and local leadership teams were visible.
- Ward staff told us that senior nursing staff, consultants and doctors could be seen on the wards and they were approachable and helpful.
- Each ward had a sister, supported by a matron who provided day-to-day leadership to members of staff on the ward. Staff told us they thought leadership at that level was very supportive and that there was clear leadership from ward sisters and the matron.
- We observed the theatres were well managed with good leadership. There was evidence of good team working to comply with NCEPOD recommendations, which was staring to show significant improvements for patients.
- The starred anaesthetist of the day and theatre coordinators was also helping to manage emergency cases more effectively.

Culture within the service

- Staff morale was low when we undertook our last inspection. During this inspection, staff told us that staff morale had improved and things were starting to settle down with teams starting to work together.
- Staff felt there had been a shift in culture and that now, if they made a complaint about unacceptable behaviour, it would be addressed.
- All the staff we spoke to commented on the positive impact the new Chief Executive (CE) had on the trust. Staff described him as "a breath of fresh air" and "he remembers everyone's name".
- Staff said there had been a change in culture since our last inspection when staff were afraid to raise concerns. Staff described an open transparent culture where everyone felt comfortable to raise concerns without fear of any consequences.
- Staff said there was a "no blame" culture, where lessons were learnt and shared when things went wrong.
- Staff described a previous dictatorial culture but now staff felt empowered that and that they could make positive changes. Staff felt they were "moving in the right direction" and had confidence that the Executive team could improve the services provided to patients.
- Staff were committed to making improvements for patients and felt they had been given the right tools to achieve this.
- Staff were proud to work at Conquest hospital with comments such as "it's empowering to work here" and "it's our job to bring up the next generation of staff".
- The trust undertook a staff survey in August 2016, which focused on 12 questions, which related on communication skills of managers/bullying and harassment. In this survey, 76% of staff either agreed or strongly agreed that their line manager encouraged those who work for her/him to work as a team. This showed that staff thought their manager encouraged them to work as a team. In the same survey, 72% of staff either agreed or strongly agreed that their line manager valued their work. This showed that staff felt their line managers appreciated their work.
- Staff described that previously that inappropriate behaviour towards others would not be challenged. Staff felt now that this behaviour would be challenged and not tolerated.

Staff engagement

- The trust had appointed a Freedom to Speak Up Guardian (FTSPUG) The role of the guardian was to have

a nominated individual in the trust that staff could raise concerns and gain advice confidentially. We did not speak to anything who said they had accessed the FTSPUG.

- We spoke to one of the domestic staff in theatres who had won the "Chairman's award" in the staff awards and wore a lanyard which showed this. The member of staff said to us "I like theatres to be as clean as my home". This showed the member of staff was dedicated to her job and took pride in her work.
- In addition, one of the receptionist is theatres was nominated for one of the "unsung heroes award" in the staff awards.
- The trust had introduced Schwartz Rounds (SR's). SR's provide a structured forum where all staff, clinical and non-clinical, can come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. We did not speak to any staff who had attended these but staff confirmed they occurred.
- Following the October 2015 staff survey, a 'you said, we did' poster was published to inform staff of changes made as a result of feedback. For example, a cold water fountain was ordered for the department. This showed that staff were having the opportunity to voice their opinions and action was taken as a result of them.
- We saw theatre staff were proud of the changes they had made since our last inspection and had developed an "Our Changes" poster. This showed staff what had been improved and included future improvement plans.
- We saw the trust had a staff engagement action planned which was regularly updated and included outcome measures.
- The trust celebrated the success of their staff through events such as unsung hero's week, annual awards, dignity day and the Christmas campaign.
- The executives all took part in a 'Walking in your shoes" programme where they shadowed individual members of staff to see what their job entailed and how the hospital felt from the perspective of different staff.
- Trust values were displayed across the hospital and appeared on the rear of staff identification badges.

Public engagement

- The service used a number of volunteers to assist with some areas of work across the wards. For example, they could help patients complete their menu requests.
- Patient satisfaction questionnaires were available on each ward and patients were encouraged to complete these. This provided the opportunity for patients to give feedback on any areas they felt needed improvement. This was an improvement from our last inspection and showed a positive change in patient involvement to improve services.
- We saw the trust was now engaging with Healthwatch and had undertaken a recent review with them regarding the management of complaints. This was an improvement since our last inspection, as previously the trust had not engaged with Healthwatch. This showed that the trust was committed to improving services for patients.
- The trust reported that over 300 local people gave views about services provided within the trust.
- All staff wore lanyards, which had their role printed on; this meant staff knew the role of all the staff.
- The trust participated in the "hello my name is campaign" this means that staff introduce themselves to patients and visitors in the hospital. This meant that staff knew the name of the member of staff and their role.
- We saw that patient feedback and actions taken were displayed on the wards for patients and visitors to see. This demonstrated that the trust was listening to patients' feedback on how services could be improved and this was an improvement since our last inspection.
- The trusts website provided information about the surgical services provided. This meant the local population could use this to make decisions about where they received their care.
- We saw there was a variety of general information leaflets regarding flu advice and smoking cessation

leaflets available for patients and visitors. In addition, there was information available for carers and relatives if they required additional financial or emotional support.

Innovation, improvement and sustainability

- The ear nose and throat department had introduced a new Fibreoptic Endoscopic (Evaluation of Swallowing service) in May 2016, which made it easier to assess and manage patients with swallowing disorders. The procedure involved passing a small endoscope (scope) up through the nose to visualise the throat during a swallowing assessment, allowing immediate feedback for patients about their condition.
- A consultant orthopaedic surgeon had written a national guide for the Royal College of Surgeons on avoiding unconscious bias, which was published on 4 August 2016. The guide focused on overcoming the unconscious opinions that everyone forms about people when they first meet them and offers advice on to get beyond this. The national guidance references the trust's Anti-bullying policy in the Doctors Clinical Handbook and highlighted the progress and work being made within the trust to address perceptions of bullying and harassment.

Maternity and gynaecology

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

Information about the service

East Sussex Healthcare NHS Trust maternity and gynaecology services are arranged across two sites covering 45 maternity beds that share the same guidelines and protocols. This report focuses on the services at the Conquest hospital.

The Conquest hospital has 38 consultant led beds in total, 24 beds are located on the postnatal ward (Frank Shaw) and 14 on the antenatal ward (Murray). There are also 10 delivery suites including one room with a birthing pool. The gynaecology unit has eight beds located within one ward (Mirrlees). Women have the choice to give birth at either location depending on their needs and preferences. There are community midwives working across both sites offering home birth options for women who anticipate an uncomplicated delivery.

There were 2805 births reported at the Conquest Hospital from April 2015 and March 2016 with an average of 234 births a month in the same period.

The service has a dedicated triage phone service that operates from EDGH Monday to Friday from 8:30am until 7pm. Outside of this time the calls are diverted to the Conquest hospital and calls are covered by midwives working on the delivery suite. There is a day assessment unit at the Conquest Hospital which covers both sites for women who may have concerns relating to their pregnancy or those requiring closer monitoring. The service also runs antenatal clinics, routine screening and ultra sound scanning, as well as fetal abnormalities screening which runs a separate clinic on Mirrlees ward.

There is a special care baby unit (SCBU) which accepts all babies who required additional monitoring and supported care at level one, babies requiring greater levels of support are transferred to other hospitals in the area with level two or three services.

The Conquest Hospital maternity unit has two theatres within the obstetric unit, one main theatre and an annex theatre for use in busy periods. These are used for caesarean sections and gynaecology surgery. There is a recovery room post-surgery. Termination of pregnancy, for fetal abnormality is carried out at the Conquest Hospital, within the delivery suite for women with 14 weeks gestation and above and on Mirrlees ward (gynaecology ward)for women who are under 14 weeks gestation period. The service provided 188 surgical and 28 medical terminations of pregnancy from April 2015 to March 2016.

We carried out a comprehensive inspection from the October 3rd to the 6th and reviewed all areas where maternity and gynaecology patients receive care and treatment. These included: day assessment unit, antenatal unit, postnatal unit, labour ward, theatres and recovery, scanning areas and the gynaecology ward. We spoke with staff from across the department including clinical leads, consultants, doctors, midwives, maternity support workers, clinical staff, housekeepers, orderlies and specialist midwives. We also spoke with 16 patients and relatives. We reviewed 10 sets of maternity records and before, during and after our inspection reviewed the hospitals performance and quality information. This included meetings minutes, policies and performance data. Our inspection team included two inspectors, two midwives and a consultant obstetrician.

Maternity and gynaecology

At our previous inspection visits in September 2014 and March 2015 we rated the maternity services overall as Inadequate. We did not at those inspections report about the different locations as the problems identified were systems wide. Issues of serious concern which we reported on included low midwifery staffing levels, poor leadership of the service with evidence of some degree of a bullying culture, little reflection and learning from incidents with the same errors and types of incidents being repeated. Feedback from service users was poor, as was feedback from staff.

Summary of findings

We rated this service as 'requires improvement' because:

- The triage system did not ensure all calls were answered in a timely manner and sometimes led to calls being missed.
- We were told of delays in the day assessment unit out of hours due to staff being moved to the delivery suite. We witnessed this during our un-announced inspection on a Saturday.
- Midwives were not always able to attend the daily risk meetings and feedback was not always ensured.
- Cleaning schedules in theatres were not always completed and we saw high level dust on inspection.
- Sterile equipment on the labour ward resuscitation trolley was not in date and two sterile packages were ripped open and left on the trolley.
- Mandatory training fell below trust targets in many areas across the whole department.
- Several of the maternity policies and procedures were outside their review date. This meant the service might not have worked to all the relevant and current evidence-based guidelines, standards or best practice.
- There were delays for patients using gynaecology services and referral to treatment times were consistently worse than the 18-week target.
- Mirrlees ward was often taking patients that were not gynaecological patients (medical outliers).

However;

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Daily risk meetings and the sharing of incident learning ensured that staff learned from incidents to prevent recurrences.

Maternity and gynaecology

- When staff identified issues we saw that they initiated projects to try and understand the causes for this. For example (HIE) cases were further reviewed to look for causes and possible actions to reduce recurrence.
- There was enough equipment to allow staff to safely treat patients. Equipment was regularly checked and maintained to ensure that it worked safely.
- Staff followed infection control procedures and demonstrated a good understanding of these. The use of personal protective equipment (PPE) was audited to ensure staff were following guidelines.
- Staff received mandatory training in safety systems, including responding to childbirth emergencies such as post-partum haemorrhage.
- Safeguarding vulnerable adults and children was given sufficient priority. Staff received an appropriate level of safeguarding training to allow them to identify safeguarding concerns and knew how to raise these.
- Outcomes for people who used services were generally positive and met expectations.
- Appraisal rates met expected trust targets. Staff we spoke with found senior staff members supportive.
- Staff treated people with dignity, respect and kindness. Patients felt supported and said staff cared about them. We saw a rapid disciplinary response from staff members when a patient's dignity was not considered by a colleague who made an inappropriate comment.
- People and staff worked together to plan care and there was shared decision-making about care and treatment. Women's wishes were understood and met if possible with clear explanation if this could not happen.
- The service made reasonable adjustments to remove barriers when people found it hard to use or access services, for example, through provision of interpreters.
- The service had good links to services within the community and outside organisations such as GP surgeries and social services.
- Response times to complaints had improved significantly since April 2016. We saw evidence of appropriate responses to complaints, and learning from complaints and concerns.
- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.
- The service proactively engaged and involved all staff through the maternity service review and other channels and ensured that the voices of all staff were heard and acted on.
- Staff felt respected, valued and supported. All staff we spoke to felt the culture had improved since our last inspection, and gave us examples of positive improvements.
- The trust had a programme of project groups related to maternity, which drove improvements in different areas of the service.
- The culture within the trust was good and staff felt supported and listened too. Staff were proud of the department and their work colleagues.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Midwives were not always able to attend the daily risk meetings and feedback was not always ensured.
- We saw high level dust in Buchanan theatre and cleaning audits had not correctly identified this. Recent cleaning audits for postnatal and antenatal wards fell below trust targets.
- There was wallpaper on walls in three of delivery suites we looked at which is not recommended in line with Health Building Note (HBN) 00-09:3.119 Infection control in the built environment.
- Mandatory training fell below trust targets in many areas across the whole department.
- We saw inadequate locks on medication cupboards in patient rooms, the cupboards could be accessed as locks were not tight enough around the handles.
- Half of the sterile equipment we checked (21 items) on the labour ward resus trolley was not in date and two sterile packages were ripped open and left on the trolley.

However:

- Incident reporting was encouraged and we saw evidence that learning from incidents had resulted in changes in practice.
- There was a robust system for investigating serious incidents and reporting occurred at all levels.
- Regular meetings around risk and incidents were held and actions were given clear timeframes for completion.
- Staff followed the trusts hand hygiene policy and used personal protective equipment appropriately.
- Patient notes were well ordered, with clear documentation including consent and risk assessments.
- Safeguarding vulnerable adults and children was given sufficient priority. Staff received an appropriate level of safeguarding training to allow them to identify safeguarding concerns and knew how to raise these.

Incidents

- Between August 2015 and July 2016 the trust did not report any never events for maternity or gynaecology. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the maternity & gynaecology directorate reported nine serious incidents (SI) which met the reporting criteria set by NHS England between August 2015 and July 2016. Of these, the most common type of incident reported involved the baby only (this includes fetus, neonate and infant). We saw reports of these which indicated multidisciplinary meetings were held and cases were reviewed at several staff meetings including morbidity and mortality meeting if appropriate.
- There was a further trust-wide SI relating to maternity and gynaecology services in October 2015 to September 2016. This incident involved the failure to report 265 newborn and infant physical examination (NIPE) screens on the trust's computer records. This meant the trust did not have assurance all newborn babies had a physical examination to check for congenital abnormalities in line with guidance from Public Health England. The trust identified all affected babies in this cohort and requested records for a look back exercise to check whether any babies missed their NIPE screen. The investigation was ongoing at the time of our inspection.
- Incidents were rated from one to four, with four being the most severe. There were 21 incidents reported from July 2015 to June 2016 rated level three and four. We saw actions had been implemented following these incidents and that some changes in practice had occurred. An example is where a baby was born in a poor condition with no paediatric registrar present. As a result of this a paediatric registrar is now called for all pre-term births and the special care baby unit (SCBU) are informed about the labour.

- Another example of a recent change is a further risk assessment for all patients entering the labour suite by a lead midwife. This change came about following a series of incidents involving missed opportunities for early intervention.
- The trust had implemented a new policy on labelling epidural lines after a recent medication error involving the wrong line being placed. As a result large yellow stickers are placed on the epidural lines to identify them and avoid any further incidents. We saw these stickers in place on all epidural lines we looked at.
- The Patient Safety Summit group met weekly via teleconference and reviewed all incidents graded level 3 and above raised via the online incident recording system in the previous week. A report was produced and circulated to all attendees, which included heads of nursing, clinical leads and lead for infection prevention and control (IPC). The meeting was chaired by the director of nursing or medical director. This comprehensive meeting provided appropriate oversight to senior clinicians within the trust of what incidents were occurring. A spreadsheet was maintained to ensure incidents were followed up in a timely manner.
- Incidents were widely reported and openly discussed. During our inspection we saw discussions at handovers, daily risk meetings and saw incidents had been minuted in ward meetings.
- Staff felt there had been a cultural shift in reporting of incidents and they felt able to raise any concerns with staff at all levels. There has been a 47% increase in incident reporting from March 2015 to April 2016 showing a huge shift in staff feeling able to report incidents.
- All incidents reported through the online incident recording system were reviewed by the clinical governance lead. All incidents were discussed at the daily risk meeting. All incidents rated three, four and five were further reviewed by the risk team within 48 hours. This included any immediate actions that needed to be undertaken to ensure patient safety, before a full report was produced. If it was decided after further review by the director of nursing that an incident was classified as a serious incident (SI) then it was passed on to the patient safety summit and a root cause analysis (RCA) investigation was conducted. Duty of candour was carried out as per trust policy. Once the RCA report has been completed, and approved by the trust corporate team, it was sent to the Clinical Commissioning Groups (CCG) as per national policy for approval. There was a robust system of discussing incidents with staff either individually or in team meetings and risk meetings.
- We reviewed three RCA reports relating to serious incidents within the department. We saw they were clearly written and followed set criteria including background and context,
- Action plans following RCA were monitored to ensure adherence within a given time frame. These were revisited every month until completed at the clinical effectiveness forum, we saw this detailed in the meeting minutes.
- There were daily risk meetings Monday to Friday, from 1pm-2pm which involved multidisciplinary staff members including anaesthetists, junior doctors, senior midwives and clinical leads. The aim of these meetings was to discuss any incidents from the day before (or weekend if a Monday), and ascertain if the correct protocol had been followed and report any learning that could be implemented. During these risk meetings, time allowing, any recent emergency caesarean sections are also discussed and reviewed to gain consensus on whether they were needed. This involved going over case notes and reviewing CTG tracings allowing for further learning.
- We attended two of these meetings and found they were mostly well structured and led by the consultant lead for that day if available or senior consultant on shift if not. They were well attended by staff including paediatricians and junior doctors and students. It was brought to our attention that not many midwives were able to make this meeting as they were needed on the wards. This issue was being addressed by the senior staff members and we were told that at times they had taken on the midwives role to allow them to attend. Although we were told this rarely happened.
- We saw five emergency caesarean sections being reviewed over the two days. Staff discussed patient history and reviewed notes and CTG tracings to determine if correct guideline had been followed. There was open discussion and differences of opinion were expressed and discussed. It allowed for learning points

to be highlighted and staff were seen to happily challenge each other. This showed a culture where staff are able to learn from each other and are not afraid to speak up.

- A weekly 'lessons learnt' email was sent to all clinical staff in the department we saw it was also displayed on the wall in the staff room and in the seminar room.
- Midwives we spoke to gave mixed feedback about receiving the information from the daily risk meetings. Some were aware of the e-mail sent out but some said they received little feedback unless it was a serious incident.
- Serious incident reports were held in a folder in the staff room for staff to read, there was however, no record of who had read these so therefore no assurance that lessons learnt had been seen by all staff members. Staff we spoke to gave mixed accounts of their awareness of these reports. We looked at this file and the last SI report was June 2015, suggesting this was not up to date and recent learning from SI was not being received in this manner.
- Joint Obstetric & Perinatal Morbidity & Mortality Meetings took place monthly and review all relevant cases. We looked at the minutes from these meetings and saw they were well attended by multidisciplinary team members. There was a clear structure and actions to be taken were detailed, precise and robust.
- A Serious Incident Group meet monthly to review reported serious incidents and then to cascade shared learning through newsletters and maternity matrons meetings.
- Under regulation 20: Duty of candour, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- All staff we spoke to were aware of their responsibilities relating to Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support. Staff told us they had recently had "lesson of the week" refresher training in DoC, and we saw posters around the hospital reflecting this. We reviewed incident data for the service and actions staff took following incidents and saw evidence staff applied DoC appropriately. We witnessed the duty of candour being discussed in the daily risk meeting and saw references to it in several meeting minutes and SI and RCA reports.

Safety thermometer

- The trust does not complete a specific maternity safety thermometer. It does however measure the metrics for perineal and/or abdominal trauma, post-partum haemorrhage, infection, Apgar scoring of below 7 and separation from baby. Apgar scoring is a method to quickly summarise the health of newborn children scores of 7 and above are generally normal, 4 to 6 fairly low and 3 and below are generally regarded as critically low.
- It was reported that the total number of women with a blood loss of over 2500mls was better than the target set by the trust with 0.36% reported against a target of 1% within the reporting period. The target of below 12% was not met for women with blood loss of 501-1000mls from the period April 2016 to July 2016 with 17% reported in July 2016.
- The trust target for emergency caesarean section was 9%. This target was not met from June 2015 to March 2016 with the rate as high as 15% in April 2016.
- Venous thromboembolism (VTE) risk assessments were compliant with the trust target of 95% from April 2016 to June 2016.
- The data we saw also showed no falls resulting in harm, no medication errors from June 2015 to April 2016.

Cleanliness, infection control and hygiene

- There was a link infection control midwife who attended the monthly Infection Control Committee meetings. These included staff from across the hospital including clinical units, infection prevention and control (IPC) link nurses, pharmacists, director of nursing, clinical commissioning groups (CCG) and local county council

members.It was chaired by the Director of infection prevention and control (DIPC). This committee also sent a report and representation to the Quality and Safety Committee.

- There was a dedicated IPC team that covers both hospital sites and the community.
- The department had recently employed four cleaning staff to ensure that all areas were thoroughly cleaned after use. They covered the hours between 7am and 11:30pm. They followed a cleaning checklist. After each area had been cleaned this checklist was displayed to ensure staff and patients were aware the area had been cleaned.
- In line with the target of 0% there were no reported cases of MRSA from June 2015 to March 2016 in maternity and gynaecology.
- The trust set the target for cases of Clostridium Difficile (C Diff) at four cases per month across the hospital, within maternity and gynaecology one case was reported in May 2016 so targets were being met. For all episodes of C Diff there was a post infection review which is multidisciplinary and comprehensive, focusing on identifying the cause and learning; the infection is signed off by the Director of Infection & Prevention Control (DIPC).
- Cleaning rotas were displayed in the cleaning cupboards and checklists were completed daily. This ensured no areas were missed or cleaned twice.
- We observed all cleaners wearing disposable aprons and following the correct procedures for preventing the unnecessary spread of germs.
- Theatres had specific housekeepers and a separate checklist for cleaning this included damp dusting. Most areas were visibly clean but we did see high dust directly above the operating table in the Buchanan theatre indicating that this area had not been cleaned. Theatres are indicated as very high risk areas in terms of infection control. According to the cleaning schedule high dusting should be completed every day.
- Audit results showed that theatres were 98% compliant in June, July and August 2016 meeting the trust target of 98% for very high risk areas. We looked at the cleaning schedule for theatres which listed high dusting was to be completed every day. The high dust we saw during inspection indicated that the trust audits may be insufficiently robust and there was a risk that poor attention to detail in cleaning theatres would increase the possibility of surgical infections.
- Cleaning audits from June and July 2016 showed that Murray ward, Frank Shaw ward and the delivery suite were all below trust targets for cleanliness. Murray ward reported 81% compliance in June 2016 which was below the trust target of 95%. Mirrlees ward reported an average of 99% compliance from June 2016 to August 2016. the same period.
- From February 2016 to July 2016 there were six cases of MRSA. Of the six cases, four were the same strain. An NHS England infection team visited the ward and advised on procedures to prevent further infection. There had been no further cases reported from April 2016.
- As a result of this visit all staff were swabbed, all areas were deep cleaned and bleached, and improvements made to two patient bathrooms on the post-natal wards. This showed that a robust protocol was in place to reduce the risk of infection and prevent future outbreaks.
- Following on from this the trust also employed four cleaning staff, this was recommended by the internal maternity review but also a recommendation from NHS England's review.
- A cleaner we spoke with confirmed they had undergone training and a period of shadowing another staff member to ensure they were aware of cleaning protocol. They had also asked about attending further training to learn why they used specific methods when cleaning.
- All departments within maternity and gynaecology are considered high risk or very high risk for infection control. The hospital was compliant with the Department of Health guidance recommending: 'All patients admitted to high risk units and all patients previously identified as colonised with or infected by MRSA, should be screened for MRSA. In addition, local risk assessment should be used to define other potential high MRSA risk.'
- Clinical staff were required to comply with the 'Five moments for hand hygiene', as set out by the World

Health Organisation (2009) and with the trust's own hand hygiene policy following NICE guidelines. Hand hygiene audits were undertaken every month in Frank Shaw ward and Mirrlees ward. The audit included hand hygiene compliance before and after patient contact and whether staff were bare below the elbows. Between February 2016 and July 2016 Frank Shaw had 100% compliance with all nine areas that were audited. Mirrlees ward also showed 100% compliance in five of the six months reported.

- Mirrlees ward had a checklist and cleaning programme in place, the ward sister told us these were checked and collected daily, but as far as she knew were not audited. We saw a folder containing these checklists from the last few months and they were fully completed on a daily basis, we asked what happened to the folders once they were full and were told the sheets got stored. Without a clear audit trail it could not be sure that cleaning schedules were adhered to over a longer period of time.
- We saw alcohol based hand sanitizer available on the wards and units in maternity and gynaecology at the hospital. We observed good use of these in all areas we visited.
- All areas we inspected were visibly clean although some refurbishment was needed. An example was in the delivery suites where there was wallpaper on walls. This is not best practice following the Health Building Note (HBN) 00-09:3.119 Infection control in the built environment which suggests 'Smooth cleanable impervious surfaces are recommended in clinical areas. Design should ensure that surfaces are easily accessed, will not be physically affected by detergents and disinfectants, and will dry quickly.' There were no specific risk assessments in place to address this issue although it was planned to refurbish all delivery suites.
- The trust has undertaken a number of refurbishment and improvement schemes within the last 12 months and confirmed that due consideration of the relevant Health Building Notices including HBN 09-02. During our inspection two patient bathrooms were being refurbished.
- Personal protective equipment (PPE) was available in all clinical areas. Staff were seen using PPE correctly and as needed. An audit into the use of PPE and bare below elbows (BBE) in April 2016 and May 2016 found clinical and non-clinical compliance was 100%.
- The majority of staff we observed followed correct use of PPE, however, we did see a staff member leave a patient room and retrieve something from a draw in the reception area and return to the patient wearing gloves throughout. This could lead to unnecessary spread of germs and went against trust policy and NICE guidance, QS61 statement 3: 'People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care'.
- Staff were in clean uniform, had bare skin below the elbows with long hair tied back. This was in line with the trusts uniform policy. We saw posters displayed with details of these expectations in the delivery suite and on wards.
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with Health and Safety Regulations 2013 (The Sharps Regulations), 5(1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed, by whom and on what date.
- Specific hand washing sinks were available in all rooms, at the entrance to bays, and on wards including Mirrlees ward. All sinks we saw were compliant with lever handles and taps positioned to cause the least amount of splash. Sinks also had hand washing technique posters displayed to ensure staff used the correct technique.

Environment and equipment

- The maternity and gynaecology department consisted of antenatal clinic rooms, a day assessment unit, an antenatal ward (Murray ward) and a post-natal ward (Frank Shaw) as well as the delivery suite. There was also the Gynaecology ward (Mirrlees), one theatre and an annex theatre which was used if a second theatre space was needed, for example, in emergencies. This meant that patients had direct access to theatres in an emergency without having to leave the maternity unit.

Maternity and gynaecology

- The postnatal ward and special care baby unit (SCBU) are also located on the same floor within a short distance from each other. This allowed mothers on postnatal ward recovering from birth to visit and spend time with their babies and to enable breastfeeding.
- Frank Shaw and Murray wards were open and with enough space to manoeuvre beds between bays and other areas.
- We saw some equipment in the corridors but it was well ordered and felt un-cluttered.
- We received a negative comment from a patient about the condition of the shower rooms in delivery suite, "the shower rooms are old and should be refurbished as soon as possible". This was also mentioned in the Healthwatch maternity review from May 2016.Most comments they received referenced the showers or bathrooms. These were described as "dirty" and "tired looking."
- We saw that there was a refurbishment plan for the delivery suite and that 3 of the rooms had already undergone refurbishment.
- There were 9 CTG monitoring machines and 9 resuscitaires shared between the 10 delivery rooms as and when they were needed. Staff confirmed this was enough and that there had been no incidences where equipment was needed and they couldn't access it.
- The department had identified resuscitaires as a risk on the trust risk register due to the age of the machines. They had recently purchased five new machines and a bid had been put in for the remaining to be replaced too but at the time of inspection no confirmation of this had been reached.
- The main theatre has its own resuscitaire which is shared with the annexe theatre.
- We checked a resuscitation trolley on the delivery suite which had over 20 items which were outside of the expiry date. When questioned, the Matron told us it was checked every day. On further examination we saw the contents of the trolley were checked but the expiry dates were not. The Matron explained she was following guidance given to her by the central resuscitation team to write the expiry dates of all medication on the checklist, which we saw, and to check sterile equipment was on the trolley but no mention of expiry dates for this equipment. During this discussion a midwife said she had been told in the past that there was not the correct equipment in stock so was told to leave the out of date equipment on the trolley, as it would be better to have something out of date rather than nothing. The impact of this could mean patients were being treated with equipment that is out of date and the correct procedures for checking these items was not in place.
- On the same resuscitation trolley we saw two pieces of sterile equipment where the packet had been ripped open and items were still left inside un-used. The opening of these packets meant the items inside were no longer sterile. The data from the daily checks was sent to a central resuscitation team for audits and storage.
- The department maintained security within the maternity and gynaecology department in-line with Royal College of Gynaecology (RCOG) 2008, 2.2.26 'Security is an issue of importance for staff, mothers and babies. A robust system must be in place for their protection. Babies born in hospital should be cared for in a secure environment to which access is restricted.' Between the antenatal and post-natal wards a swipe card was needed for to enter. The entrance to the day assessment unit, surgical, post and antenatal wards and the delivery suite also had swipe card assess and intercom for patients and visitors. This ensured all people were monitored leaving and arriving on the wards.
- The Conquest hospital had one water birth room which had recently been refurbished. We saw this had been regularly serviced and had a cleaning checklist completed after every use.
- We checked 25 pieces of electrical equipment throughout all areas we visited. All had green 'I am clean' stickers on which included the date and time they were cleaned. Equipment was checked daily.
- All equipment we looked at had a servicing maintenance sticker on to show when it was last checked and the date of the next service. This meant staff could be sure the equipment they were using was safe and regularly serviced.

- There were new fetal blood sampling, postpartum hemorrhage (PPH), pre-eclampsia and an epidural trollies available on labour ward. These were well organised and checklists carried out daily to ensure that all equipment was in date and available.
- In theatres we saw specific packs for caesarean section, 3rd degree tear and hysterectomy. The packs contained sterile equipment specific to the surgery and aimed to help surgeons and theatre staff by speeding up the process.
- Staff told us they had access to equipment needed to deliver safe care. We saw adequate numbers of CTG machines, resuscitation equipment, fetal blood analysers and fetal heart rate monitors.
- We were told however, that the equipment was limited in the day assessment ward and that staff had not had appropriate training to use some equipment, for example ultra sound. This could sometimes lead to delays in seeing patients. We heard from patients and staff that delays in day assessment had a negative impact on the service.

Medicines

- We looked at the arrangements for storing medication on the postnatal ward. We found that they followed best practice and had a locked controlled drug cupboard, inside another cupboard, and all the drugs we checked were in date.
- Medicines that needed to be stored within fridges were also all in date and stored at the correct temperatures. Fridges were checked daily and the minimum and maximum temperatures recorded. Staff signed to say these had been checked and we saw a protocol which should be followed if the fridges were not in the correct limits. This is in line with best practice guidelines.
- Staff told us that the pharmacist visited daily and checked the drugs and charts. We saw checks of controlled drugs were complete.
- In theatres the theatre practitioner held the keys to the drug cupboards to ensure they were safely stored.
- We also checked the storage and management of medication on the gynaecology ward. We saw drugs were locked in a cupboard in a room with key code access.
- We witnessed a patient being discharged with specific Venous Thromboembolism (VTE) drugs as they had an increased risk of developing this. VTE is a medical condition where a blood clot forms in a vein. The patient was reminded of when and how to administer these drugs including the time of day, and they were provided with a sharps bin which the community midwife was to collect during routine visits.
- On the labour ward some patient rooms had medication cupboards which had a loose lock around both handles. We were able to reach inside and remove medication from within these cupboards meaning they were not secure. We mentioned this to staff who said new coded locks were replacing them in the future, however at the time of inspection these drugs were not secure.

Records

- Women held their own paper maternity record which was used throughout the pregnancy and used to record information from appointments. These were in addition to the hospital recording system. These included useful information about pregnancy, screening, pain relief and birth choices.
- Patient notes were stored offsite. We had mixed feedback on how this worked in maternity and gynaecology but most staff felt it posed no issues as the patients were booked in advance so notes could be called upon in a timely manner. There were no incidents relating to notes retrieval in the reporting period.
- Patients are given a 'red book' on discharge to keep records of their baby's growth, development and for use in the community and transfer between services. We saw midwives check with women prior to discharge that they had this book before they left.
- We saw a variety of different forms filled out prior to discharge, including to the community midwives, social workers, and GP surgeries. This ensured that the care of patients continued after discharge.
- Records were stored securely both within offices and on the wards. Patient's records were locked safely in cupboards when not in use. There was a lockable trolley for use on ward rounds.

- We reviewed 10 sets of patient notes at Conquest hospital. These were all well-ordered and mostly complete. However, there were loose pages which could have been lost or misplaced.
- We saw patient notes were mostly legible and contained appropriate referrals and consent paperwork as needed. All women had a named consultant (for high risk pregnancies) or a named midwife (for low risk). We saw appropriate risk assessments had been undertaken and also saw evidence of further risk assessment upon entering labour ward, in line with hospital policy.
- Patient records were kept on Mirrlees ward for up to two weeks post discharge. This meant if there were any queries or re-admissions the notes were easy to access. We were told they kept women's' records for suspected ectopic pregnancy (a condition where the foetus grows outside of the womb) in a specific filing cabinet for quick retrieval if needed.

Safeguarding

- The trust followed the multi-agency Sussex Safeguarding Adults Policy and Procedure Manual. All staff we spoke with across the whole department (including the gynaecology ward) had a good knowledge of safeguarding. They were aware of how to raise and escalate safeguarding concerns and could give examples when this had been necessary.
- Two specialist safeguarding midwives worked across the two hospitals with dedicated time to address safeguarding issues.
- Staff were appropriately trained in safeguarding with a lead safeguarding midwife appointed. Staff were aware of which staff member to contact if they needed any support with regards to any safeguarding issues. However, level three safeguarding training had been completed by 87% of clinical staff against a requirement of 90%.
- We saw information behind nursing stations with a clear flow chart of processes for reporting safeguarding acting as a reminder to staff.
- The hospital used Additional Support Forms (ASF) which all staff could complete. These highlighted any safeguarding concerns or women who may be vulnerable. These are available online and shared with the safeguarding midwife, community midwife and GP services.
- During our visit we were shown the notes of two patients who had a safeguarding plan. The notes were robust in the information recorded and showed good multidisciplinary working between hospital departments and the community. Staff were aware of the women's situation and in one case security were present on the ward to protect staff and patients.
- We saw medical records of how these women were to be cared for after admission and found these to be in-depth and complete. They took into account the needs of both mother and baby and documented the other agencies that were involved, for example, Social services.
- Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had Female Genital Mutilation (FGM) or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patient's health record. We saw a clear process in place to facilitate this reporting requirement and clear guidelines on FGM including recognising and supporting women who may have experienced FGM.

Mandatory training

- Mandatory training included fire safety, infection control, mental health, safeguarding adults at risk (SAAR), safeguarding children level one to three, equality and diversity, blood transfusion, health and safety, information governance, and basic life support. The trust set targets of 90% for all mandatory training.
- Staff also received mandatory training in specific maternity safety systems, including responding to childbirth emergencies such as post-partum haemorrhage (excessive bleeding following delivery) and umbilical cord prolapse, a condition where the umbilical cord comes out of the uterus with or before the presenting part of the fetus.
- Mandatory training records showed that targets were not being met across the unit. We saw an improving

picture but mandatory training targets are still not being met. Examples included in theatres compliance in infection control and moving and handling were 67% against the trust target of 90%.

- We saw the training records from November 2015 to April 2016. We saw that within this period 86% or above had completed their mental health training, with this number reaching 91% in December 2015 which met the target of 90%.
- Figures as low as 48% with a high of 62% of staff had completed the equality and diversity training which is below the target set.
- We spoke to the nurse practitioner about mandatory training and she told us of a new initiative to make sure staff completed training. She had made sure all staff had been given advance warning of training days and ensured all staff coming back to work after long term sick leave or maternity leave completed training before they returned to work. We were told that if staff did not complete mandatory training in a timely way that it would be reported to their manager and would be bought up at 1-1 meetings or reviews.
- Training data forms part of the 6 monthly risk meeting to ensure compliance and address issues arising from non-completion.
- An action plan had been completed from May 2016 to October 2016 which aimed to increase mandatory training figures. It included monitoring monthly numbers and advising matrons of staff whose training was out of date.
- Staff were given four days to complete training a year and training was primarily by e-learning or booked training courses. Staff reported this was enough time and they felt supported to complete training.
- Practical Obstetric Multi-Professional Training (PROMPT) training was incorporated into mandatory training. Four staff members attended a course to become trainers in PROMPT and now they offered monthly sessions. There was now a multidisciplinary faculty of trainers including consultants and anaesthetists as well as midwives.
- The department had identified a need for further CTG training, this included getting external trainers to come in. This happened every 6 months and was said to be successful and well attended. There was also opportunity for analysis of CTG at the daily risk meeting.

Assessing and responding to patient risk

- The trust reported a midwife to birth ratio of 1:28 across the trust. This was equal to the trust target and in-line with the national average. The trust had a target of 100% for 1:1 care in labour however there was no formal records to confirm this was achieved at the time of inspection.
- Patients were continuously risk assessed using the Modified Early Obstetric Warning Score (MEOWS). Patient notes we reviewed showed comprehensive completion and evidence of escalation if a patient was seen to be deteriorating.
- The service followed the 'Five Steps to Safer Surgery' World Health Organisation (WHO) checklist which included a sign in, time out and sign out checks. Patients had a copy of the 'Five Steps to Safer Surgery' WHO checklist in their notes and is recorded on the theatre database. Where appropriate, this had been fully completed in notes we reviewed.
- A band 7 midwife carried out checks every day at 8:30, 1pm, 5pm and 8pm to ensure appropriate care is being delivered in a timely way. These checks include pain scoring and checks on whether patients need anything to make them more comfortable. We saw this documented in the patients records.
- A recent change in practice meant women are risk assessed during initial triage and then again on arrival to hospital. Each patient has a fresh risk assessment by a band 7 midwife or lead midwife. This change was implemented following a series of incidents where patients' risks were not re-assessed on entering the hospital. It showed patient risks were being considered and improvements have been made to ensure patient safety.
- All patients received a VTE assessment on arrival this was repeated 24 hours later to check for any increased risk.
- From the period April 2015 to April 2016 there were 6 reported cases of HIE in four out of the six cases it was

concluded that there was avoidable harm. Routine RCAs were conducted in-line with trust policy but the operational lead for Obstetrics and Gynaecology had also undertaken her own review to identify trends and key learning points. It was established that the three main factors were misinterpretation, triage delays and reoccurrence of reduced fetal movements. CTG

- The department had tried to tackle reduced fetal movements incidents by creating a 'movements matter' sticker for patient notes enabling multiple occurrences to be instantly visible. The department also had an outside trainer in CTG interpretation visit the department twice a year to train staff. It has been agreed that women attending the day assessment unit on two or more consecutive occasions will require a review by a consultant obstetrician.
- As a result of the HIE case review and recent reported incidents the department are in the process of compiling a list of 'triggers' for escalation in the day assessment unit. For example: if a patient has been waiting longer than 30 minutes for an initial assessment, staff should escalate and further staffing requested if needed.
- One RCA we looked at showed contributing factors that led to severe brain injury as a result of birth asphyxia, a The process for confirming spontaneous rupture of membranes was not followed in accordance with the current trust guidelines also the process for monitoring fetal wellbeing in the presence of repeated episodes of reduced fetal movements, in accordance with ESHT guidance was not followed. There was also delay in speeding up delivery in the presence of an abnormal, antenatal CTG. This showed that despite an effort to increase awareness over fetal movements and CTG interpretation incidents were still occurring.
- The department uses a system of 'fresh eyes' on all CTG monitoring. This is a system where a review of the CTG printout is undertaken by another midwife or medical staff to check there is agreement in its interpretation. This system helps identify possible misinterpretation. We spoke to staff who said they felt able to challenge colleagues if they disagreed with a reading. Some staff spoke of wanting central monitoring of CTG. This is where all interpretations are sent to a central monitor for continuous review by staff and open discussion around interpretation. There was no plan for central monitoring to be used at the time of our inspection.
- Mirrlees ward used a new mobile clinical system that monitored and analysed patients' vital signs. It is electronic tablet based and allowed users to input National Early Warning Score (NEWS) scores and document routine ward round checks. It also allowed the user to input individual patient parameters. For example a patient with higher risk will have different scoring triggers than a stable patient.
- The mobile clinical system was also used to audit the time between sets of observations and NEWS scores. This data was then sent to ward matrons for performance review and support offered to improve compliance if needed. Staff reported it was a useful tool and reported it was easy to use and helpful to identify patients' needs quickly.
- A recent audit showed that from March to June 2016 Mirrlees ward were between 92% and 94% compliant with taking patient observations on time which was equal to or better than the target of 92%.
- No clinical audits have been registered against (NICE) CG190 This guideline covers the care of healthy women and their babies during labour and immediately after the birth. The Deputy Patient Safety Lead also confirmed the trust had not conducted an audit against this guideline. The Clinical Commissioning Group (CCG) are scheduled to conduct an audit on Cardiotocography (CTG) within Maternity' during 2016-2017. This had not been completed at the time of inspection.
- There was a twice daily safety huddle which gave staff the opportunity to discuss patients who may require extra care and update staff on the progress of women throughout the service. This was attended by multidisciplinary staff members including consultants and junior doctors.

Midwifery staffing

- The trust reported that staff numbers fell below their target for June 2016, reporting that nurse staffing levels were 90.6% compliant with trust targets. For example on

the Frank Shaw ward, Murray ward and the delivery suite the target whole time equivalent (WTE) of 61.43% was not met with the number of midwives and nurses in post at 54.37%.

- The planned midwife to birth ratio target was 1:28. From April 2015 to March 2016 this target was met with six out of the 12 months reporting a ratio that was 1:24 which was better than the planned ratio. These targets were achieved with the use of bank and agency staff when needed.
- From April 2015 to March 2016 the average hours of agency use each month was 645. The highest month reported 851 hours in March 2016 with the lowest number of hours (379) reported in December 2015. There was currently no target set by the department for agency use.
- Staff numbers were displayed on each ward with the planned and actual numbers shown. This was updated daily and during our inspection all targets were met. This was 10 midwives and four Midwife support workers (MSW) on each day shift. There was a senior band 7 lead midwife on each shift. We analysed the past two months of rotas and saw that of 168 shifts, 33 had more than one midwife short which accounts for 19.6% of shifts between August 2016 and September 2016.
- A supernumerary labour ward co-ordinator was planned for all shifts, however sometimes staff shortages meant this did not always occur. The trust had agreed to advertise for another band 7 midwife to ensure that a supernumery labour ward co-ordinator was always on shift.
- The trust used a nationally recognised acuity tool to calculate the required number of midwives to maintain one to one care for women in labour. Trust data showed that in June 2016, the service had a planned ratio of one midwife to every 28 women across the trust. This was in-line with evidence-based guidance set out in the intercollegiate document, Safer Childbirth (2007): Minimum Standards for the Organisation and Delivery of Care in Labour. The intercollegiate guidance suggested this ratio was appropriate for the acuity level of the service provided at Conquest Hospital to ensure the capacity to achieve one-to-one care during labour. We were told one to one care was provided most of the time, however there was no formal record of when this had not occurred.
- During our un-announced inspection we visited Murrey ward and the day assessment unit on a Saturday. We saw patients had been waiting for long periods of time. A single midwife was covering four day assessment beds and 14 ward beds with one agency support worker. The midwife expressed frustration because when the day assessment unit is open there should be two midwives on shift but she said this “rarely happens”.
- There were three community midwives’ teams based at the Conquest hospital and two based at Eastbourne District General Hospital and they work cross site if needed, for example if there are staff shortages.
- The department had identified staffing on the trust wide risk register. Throughout our visit staffing levels were often mentioned as a challenge across the department. It was reported that in August 2016, 52 shifts on labour ward were not covered with a Band 7 midwife. It was reported this was due to staff maternity leave, long term sickness and student midwives not yet in post.
- The maternity review also highlighted a lack of high grade midwives being an issue. As a result there was currently a supernumery band 7 post advertised which many staff we spoke to felt would make a positive change.
- The recent maternity review highlighted community midwives on call and the hours they worked as a potential risk. There were two midwives in the community on call at night for homebirths trust wide. There were occasions where the midwife on-call has to attend to a woman at night and then do a shift the next day. This could mean they were at risk of becoming over tired and unable to perform through tiredness. The new triage business plan included a community midwife covering triage at night and also acting as a third community midwife on call, if needed. This would help relieve pressure on both labour ward midwives dealing with triage but also act as a back up to community midwives if needed.
- All practising midwives in the United Kingdom are required to have a named Supervisor of Midwives. A

Supervisor of Midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (Rule 8, NMC 2012).

- Nomination, selection and appointment of Supervisors of Midwives (SOM) occurs as per Local Supervising Authority (LSA) guidance and there was a robust succession plan in place. This was reviewed on a regular basis and recruitment was in line with maintaining the SOM ratio. At time of inspection there was one SOM awaiting appointment and two midwives will be starting the preparation programme.
- SOMs were allocated 7.5 hours per month SOM time. The team are available and accessible 24 hours per day via an on call system. Rotas with contact details are available via switchboard for midwives and women and the process of how to contact a SOM is on the trust website.
- We reviewed the trust website and observed information posters for women on noticeboards about the SOM's role and how to access one.
- The overall SOM to midwife ratio was 1:17 which is worse than the recommended ratio of 1:15. We were told two midwives were due to start the preparation programme.
- The trust provided some specialist services for maternity including, Practice Development Midwife, Project Lead Midwife, Perinatal Mental Health Midwife, Infant Nutrition Midwife, Bereavement Midwife, Midwifery Preceptorship Facilitator, Maternity Practice Education Facilitator and two Safeguarding midwives. A teenage pregnancy midwife has been advertised but was not in role at time of inspection.
- Mirrlees ward had two trained nurses and one healthcare assistant (HCA) on day shifts and one trained and one HCA on nights and weekend. We told that they often have to use agency as there were times when no bank staff were available.

Medical staffing

- Consultants were available 24 hours seven days a week. Consultant obstetricians provided 72 hour presence on delivery suite to support junior staff. This is better than the recommended Safer Childbirth and RCOG guidelines of 60 hours of consultant presence for 6000 births a year or greater.
- The on-call Consultant was present on the labour ward from 08.30-20.30 Monday to Friday and 08.30-14.30 Saturday and Sunday. Outside of these hours they were on call from home within 30 minutes of the hospital.
- There had been three new consultant appointments this year which staff told us had helped ease the pressure managing the rota and improved the service for women.
- A copy of the Consultants on call rota with contact numbers was on the wall behind the staff station. There were no reported problems getting hold of an on call consultant.
- The obstetric team did not participate in the hospital at night generic cover due to the specific skills required for obstetrics. Also the nature and breadth of cover does not allow the obstetric team to assist with the other wards.
- A registrar and senior house officer (SHO) was on call and on-site 24 hours a day, in addition to a dedicated additional registrar and SHO available on site from 8:30am to 5 pm.
- There was a room dedicated for handovers within the unit. This ensured confidential discussion about patients. A communication tool 'Situation, Background, Assessment and recommendation' (SBAR) had been introduced for staff handovers and advice calls between midwives and doctors. Staff reported this new system had improved handovers.
- The service used locums to cover as recently some consultants had left the service. Currently three locums work within the service with consultants posts being currently advertised.
- We saw paediatric consultants were involved in risk meetings within the department. We heard that paediatric doctors were available if needed and there was a good relationship between the departments.
- We conducted an unannounced visit on a Saturday and saw during our visit one registrar and one senior house officer (SHO) in attendance; They were covering antenatal, day assessment, postnatal, labour ward and

the gynaecology ward with a single midwife covering four day assessment beds and 14 ward beds with one agency support worker. The midwife felt patients were waiting excessive hours to see a doctor due to low staffing levels.

Major incident awareness and training

- We reviewed the trusts major incident response plan which established the framework for the trust's response in the event of any major emergency, regardless of cause, which produces, or is expected to produce, significant numbers of casualties. The trust recently reviewed the policy in August 2016, and it was available to all staff via the staff intranet. The policy stated that EDGH would be a 'supporting hospital' in the event of a major incident. Conquest Hospital was allocated a primary role as a receiving hospital in response to any major incident involving immediate casualties.
- This plan reflects the NHS Commissioning Board Emergency Preparedness Framework 2013, the NHS Commissioning Board Command and Control Framework and the Civil Contingencies Act 2004.
- Clinical Units are responsible for conducting periodic checks, at no more than 6 monthly intervals, that their staff are aware of their individual emergency roles and that they are conversant with the responsibilities they may be required to assume as outlined in the relevant Action Cards. Assurance of these checks will be provided by the General Manager of each unit at the November and May Operational Preparedness Group meetings.
- All senior managers on call attended mandatory training in tactical leadership in a crisis. Records that showed service managers for women's services had attended training within the last 12 months.
- We spoke with the clinical lead that was aware of their duty in respect to a major incident and attended these meetings.
- Work is underway on preparing an Emergency Preparedness, Resilience and Response (EPRR) Policy. This will be presented at the Trust Operational Preparedness Group in August or September, aiming for ratification in October. The policy will reflect the Cabinet Office decision to change the definition of a Major Incident.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- Care was generally given in line with recommended evidence based guidelines and these were monitored to ensure consistency of practice.
- People were given comprehensive assessments of their clinical needs and outcomes were discussed with patients and staff appropriately.
- There was participation by the service in reviews including peer reviews and up-to-date information about its effectiveness is shared.
- Staff were supported through supervision and appraisal and when staff are performing below standards support is offered. New midwives joining the trust complete a comprehensive preceptorship programme.
- We saw strong multidisciplinary working between teams within the hospital and external providers. Patients had hand held notes alongside hospital notes and were discharged to the community with clear processes and handover information.
- Consent was appropriately obtained and women were provided with support to enable them to make decisions about the care they received.
- Staff showed a good awareness of the Mental Capacity Act (2005) and gave examples of when this had been used in practice.

However:

- Written policies did not always reflect the most recent guidance and review dates for these were often out of date.
- Policies were extended past these review dates but we saw examples where this had been extended for over a year because of a disagreement in process.
- The trust failed to submit data for a mandatory audit as part of the National Clinical Audit Patient Outcome Programme (NCAPOP) list for 2015-16 compiled by the Department of Health

- There was no robust mechanism in place to monitor and audit abortion completion and a risk Department of Health was not receiving notifications in a timely manner.

Evidence-based care and treatment

- We found from discussions with staff and patients as well as our observations that care was being provided in line with (NICE) quality standard 22. This standard covers the care of all women up to 42 weeks of pregnancy. It covers all areas of ante-natal care including community and hospital settings.
- Women who needed a caesarean section, whether planned or not also received care in-line with the NICE recommendations (Quality standard 32). For example, Quality statement 1: Vaginal birth after a caesarean section. A vaginal birth after caesarean (VBAC) clinic runs once a month. The served to help women who wish to have a VBAC and offers information and advice from an obstetrician and a midwife. In April 2016 the successful VBAC procedures were recorded at 30%; however these figures rose significantly to 64% in May and June and 71% in July which demonstrated the effectiveness of the service.
- There was evidence to indicate that NICE Quality Standard 37 was being adhered to in respect to post-natal care. Examples included staff discharging patients with appropriate checks and with correct medicines. All patients we spoke with had been given breastfeeding advice and support.
- The observations and discussions we made reflected that the trust were following recommendations from NICE Quality Standard 190: Intrapartum care. Women were offered a choice of birthing locations and choice of care throughout labour. We witnessed several discussions between staff over patient's choice and how they could accommodate them; this showed they were focusing on the women's needs.
- Growth was monitored from 24 weeks by measuring and recording the symphysis fundal height as highlighted by MBBRACE) UK (2015) and in line with current NICE guidelines (NG3, 2015).
- The department did not carry out termination of pregnancy on women where there was indication the foetus was over 21 weeks. This was in line with RCOG evidence based guidelines related to feticide: section 6.7. Any termination for fetal anomaly over 21 weeks was sent to a tertiary centre for feticide prior to induction of labour at Conquest, which was also in line with RCOG guidance.
- From evidence we reviewed and from talking to staff the service adhered to The Abortion Act 1967 and the Abortion Regulations 1991. We saw the correct completion of HSA1 form which are signed by two doctors before admission. However, There was no robust mechanism in place to monitor these processes and incomplete forms could risk the Department of Health not receiving notifications in a timely manner.
- We found variation in whether policies were reviewed by the set date. We reviewed 22 policies and 15 of these were beyond their review date, these included: Raised BMI, Homebirth, New-born wellbeing and Vitamin K for babies. This could mean the most up to date information was not included in these documents and could lead to patients not receiving best practice care.
- For example we saw a fetal monitoring policy that needed review in 2013. It included advice in-line with The National Institute for Health and Care excellence (NICE) guideline 2007; however the most recent NICE guidance was updated in 2014. This meant they were not following current guideline for fetal monitoring.
- We also saw that some policies and procedures made no reference to appropriate national guidance. For example, the "care of routine healthy pregnant women" made no reference to NICE guidelines. However, we saw areas of evidence-based antenatal practice. For example, the trust offered fetal anomaly screening in accordance with current UK National Screening Committee programmes. This was in line with NICE quality standard QS22: Antenatal care.
- We saw the policy and procedures for pool evacuation in the event of an emergency. These referred to a hoist being used, however no hoist was available. When asked staff told us that a Patslide (and nets were going to be purchased. We saw no evidence of a policy/ guidance on the correct method to be used. This could pose a risk to patients if a situation arose when quick evacuation was needed and staff were unsure of which procedure they should be following.

- We saw information next to a nursery resuscitaire which was dated 2010, there was new guidance produced in by the Resuscitation Council in 2015, meaning they were not displaying relevant and up to date guidelines.
- The trust reported that out of the 39 standards recommended within NICE guidance (74%) have been responded to, of these, four are applicable, of the 4 applicable, 3 are compliant; 1 non-compliant with an action plan in place. They report that 6 (15%) are outstanding for an initial response.
- A Guideline Group (GIG) meets bi-monthly, led by a consultant obstetrician. The role of this group was to review latest guidelines and implement any changes to policies in a timely manner.
- Some revisions had been extended as there was disagreement amongst the consultant group. For example there has been an ongoing debate over the use of Syntometrine or Syntocinon after delivery. Syntometrine and Syntocinon are drugs used to advance labouring women in the third stage of labour. NICE guideline recommends Syntocinon should be used due to fewer side effects but there is some debate. We saw this minuted in the GIG meetings and Labour Ward Forum meetings regularly but note it has still not been resolved even though it has been debated since April 2015.
- Once guidelines had been changed it goes out to all staff groups for consultation and changes before it gets passed on to guideline group for discussion.
- We were told new NICE/RCOG guidelines can be passed down from the trust, obstetricians or the practice development lead.
- The department recently started using 'survey monkey' to evaluate any gaps in learning and policy implementation. It has proved very successful and identified new policy changes quickly.
- The trust holds a gap analysis of all NICE guidelines to ensure new recommendations are included.
- A new communication tool 'Situation, Background, Assessment and recommendation' (SBAR) had been introduced for staff handovers and advice calls between midwives and doctors. Staff reported this new system had improved handovers.
- A new 'NIPE smart' system had been introduced to ensure that neonatal screening and referral pathways are in place andincluded a mechanism that meant that babies not screened within 72 hours of birth would be identified.

Pain relief

- Women had access to a range of pain relief methods following NICE guidance CG190. This included Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour.
- Epidurals were available 24 hours seven days a week. Women generally received epidurals within 30 minutes of request.
- We spoke to several women over the three days of our inspection and all reported their pain was managed well.
- A woman we spoke to had recently had a caesarean section she reported that she was advised of her pain relief options before surgery and that her pain had been monitored well.
- We were told women requesting an induced abortion are routinely offered pain relief in-line with RCOG guidance 'the care of women requesting induced abortion'. We saw guidance that women should routinely be offered pain relief such as non-steroidal anti-inflammatory drugs (NSAIDs) during surgical abortion.

Nutrition and hydration

- Patients were offered a choice of menu options and dietary requirements were taken into consideration. Patients we spoke with reported the food was good and options were available.
- Patients were invited to help themselves to a variety of breakfast items from a trolley on wards; if a woman was not mobile then staff helped her choose and delivered it to the bedside.
- Hot drinks were available for patients and visitors at all times from a trolley in ward areas.
- Peer support workers were trained to support women with feeding their babies. They attended both the Conquest and Eastbourne Maternity Unit every week.

- The department offered breastfeeding workshops which were held twice a week. These aimed to help women struggling to breastfeed and support them to do it.
- All patients we spoke to said they had received support to breastfeed soon after birth, and that this had continued on the post-natal ward.
- Patient information of breastfeeding support was seen throughout the department. We also saw information on the drop in breast feeding service at Eastbourne District General Hospital.
- A specialist breastfeeding midwife was employed to offer extra advice and support along with further guidance to women experiencing difficulties with breastfeeding.
- If women wished to bottle feed sterilisers were readily available.

Patient outcomes

- There were 2805 births reported from April 2015 and March 2016 at the Conquest Hospital. Normal deliveries accounted for 59% of these births. Births by caesarean sections accounted for 27% and instrumental delivery for 14% of all births recorded.
- More recently the maternity dashboard from April 2016 to July 2016 showed spontaneous vaginal deliveries had increased with between 67% and 71% of births recorded. This was within the RCOG 'Making normal birth a reality' 2008 guidelines and showed measures to improve the number of normal births were having an impact.
- The emergency caesarean section rate was worse than the trust target for April to June 2016, it ranged from 15.6% to 13.4% with the target set at below 13%. This target was met in July 2016 with 10% of births resulting in an emergency caesarean section.
- Women who experienced 3rd or 4th degree tears during birth between April 2016 to July 2016 was better than the trust target of 5%, with the lowest being 1.75% in April 2016.
- There were no In utero transfers from April 2016 to July 2016 shown on the dashboard. This is the transfer of a mother to another hospital for maternal care or predicted neonatal care for her newborn.
- Babies of less than 29 weeks gestation should have their temperature taken within an hour after birth. From April 2015 to March 2016 it was reported that 92% of babies had their temperature recorded. This was worse than the trust target of 98%, and did not meet the National Neonatal Audit Programme (NNAP) recommendation that of 98-100% of babies have their temperature taken within an hour of birth.
- An average of 86% of all mothers who delivered babies between 24+0 and 34+6 weeks gestation are given a dose of antenatal steroids. This is better than the trust target of 85%.
- The trust had less stillbirths that the national average. During the period April 2015 and March 2016 there were 10. This accounts for 0.35% of births in the reporting period.
- There were two reported early neonatal deaths between April 2015 and March 2016 and this accounted for 0.07% of all births. This was well below the national average of 0.27%.
- East Sussex Healthcare NHS Trust does not have a Neonatal Intensive Care Unit (NICU) on site; there been 50 admissions to NICU's of these 19 were full term babies. Babies requiring intensive care are transferred after birth or where known in advance. Their mothers are encouraged to deliver at a hospital with neonatal facilities. There were 536 admissions to special care baby unit (SCBU) which is based at the Conquest.
- The supervisory team had undertaken a range of clinical audits over the preceding year. We saw audit reports and action plans for controlled drugs, record keeping, care in labour and call outs. This showed the department were actively trying to benchmark and keep a continuous record of activity within the department to ensure high standards.
- The department had concerns around the number of inductions of labour that were undertaken. An ongoing audit is now taking place to try and understand the reasons for the increase in induction of labour. It is worth noting however the caesarean section rate following induction of labour had not increased meaning that the risks of caesarean sections following

early induction of labour had not increased. The reduction in emergency sections suggests that the increased use of appropriate induction had allowed the trust to improve the rate of normal births.

- At the time of our inspection, the trust was auditing their performance against national standards for the quadruple (quad) test. The quad test is a blood test taken during pregnancy to screen for the likelihood of genetic conditions such as Down Syndrome, and neural tube defects, such as spina bifida, in the unborn baby. The results of this audit were not available at the time of our visit as staff were writing the report.
- We saw that the trust participated in various other national and local audits. These included the British Society of Urogynaecology Audit Database, VTE assessment in antenatal & postnatal patients on maternity, Management of Diminished Fetal Movements, and local record-keeping audits in gynaecology.
- We saw on the trust's incident log that they had not participated in the pregnancy in diabetes 2015-16 national audit. The reason for this was a lack of staff to carry out the audit. This audit was mandatory as part of the National Clinical Audit Patient Outcome Programme (NCAPOP) list for 2015-16 compiled by the Department of Health. Non participation in relevant NCAPOP audits may cause a breach of the trust's NHS contract with clinical commissioning groups. However, we saw from the trust's audit schedule that they were participating in the 2016-17 NCAPOP pregnancy in diabetes audit at the time of our inspection.

Competent staff

- New midwives joining the trust completed a comprehensive preceptorship programme. This included completing a 55 page midwife development handbook, where evidence of competency is documented and awarded.
- These handbooks included a comprehensive list of competencies including administration of oral medication, administration of intravenous (IV) medication, epidural infusions, bereavement care, maternal resuscitation and CTG interpretation.
- The trust employed a dedicated preceptorship midwife and a midwifery placement educator who met with midwives throughout their employment. They also helped with the training development of student and newly qualified midwives.
- We spoke to a band six midwife who had recently joined the trust. She said she felt welcomed and had one month in a supernumery position and felt that her orientation had been good.
- A bank healthcare assistant (HCA) told us they were given four shifts as a supernumery member of staff alongside one week classroom based training.
- Consultant appraisals were managed centrally by the trust. All consultant appraisals were up to date. Obstetrics and gynaecology staff were usually appraised by consultants or associated specialists in other specialties.
- Agency staff were given an induction pack on Mirrlees ward. We saw it covered areas such as uniform policy, manual handling NEWS chart, IV use, and medical devices such as oxygen, use of the electronic recording system and a declaration of competency to work. It also had a page to sign to say they had understood and for the nurse in charge to sign. However there was no assessment of competency to work unsupervised, for example agency staff taking blood from a patient if necessary without being supervised by a permanent member of staff. This means there is no visual competency check on new staff member's ability to deliver such care.
- We saw the trust's Local Supervising Authority Audit Report for 2015-16. This showed 99% of midwives had an annual review with a supervisor of midwives (SoM) in 2015-16. One of the purposes of the annual review was to determine that individual midwives met the NMC requirements for revalidation, including evidence of continuing professional development. We were told that nurses and midwives had hours put aside for revalidation to ensure they had appropriate support. The LSA reported all members of the SOM team have completed their self-assessment competency document and activity sheet

Maternity and gynaecology

- Matron on Mirrlees ward was trained in gynaecology. The sonographer was a specialist in gynaecology scanning ensuring appropriate specialist knowledge in gynaecology.
- Midwives do not perform the role of 'scrub nurse' in theatres. Theatres had their own team which was separate to the staff on the postnatal ward, antenatal ward and delivery the delivery suite.
- We were told that nurses and midwives had hours put aside for revalidation to ensure they had appropriate support.
- Midwives attended annual 'prompt' study days. This involved scenario-based training covering emergency obstetric situations such as post-partum haemorrhage, cord prolapse and shoulder dystocia. Midwives told us they found these sessions useful and attending allowed them to keep their skills up-to-date should an emergency happen.

Multidisciplinary working

- Staff we spoke to reported good multidisciplinary working relations between midwives, midwifery support workers, doctors in the maternity day unit, and other staff. Midwives told us they contacted consultants if they needed advice, for example, around risk assessments, and found consultants approachable.
- We saw several examples of multidisciplinary working. The daily risk meetings were well attended by staff across the whole women and children's department including paediatricians, anaesthetists, junior doctors, lead clinicians, ward clerks, midwives and department leaders.
- We witnessed a junior doctor make a suggestion on referrals which involved filling out a form so it was easily accessed by staff. They provided a template and their idea was listened to and accepted by the wider team. This showed a cohesive way of working where team members of all levels are listened to.
- We heard from managers and staff that multidisciplinary working was essential for the smooth running of the department. We heard good examples of community midwives engaging with women who were nervous of coming into hospital for antenatal treatment.
- The trust is part of a new initiative 'East Sussex Better Together' which aims to achieve a fully integrated health and social care system in East Sussex by 2018, ensuring every patient or service user enjoys proactive, joined up care that supports them to live as independently as possible and achieve the best possible outcomes.
- Meetings across the department were attended by multidisciplinary teams, for example the labour ward forum was attended by midwives, matrons, consultants, physiotherapists, specialist midwives and consultants.
- We were given example of external working between maternity departments in neighbouring NHS hospitals with regards to transferring babies to NICU.
- We saw effective working between social services and the midwifery team when dealing with women with addiction problems.
- We were told of good working relationship between the physiotherapists and staff within the department. We were given an example of where joint working had enable the team to provider very good, personalised care to a woman with cerebral palsy.

Seven-day services

- Consultants and anaesthetists were available on site from 8:30am to 8:30pm and on call outside of these times on a rotation basis. This ensured women had access to consultant advice at all times.
- Fetal anomaly screening was available Monday to Friday and routine ultrasounds examinations were available on the day assessment units at all times.
- There was an onsite pharmacy which was accessible at all times of the day and night.
- The gynaecological ward was open 24/7 and could take emergency patients admitted over the weekend and out of hours in the evenings.
- The day assessment unit accepted patients at all times. We were told that this often resulted in long waits for patients as at certain times there were less consultants and doctors around to see women.

Access to information

- Staff told us they could access policies, protocols and other information they needed to do their job through

the trust intranet. They also had internet access to evidence-based guidance from bodies such as NICE and the (NMC). We saw computers available to allow them to do this.

- Women who used maternity services had hand-held antenatal records that they brought with them to all appointments. This allowed multi-disciplinary staff to access up-to-date records to enable ongoing care.
- Midwives sent discharge summaries to community midwives and GPs when a woman and baby went home from hospital. This enabled ongoing care within the community.
- The hospital kept centralised records for gynaecology patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A recent trust wide audit revealed 100% of audited records had a signature by the patient or parent where relevant (Consent forms 1 and 2) as evidence that informed consent had been sought, prior to the procedure being carried out. The consent process was carried out by a competent member of staff in all cases, who had a full understanding of the procedure to which was being undertaken. It found 100% of consent forms had the date the consent was obtained recorded this was an improvement from 92% in the 2014 audit.
- Staff used an adapted version of the consent form (consent from 4) when it was determined that a patient lacked capacity to consent. Trust wide audits showed that where the consent form 4 had been used the patient had been assessed properly by a suitably skilled professional and a best interest decision had taken place for 71% of patients.
- We spoke with staff members about the Mental Capacity Act 2005 and staff demonstrated a good awareness of consent procedures. One midwife explained she had recently had concerns about a patient in her care and had escalated to the consultant who was going to see the women with the perinatal mental health specialist.
- We saw staff verbally gaining consent before commencing any treatment. Staff were seen fully explaining procedures and the associated risks of accepting the treatment or not.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Patients we spoke with were positive about the treatment they had received and the staff they encountered.
- Staff treated patients with dignity and respect. We saw compassionate interactions between all staff members and the patients they interacted with.
- We witnessed a rapid disciplinary response from staff members when another staff member spoke about a patient inappropriately during an internal meeting.
- Patients were involved in the care they received and their demands were met if possible.
- Women were supported in making informed choice about birth settings which are appropriate to clinical need and risk.

Compassionate care

- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test performance (% recommended) was generally in line with or higher than the England average in all of the four areas of Maternity.
- In August 2016 the trust's percentage recommend for antenatal was 100% compared to a national average of 95.2%.
- In August 2016 the trust's percentage recommended for birth was 93.7% compared to a national average of 96%, with a response rate of 30.4% compared to the national average of 22.9%.
- In August 2016 the trust's percentage recommended for postnatal ward was 91.5% compared to a national average of 93.3%, and 100% for postnatal community compared to a national average of 97.4%.
- All women are asked to fill out a questionnaire before leaving on an electronic tablet; the results of these were used in department meetings to address any issues raised.

- We saw staff introducing themselves to patients and explaining their roles within the department. This was in-line with NICE guideline QS15, statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.
- We saw staff taking time to interact with patients and saw examples where staff demonstrated the importance of gaining the trust of women they were seeing.
- When asked, patients were able to tell us the midwife that was in charge of their care on that day along with the named consultant.
- Positive comments included: "All staff were amazing, even during busy periods," and "So helpful and attentive, the call bell was always answered."
- We saw photographs of all staff displayed within the department. This helped patients to identify staff members during their stay.
- Team working 'Compassion in practice' was part of mandatory training and included a section on feedback from patients and recent complaints.
- Staff pulled curtains around patients before undertaking examinations or providing care maintaining patient's privacy and dignity.

Understanding and involvement of patients and those close to them

- Staff communicated with women and their families and care partners making sure they understood the treatment they were to receive and the risks associated with this.
- We spoke with a mother who had given birth the day before. She had planned to give birth at the midwife led unit at Eastbourne District General Hospital but due to complications had to be induced at Conquest. She felt the staff had looked after her and explained all procedures and what was happening at all stages. She said that the: "Staff were brilliant, really attentive".
- We witnessed a staff member explaining the risks of induction to a lady who had been admitted with reduced fetal movements. They outlined both the positive and negative aspects of the care plan and allowed time for the patient to ask questions.
- Whilst on the delivery suite we heard discussion about a woman who was using a Doula. A Doula is a non-medical person who assists a person before, during, and/or after childbirth, as well as her spouse and/or family, by providing physical assistance and emotional support. The team were discussing the ladies wishes and trying to respect her decision to be left alone in labour while still considering the risks associated with this. It showed a team who were respectful of women's' birth choices but also concerned for patient safety.
- We spoke to a lady who had experienced delays in her induction of labour. She felt she was not informed about the cause of this delay but felt it was to do with how busy the ward was on the day she arrived.

Emotional support

- The trust had named bereavement midwives who supported women and their families following stillbirth or neonatal death. The bereavement team was nominated for a "butterfly award" by bereaved parents in recognition of the outstanding care of their baby. The butterfly awards were a national ceremony to celebrate survivors and champions of baby loss.
- Patients are assessed for any extra care needs they may require at booking in with the community midwives. This includes an assessment for post-natal anxiety and depression.
- Women had access to counselling and could be referred to by consultants, if needed. We saw patient information on these services and advice to women about support services available.
- All midwives undertook bereavement training as part of their mandatory training.
- When speaking to the fetal anomalies obstetric sonographer she showed compassion towards patients and an understanding of patient needs in regards to bad news being given. The appointments are long (30 minutes) to allow for any support she needs to offer women and their loved ones in the event of bad news. She worked in line with accepted authorities in this field and followed Antenatal Reproductive Choices (ARC) and had relevant accreditation and audit in line with the National Screening Committee guidance for screening for detection of fetal anomaly.

Maternity and gynaecology

- We spoke with a patient who had a complicated pregnancy requiring multiple admissions; she was positive about the advice, care and said all staff were kind and caring. “Absolutely everything was well explained” She said that she received breastfeeding support immediately and that this continued once on the ward.
- There was a Facebook page for mothers to get support from peers and meet new people. Staff and patients said this had been a useful tool in helping new mothers feel more prepared and supported.
- Women undergoing termination of pregnancy were offered support and counselling before and after procedures.

Are maternity and gynaecology services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Women using maternity services could experience delays out of hours through the day assessment unit. Although measures had been considered to improve the flow through the unit these were not in place at time of inspection.
- An average of 86.1% of women receiving antenatal care at Conquest saw a midwife for their booking appointment by 12 weeks and six days of pregnancy in April 2016 to June 2016. This was worse than the trust target of 90% agreed with the local strategic health authority.
- The triage system did not ensure all calls were answered in a timely manner and sometimes led to calls being missed.
- The referral to treatment targets (RTT) were low in gynaecology and did not meet the national indicators in any month from March 2016 to August 2016.
- Mirrlees ward was often taking patients that were not gynaecological patients (medical outliers).

However;

- Services were planned and delivered in a way that met the needs of the local population. We saw that care and treatment was coordinated with other services and providers.
- The service made reasonable adjustments and took to remove barriers when people found it hard to use or access services, for example, through provision of interpreters or access to community care.
- Staff understood and respected people’s cultural, social and religious needs and took them into account.
- Bereavement support was offered in line with ‘Stillbirth and Neonatal Death’ SANDS guidelines alongside other means of community support, including the use of social media to encourage community support.
- Response times to complaints had improved significantly since April 2016. We saw evidence of appropriate responses to complaints, and learning from complaints and concerns.

Service planning and delivery to meet the needs of local people

- Bed occupancy levels for maternity services were higher than the England average, with the trust having 80.6% occupancy between December 2015 to March 2016 compared to the England average of 60.6%. To address this increase the trust had recently employed more midwifery staff and made adjustments to the structure to provide support to staff, for example by employing a new clinical lead and maternity project lead midwife.
- The trust’s maternity dashboard showed an average of 86.1% of women receiving antenatal care at Conquest Hospital saw a midwife for their booking appointment by 12 weeks and six days of pregnancy in April 2016 to June 2016. This was worse than the trust target of 90% agreed with the local strategic health authority.
- There were no antenatal classes available for women however there were a range of classes including breastfeeding workshops, homebirth evenings, antenatal physiotherapy and rhesus negative sessions.
- Patients are triaged before arrival onto the unit. Patients with additional needs should be flagged at this point so staff are aware pre-admission if any extra care needs to implemented. During a risk meeting we attended it had been raised that a patient had arrived to the unit over

the weekend and this system had failed flag her extra needs. The computer system was said to have faults and the clinical lead was going to attend a course on upgrading this system which would hopefully help prevent further lapses.

- There was no allocated room to talk to patients about difficult situations on the maternity day assessment unit, however we were told there are lots of side rooms and assessment areas that would offer privacy if needed.
- Local GP s referred women for gynaecological procedures. Women attend an outpatient gynaecological clinic with a sonographer and consultant present.
- Women were given a discharge date when they were booked in for a planned caesarean section. This enabled women to plan discharge arrangements and family support if needed. We asked two patients post caesarean if they had a date for discharge and both were aware of their planned discharge date. The trust recently employed a specialist midwife to lead the planned caesarean section pathway of care. Her role had not started at the time of inspection.
- A vaginal birth after caesarean (VBAC) clinic runs once a month. This serves to help women who wish to have a VBAC and offers information and advice from an obstetrician and a midwife. In April 2016 the successful VBAC procedures were recorded at 30%; however these figures rose significantly to 64% in May and June and 71% in July, which demonstrated the effectiveness of the initiative.
- Sessions were also provided for parents if they were interested in having a home birth. These sessions were also attended by parents who had recently had home births to share their experiences. The home birth rate had increased to 4.9% of births in the Hastings area. This was better than the national average of 2.3 %, and indicated this service was having a positive effect.
- The department had two bereavement midwives across both sites. Their role included attending 'Stillbirth and neonatal death' (SANDS) meetings and working with the SANDs guidelines to provide women with adequate support following the loss of a child. A perinatal mental health specialist was employed within the department. This ensured a specialist midwife was available to advise on patients and help patients who needed extra support.
- The trust followed Human Tissue Authority HTA guidance (2015) of the disposal of pregnancy remains following pregnancy loss or termination.
- Patients with mental health issues are put on a care pathway and have regular contact with the perinatal mental health midwife and lead consultant. An alert was placed on the system so anytime the lady contacts the department staff are aware of her extra needs and care plan.
- The maternity review included the views of women who had used the service. They were involved in one to one interviews, tours and offered feedback about the unit and workshops. This showed that the views of service users were valued and feedback used to drive changes.
- As part of the maternity review it was recognised that a pathway of care for women in the latent phase (early labour) was needed. A new latent phase room had just been opened which can accommodate up to two women and their partners if they would prefer to be in hospital rather than travel home in the early stages of labour.
- The Midwife Services Liaison Committee (MSLC) regularly involved service users in meetings, recent involvement included meetings with the CCG on strategic planning and integrating services.
- The trust offers a diabetic clinic for women who have been identified as at risk of gestational diabetes. It is located in a separate area alongside the routine screening clinic.
- A closed Facebook group for parents 'Focus on making it happen' has been set up for local women to share experiences, insights and ideas about how to improve the maternity services across both sites.

Access and flow

- The maternity and gynaecology department at Conquest Hospital has reported no closures since February 2016. The unit did not report any diverts due to closures since April 2016.

Maternity and gynaecology

- The referral to treatment targets (RTT) in gynaecology did not meet the national targets in any month from March 2016 to August 2016. The highest percentage reported was 54% in April 2016 against a national average of 81%. The worst performing month was March 2016 where only 39% of RTTs were met against a national average of 83%. This showed that the gynaecological needs of women were not being delivered in a timely way.
- Mirrlees ward was often taking patients that were not gynaecological patients (medical outliers). We were told that this was a daily occurrence and that it had an impact on staffing. .We saw that one outlier was on Mirrlees ward had been there for 10 days; this meant that her bed couldn't be used for gynaecological patients during that time.
- The Gynaecological ward (Mirrlees) was small and cramped. Within this area, fetal abnormality scans were undertaken which meant patients were often waiting in the corridor with no specific waiting area provided. There were eight beds on the ward including two side rooms.
- On the days of our inspection half of the beds were being held by patients that were not gynaecological.
- The maternity day assessment unit waiting room was a large but un-inviting area. There was warped lino on the floor and patients had little comfort within the area apart from a handful of toys in the corner. We heard examples where, out of hours, women were waiting for up to 4 hours in this area without being seen by a doctor.
- Staff on the day assessment unit told us it was often very busy. The day assessment unit reported seeing upwards of 30 women a day. The unit ran booked appointments but also saw women who required urgent review, such as women who experienced low fetal movement. The added pressure from urgent cases meant that women had reported waiting up to four hours to be seen by a doctor. This was further reflected in some formal complaints we reviewed.
- The maternity review also addressed this issue and staff groups were agreeing a list of 'red flags' to initiate an escalation policy which would give staff clear directions as to when to call for extra staff to ease pressure on the unit. This was under review at the time of inspection.
- The maternity review also identified that this system was putting a strain on staff particularly out of hours when midwives were attending to patients and also expected to cover the triage calls. This had led to calls being missed. During our inspection during a daily risk meeting six missed calls were reported from the previous weekend. This could lead to women not receiving vital advice and directions and could compromise their safety.
- As a result of incidents relating to calls being missed, staff pressures and the maternity review the department recently trialled bringing in community midwives to manage the triage calls. This pilot had been largely successful and a business plan has been put forward to make it a permanent arrangement.
- Women had 24 hour access to the triage phone line for advice or if they were in labour or experienced any immediate problems, such as bleeding. The triage system for all women went through a dedicated triage midwife at Eastbourne Midwife Led Unit. This system was in place from 8:30 am until 7pm Monday to Friday. Outside of this time the calls were diverted to Conquest and women were bought into the day assessment unit or directly to labour ward depending on their needs.
- We looked at the triage consultation form which was completed for all calls coming into the unit. It includes planned place of birth, risk factors (for example: headaches, raised blood pressure), past history, medical conditions, fetal movement, (PV), pain and any blood loss.
- The delivery suite consisted of 10 single rooms with en suite facilities. One of these was a home from home room with a large birthing pool and a much less clinical feel enabling women a more 'home from home' experience.
- Frank Shaw ward had 23 beds including three single side rooms. We were told they tried to put women in bays specific to their needs post birth, for example, women who may need more assistance following a caesarean section. A transitional bay with six beds allowed mothers and their babies to receive extra care and was located opposite the nurse station. Higher risk patients across all wards were placed near the nurse's station so they were close to medical staff if needed.

- The day assessment unit had four beds and the use of up to four side rooms if needed for assessment.
- There was an initial assessment room on Murray ward so that women attending for urgent care could hold discussions in private.
- The department had one main theatre and an annex theatre with a separate scrub area for busy times. The hospital planned for two caesarean sections a day on weekdays, except Thursdays when only emergency surgery would be undertaken. Occasionally three patients were booked in on one day but staff told us that often they could move patients to ensure an even workload.
- Women who were booked for planned caesarean section were given spinal and general anaesthetics in theatre, and post-surgery were taken to the recovery area and then to the post-natal ward.
- Patients undergoing gynaecological surgery were collected by the (OPD) and taken to theatre, after the procedure they are taken to recovery then back to Mirrlees ward for further recovery.
- Patients were discharged with a contact number to call for any issues which arose after leaving hospital. We saw a midwife explaining to a patient they were available 24/7 and to call if she had any worries.
- Discharge planning included information packs for women outlining medication needs, doctor's appointment and follow up, and women's contraception methods. We saw all of this discussed with patients before departure and advice was given on cot death risks including smoking and sleeping positions for baby. Patients were given an opportunity to offer feedback about the care received.

Meeting people's individual needs

- Safer childbirth standard 2.2.20 states 'Women have the right to choose where to give birth. If a woman chooses to give birth at home or in a midwifery unit contrary to advice from midwives and obstetricians, there needs to be clear documentation of the information given. We saw documented evidence that this standard had been met in patients notes and speaking to women on the postnatal ward where there birth plan had not been possible.
- Recent maternity matters guidelines suggest 'All birth environments designed to offer a home-like comfortable environment with en suite facilities, including equipment such as comfortable chairs, beanbags, mats, balls, baths and birth pools.' We were told that birthing aids were bought to women during labour and that they did not need to be requested prior to birth.
- Women were given a named midwife and contact number on booking, in line with NICE guideline QS22 statement 2.
- Community midwives identified patients who would need translation services at booking. Staff within the hospital were made aware before admission and translation services put in place. These are primarily through telephone translator services. Midwives reported this was usually successful but did recall a time where a patient was too shy to use this service so had to translate through her husband. She did report this was highly unusual and was only implemented as the situation was escalating and the woman was getting distressed. The midwife knew this was not recommended practice.
- Bariatric patients could be found a suitable bed from other areas of the hospital if needed. There was an order for 10 new maternity beds on labour ward and one of these was planned to be suitable for bariatric patients.
- The department had pathways of care for patients with learning disabilities. Patients were identified in the booking stage and offered advice and extra support if needed.
- Patients with mental health issues are put on a care pathway and have regular contact with the perinatal mental health midwife and lead consultant. An alert is placed on the system so anytime the lady contacts the department staff are aware of her extra needs and care plan.
- The trust staff were able to recount times when they had tried hard to meet the needs and preference of individual patients with additional needs. We were given a recent example where a patient with cerebral palsy had wished to have a vaginal birth. She met with a

physiotherapist and the lead midwife to see if they could find a comfortable position for her to birth in she was given a plan of care and also a side room with en suite to cater for her individual needs.

- We were told conditions such as dementia were hard to manage on Mirrlees ward due to the time consuming nature of their condition. There was a link dementia nurse who would be involved if dementia outliers were admitted. The hospital also used "this is me" dementia passports. Dementia passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient's individual needs.
- A teenage pregnancy specialist midwife had been appointed but had not started at the time of inspection. Her role would be to offer extra support to younger girls who were pregnant.
- We witnessed a multi-disciplinary staff discussion around a patient who had drug addiction and alcohol dependency and an abusive partner. Staff identified issues around getting the woman to attend antenatal check-ups and had identified the community midwives would need to be mindful to allow the women to choose a time that was suitable for her and if necessary provide transport for her to get to hospital. This showed an understanding of the woman's venerable situation and a positive team approach. This is in-line with NICE CG 110: Recommendations for pregnant women who have complex social factors.
- There was a dedicated bereavement room on the delivery suite. This room was in need of development as it was clinical and had only a medical bed in situ. We were told that the local SANDs group along with the bereavement midwifes were fundraising to make improvements to this area.
- There were two side rooms on Mirrlees ward for women who had experienced miscarriage that offered them some privacy away from other patients.
- Post mortem examination was offered in all cases of stillbirth and neonatal death. This was following recommendation 4 of the MBRRACE UK to improve future pregnancy counselling of parents. We saw the documentation related to this in a checklist which was completed following stillbirth or neonatal death.
- Partners were not able to stay on post-natal wards. The department had recently trialled having partners stay on the wards but the outcome was not positive and patients and staff felt it had been unsuccessful.
- Partners can visit between 7am and 11pm and parents own children from 9am-6pm. General visitors from 2pm-8pm and limited to two at one time. Women we spoke with generally thought visiting hours were reasonable.
- Patients are offered food options and include religious choice, for example, halal options. Staff can ring the kitchen to make meal requests and cater for patient needs if possible.
- 'Congratulations on your birth' information was given to all women post birth. This included information on meal times, time of drug rounds. Patients were informed to ask staff outside of these times for pain relief if needed.
- Babies had hearing screening within the postnatal ward, if this was not possible there was also a clinic available and women were given appointments for this before they left.
- All babies should have a NIPE) check prior to discharge. Patients are warned of delays waiting for NIPE examinations due to a lack of qualified staff able to carry these out.
- Leaflets were not readily available; we did not see leaflets in the ward areas or corridors. When we asked we were printed off some and told these were the ones that patients received. We looked at these and found many were out of date for example guidance on Obstetric Cholestasis (Obstetric Cholestasis is a condition that affects your liver during pregnancy) this referenced RCOG guidance published in 2007 which has since been updated in 2011. The review date for this leaflet was also 2011.
- We also saw five more patient information leaflets that were past the listed review date, including Induction of labour patient information, that needed review in 2009 and one referenced 'Crowborough Maternity Unit' which is no longer run by the trust. This meant that patients were not always receiving appropriate information and it was not openly accessible.

- Leaflets were seen in the community midwives office and included 'what information we keep about you', 'smoke free' leaflet, 'PHE screening', 'free milk', and 'kicks count.'
- There was no immediate availability of leaflets in other languages, however, we were told by staff they could access these online if needed.
- A recent audit by the trust identified some areas of concern in relation to the provision of information leaflets. From June 2015 to July 2016 only 40% of patients reported being provided with any written information about treatment or services they were receiving. Where there was an indication that the patient had received written information there is no recording of the version provided. This is an improvement from 23% during the 2014 audit.

Learning from complaints and concerns

- The complaints policy stated that complaints were acknowledged within three to seven days. This contact was, where possible, by phone. If this was not possible a letter was sent outlining what exactly will be investigated and complainants were asked to confirm they were happy with this process.
- Following on from this a letter is sent to clinical teams asking them to respond with a set timescale. There were dedicated complaints advisors who were attached to specific departments.
- We saw evidence of appropriate responses to complaints, including apologising to patients and meeting with them to review their notes and offer explanations. We saw evidence of learning from complaints. An example of this was providing additional training for staff performing antenatal ultrasound scans.
- We were told the Director of Nursing would arrange visits with the complainants in their home, if necessary.
- The new CEO was actively involved in dealing with complaints and was committed to resolving issues. This included looking for trends in complaints. We saw an example where the CEO had personally addressed a member of the medical staff where there was a history of repeated complaints relating to their attitude.
- The link facilitators took learning to clinical teams at weekly meetings.
- Evidence of any actions taken must be updated on the electronic recording system before a complex complaint was closed down
- The local Healthwatch undertook a review of 60 complex complaints and made several recommendations which the trust was addressing. An example was a recommendation to include the names of the senior managers, clinicians and nurses involved in the complaint within the final response letter. We saw this change had already been implemented.
- A new questionnaire had been developed within the trust to understand how the patient had found the complaints procedure. So far one response had been returned which was positive.
- We did not see any information on making complaints across the department. When asked patients were not aware how to make complaints but generally said they would raise it with the midwives.
- We spoke to a new member of staff who was not aware of any leaflets, but she was able to tell us she would direct the patient to Patient Advice and Liaison Service (PALS) service and escalate to the matron to try and solve any issues informally first.
- A dedicated trust complaints officer attends a weekly meeting with head of nursing to update on progress of complaints.
- There is a new 'customer care' module in mandatory training, this included going through comments about staff attitudes and any complaints received.
- At the entrance to the day assessment unit there was a board with information on staffing levels and patient information. It also included a 'You said, we did' section. When asked we were told this was updated regularly.

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- Staff in all areas understood the vision, values and strategic goals of the maternity services and the wider

hospital. Staff felt respected, valued and supported. All staff we spoke to felt the culture had improved since our last inspection, and gave us examples of positive improvements.

- The board and other levels of governance within the organisation function effectively and we saw good interaction and accountability.
- The organisation is beginning to manage current and future performance with new data collection and recording having been introduced and emphasis placed on the importance of these. There has been an improvement in outcome as a result of this.
- Leaders shaped the culture through effective engagement with staff and people who use the services as well as engagement with the wider representatives and stakeholders.
- We saw an active staff group who want to improve the service and experience for women.
- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.
- The service proactively engaged and involved all staff through its maternity service review and other channels and ensured that the voices of all staff were heard and acted on.
- The trust had a programme of project groups related to maternity, which drove improvements in different areas of the service.
- Through the daily maternity risk meetings, there was candour, honesty and transparency to enable the entire service to learn lessons and make improvements.

However:

- The ratio of supervisors of midwives (SoM) to midwives was worse than the ratio recommended by the nursing and midwifery council. However, the trust had begun to take action to address this by recruiting an additional SoM.

Vision and strategy for this service

- The values and vision for the department were displayed in ward areas. This was to provide efficient and effective service to women and their families, to be friendly and supportive to each other, in a calm, stress-free, productive dynamic, tidy well organised environment.
- There was a clear vision for the service and a strategy already in progress. This included the Maternity Service Review, monthly staff newsletters, weekly staff forums and a band 7 development programme.
- The recent Maternity Service Review had been very successful and staff told us it had helped them feel valued and included in the future vision for the service. Every member of staff we spoke to reference this review and the positive impact it had on the service.
- Staff were able to tell us about upcoming improvements and talked enthusiastically about recent changes in the department.
- The trust has a shared vision of becoming outstanding by 2020. We saw staff referencing this vision and when asked if it was achievable the majority said they thought it was

Governance, risk management and quality measurement

- The service has recently made changes to the governance structure. Despite the recent changes the service has adapted well and staff felt positive about the future of the service.
- Recent changes included recruiting another clinical service manager working alongside the acting head of midwifery. Staff spoke positively about how this had allowed the acting head of midwifery more time to speak with midwives and the daily running of the department.
- Midwives and maternity support workers (MSWs) reported to the ward matrons. The matrons then reported to the clinical services managers who reported to the head of midwifery. Clinical services managers and the head of midwifery sat on the trust's internal accountability and governance committee for women's, children's and sexual health services. The committee met monthly and provided quality and safety assurances to the trust board. We saw that matrons

received copies of the minutes and disseminated any learning points or changes of practice to all relevant staff. We heard from staff that they were informed about any changes in ward meetings, or via e-mail.

- Maternity services also held a trust-wide daily maternity risk meeting held at Conquest Hospital. Matrons and clinical services managers attended these meetings, as well as the head of midwifery. Risk meetings were open for all staff to attend if they wanted to. Midwives said they were often too busy to attend, but that they always received learning feedback from these meetings.
- Regular meetings fed into the executive structure, these included the monthly risk meeting, patient safety summit, serious incident review group and monthly performance meetings.
- We spoke to the midwife leading on patient risk, we found there were reliable risk management processes in place including systems for learning from incidents and implementing change. When action plans were developed following incidents we saw the changes were tracked at trust level to ensure completion.
- Performance management issues in maternity and gynaecology were managed by the head of midwifery. She gave us examples where she had spoken to staff members involved in poor behaviours. During our inspection we witnessed an incident where the head of midwifery had taken direct action when a staff member had spoken out of turn. Further to this staff we spoke to felt she would address any issues they raised in terms of staff behaviours and felt confident to report any issues to her.
- All midwives had a named supervisor of midwives (SOM). While rotas ensured 24 hour availability of SOM, the overall SOM to midwife ratio was 1:26 in 2015-16. This was worse than the ratio of 1:15 recommended by the Nursing and Midwifery Council. As a result, the SoM team were unable to evidence 75% attendance at local SOM meetings as set out in the local supervising authority standards. However, the trust recently recruited a full-time SOM to help address the balance and allow more time for supervisory activities.
- The Supervision audit action plan and annual report to the local supervisory authority (LSA) was presented to the wider Trust and Board in the last practice year and there is a plan for this to be repeated.
- The contact supervisor of midwives (CSOM) met with the Director of Nursing on a quarterly basis to brief her on supervisory activities in the preceding quarter. Minutes of the meeting and briefing template were provided as evidence of this.
- The dashboard was only recently introduced so the department had only been able to report on the previous three months. The dashboard was reviewed at the trust's internal accountability and governance committee for women's, children's and sexual health services.
- We saw the maternity, gynaecology and sexual health risk register. This highlighted the issue of community midwives being called into the Conquest labour ward at night. Community midwives were then sometimes unable to take an adequate rest break to sleep before starting their shift the next day. This practice was not compliant with the European Union (EU) working time directive.
- However, we saw the trust was taking action to address this risk through their night-time triage pilot scheme. All staff we spoke to felt the pilot scheme was very successful. The pilot also addressed the lack of night-time triage to improve services to women who went into labour during the night or at weekends. Managers told us, and we saw from the risk register, that the service had submitted a business case for funding for night-time triage to continue on a permanent basis.
- We spoke to the midwife leading on patient risk, we found there were reliable risk management processes in place including systems for learning from incidents and implementing change. When action plans were developed following incidents we saw the changes were tracked at trust level to ensure completion.
- During the daily risk meetings we saw effective discussion around CTG interpretation, it was clear that staff felt able to challenge each other in a friendly environment.
- We saw that the trust had comprehensive programme of 24 local and national audits. However, the trust had still not received reports for several audits long after the expected end dates. For example, we saw that the trust

had still not received a report from an audit into the appropriateness of Induction of labour and outcomes for babies. The anticipated end date for this audit was September 2015.

- However, we saw evidence of action to address the issues around clinical audit. Minutes from the women's, children's and sexual health governance and accountability meeting on 1 July 2016 stated an action for senior staff to contact audit leads for action plans. We saw from the following minutes on 22 July 2016 that the committee followed this up further, with the divisional manager arranging to meet with relevant staff to clarify expectations around clinical audit.

Leadership of service

- The department had direct access to the chief executive every month through a performance meeting; he chairs the meeting and discusses quality with the clinical leadership teams. It was through engagement at these meeting that the maternity review was launched.
- All staff we spoke to felt supported by their line manager. Staff also felt the newly appointed head of midwifery was visible and approachable.
- Midwifery staff spoke positively about the leadership of the department and the support they were offered. Positive comments included "We are like a family" and "Staff want to support each other, as we know how hard this job can be".
- We were told the leadership team were visible and approachable. We were given examples of the leadership team supporting each other during a period of bereavement.
- We saw that interactions between staff of all grades were effective and friendly.
- We met with staff during focus groups before our site visit to allow as many staff members as possible to give their views on working for the trust. Staff we spoke with were positive about the new chief executive telling us he drove through changes and listened to staff from all levels.
- Supervisors of Midwives (SoM) attend and contribute to the maternity governance meetings, incident reviews and policy group. Policies are reviewed by the SoM for the impact on safe evidence based midwifery practice and they contribute to the dissemination and implementation process. These are highlighted to staff through one to one discussions, at mandatory training and through the electronic records system.
- Non-Executive Directors (NEDs) take part in four or five quality walks a month each, these occur on randomly selected ward. From these they provide feedback to the area and report any findings to the Board. The NEDs hold monthly meetings and have a programme of 121s and personal development programmes.
- External confidence of CCG has improved, the Maternity Project Lead described discussions as more focused on what good looks like and how to progress towards this, not just reporting to them.

Culture within the service

- We spoke with a Supervisor of Midwives who had recently returned to the trust she described the culture as much improved "Feels different."
- This was something that was echoed by every staff member we spoke to. They all reported that it was a different place to work than a year ago and that positive changes to leadership had been the driving force behind the changes.
- Staff said they "Felt involved and like our opinions mattered", and "We all try to pull together at busy times now."
- We were given an example where due to staff sickness a shift was short staffed and very busy. Staff put a call out and within an hour they had two consultants and two midwives on the ward to support and get through the busy period. This shows a workforce willing to help each other out as a team.
- The inspection team were welcomed into the unit by all staff members. Staff were willing to talk to us and be open about what the service was like. This showed an open work force who welcomed review.
- The trust recently provided training sessions for staff on Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. Staff could describe DoC and their responsibilities relating to it.

- We saw a clear process for escalating any concerns over performance issues and staff felt able to challenge each other and take ownership of the department. For example open staff discussion were had during the maternity review which led to positive change.

Equalities and Diversity

- There is currently an ongoing Investigation into an allegation of racism towards a patient by a former staff member. Staff were not aware of the allegation and the confidentiality of the staff member had been ensured.
- There is a clear policy around staff behaviours in regards to equality and diversity and bullying. We were given examples where staff had been suspended if found to be breaking the code and a full investigation was launched.
- Staff we spoke with felt there was a 'zero tolerance' approach and a new policy has been produced on race equality since new executive structure has been in place.
- If patients behave in an unacceptable manner a letter is sent to the patient explaining it will not be tolerated. Staff were encouraged to report any incident of bullying or racism through their line manager or the trusts 'speak up guardian'.
- We were given examples where the interim head of midwifery had arranged meetings and acted a mediator between staff alongside HR to resolve any issues amongst staff.

Public engagement

- Maternity users were involved in governance through the Maternity Services Liaison Committee (MSLC) they met every two months. We witness a part of this meeting which was well attended.
- Service users were also engaged in a Women's Focus Group, Normalising Birth Group and the Better Beginnings service consultation process. Users were involved with the SOM team on the recent development of the midwife led care room on the delivery suite and on the production of patient information leaflets. Users were also involved in the Normalising Birth group leading to refurbishment of the Water Birth Room.
- The maternity review involved women who had used the services they were involved in one-to-one interviews, tours and feedback of units and workshops.
- The service actively sought users' viewpoints when making changes to the service, for example the 'Movements Matters' literature was uploaded onto the user's Facebook site for feedback.
- We were told that supervisors complete 'Walk the Patch' forms with women to gain feedback and discuss at SoM meetings with a view to actioning change.

Staff engagement

- The department holds monthly debates for all staff to attend. Last month the debate was on CTG interpretation and we were told the next debate was on induction of labour. This discussion has been decided as there is a growing concern over a number of women being induced earlier than 40 weeks due to fetal movement. We were told there was good involvement and engagement from staff. Several members of staff we spoke to mentioned these debates positively.
- A closed Facebook group called 'make it happen' has been set up for staff to engage in service changes. This group includes midwives, student midwives, nurses, maternity support workers and ward clerks. It also enables staff to get shifts covered and support when needed. It is reported to have been successful in enabling less agency use, however, we don't have recent enough figures number to say if this is true. February and March 2016 had the highest number of agency hours reported with 816 and 815 hours reported.

Innovation, improvement and sustainability

- The trust is part of the 'East Sussex Better Together' the aim of this group is to develop a fully integrated health and social care system in East Sussex by 2018, ensuring every patient or service user enjoys proactive, joined up care that supports them to live as independently as possible and achieve the best possible outcomes.
- East Sussex Better Together (ESBT) is a 150-week programme to transform health and social care services. It hopes to use the combined £850million annual budget to achieve the best possible services for local people. The programme started in August 2014 and is

led by two local NHS clinical commissioning groups, East Sussex County Council, East Sussex Healthcare NHS Trust and Sussex Partnership NHS Foundation Trust.

- Following the project lead midwife's maternity review, the trust had programme of project groups related to maternity. These included the pilot scheme of a new homebirth and triage role for community midwives, and a perinatal mental health specialist midwife role.

Services for children and young people

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

Information about the service

Services for Children and Young People at East Sussex Healthcare NHS Trust are located across both Eastbourne District General Hospital and the Conquest Hospital. It is an integrated service with a number of staff working across both sites. There is an inpatient ward (Kipling Ward) located at the Conquest site that has 21 beds. There is also a Short Stay Paediatric Assessment Unit [SSPAU] operating seven days a week from 7am to 9pm, adjacent to the inpatient unit. There is another SSPAU located at the EDGH site that operates seven days per week from 7am to 9:30pm with admissions stopping at 7pm Mon-Fri and 10am to 6pm at weekends with admissions to the unit stopping at 4pm. Day surgery is carried out on both sites and there are also paediatric outpatient clinics on both sites.

Young people from their 16th birthday onwards will usually be referred to or admitted to the adult services, unless they have a long-term condition and are under paediatric outpatient follow-up or have special learning needs and are under the care of a community paediatrician in which case they will continue to be treated up until their 19th birthday.

There is also a Special Care Baby Unit (SCBU) located at the Conquest hospital with 12 cots, and has ability to expand the number of cots, if required. This Unit is co-located with the Inpatient Paediatric Ward. Neonates - babies under 14 days old may be considered suitable for readmission from the community to the SCBU, Transitional Care or Maternity Unit. The place of admission will be determined by the reason for admission and the care they require.

The inspection team visited the SSPAU and outpatients department at both sites as well as the Kipling ward and SCBU at the Conquest Hospital. They also visited the accident and emergency department at each site as well as the general outpatients department at the Conquest Hospital where children attended for dental treatment.

The Trust had 5,703 spells of attendance between April 2015 and March 2016. Emergency spells accounted for 95%, 4% were day case spells, and the remaining 1% were elective spells.

We spoke with a total of three children across both sites and 18 parents or family members of children. We spoke with 11 nursing staff, 2 medical staff and three other staff at the Conquest Hospital.

Following our inspection visit in September 2014, we rated the service as 'requires improvement'. The issues identified at the time included the poor condition and completion of patient records, staffing levels (particularly in the children's outpatient area) and low uptake of mandatory training. When we returned in March 2015 we only reviewed the core services that had been of greatest concern in 2014. The children and young peoples' service was not one of the core services inspected.

Services for children and young people

Summary of findings

We rated this service as requires improvement because:

- The environment was generally cluttered with equipment stored in the corridor. One bay was crowded with insufficient space for the number of beds. This was rectified during our inspection.
- Feedback and learning from incidents was mixed with some staff saying that they didn't get feedback when they had reported an incident. We also heard that some incidents weren't reported as the process was too long or staff wouldn't report some incidents in case there were repercussions.
- Outpatient waiting times were excessive with 79 of 1106 patients waiting over 18 weeks for their appointment.
- There was no play specialist to lead and develop play services.
- There was no parents' room that could be used to have private or difficult conversations
- The outside play area was not able to be used due to the type of flooring. The equipment available had also been left for so long that it was not fit for use.

However:

- Staff understanding of child safeguarding responsibilities, processes and protocols was well embedded. We found there was a strong focus on safeguarding when staff were caring for children.
- Although cluttered, the equipment on the ward and the ward was clean. This was reflected in the cleanliness and hand hygiene audits.
- The trust had appointed a consultant who had dedicated time to review all National Institute for Health and Care Excellence (NICE) guidelines and implement them.
- Internal auditing was comprehensive and each audit was given a priority rating.
- There was an appropriate response when a child's condition deteriorated.
- We observed compassionate care from all staff who had interaction with both children and their families
- Safety huddles, which started at Eastbourne SSPAU and on the SCBU were introduced on the Kipling ward in August 2016
- We heard how the culture across the ward was supportive, praising and caring which promoted close working relationships across the teams.
- There was a published strategy for Womens and Childrens Services with explicit priorities and measurable performance indicators.
- There was clear leadership of the children's services with Board level representation.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Although incident reporting had improved significantly since our visit in September 2014, feedback and learning from incidents was mixed with some staff saying that they didn't get direct feedback when they had reported an incident.
- We also heard from a few staff that they didn't report some incidents as the process was too long or in case there were repercussions.
- The environment was cluttered with equipment stored in the corridor.
- One bay was also crowded with too many beds for the available space. Interim measures were put in place during our inspection.
- There were supply issues with some medicines on the SCBU. This meant that some babies were kept in hospital when medically fit to be discharged.

However:

- Staff understanding of child safeguarding responsibilities, processes and protocols was well embedded. We found there was a strong focus on safeguarding when staff were caring for children.
- Staff spoken to had a good understanding of the incident reporting systems and were confident in reporting using the electronic reporting system.
- Root Cause Analysis investigations took place, following serious incidents. Staff had a good understanding of the duty of candour.
- Incidents reported were investigated locally or through the divisional governance structure.
- Safety Thermometer data showed that the trust provided harm free care to children and young people.
- Although cluttered, the equipment on the ward and the ward itself was clean. This was reflected in the cleanliness and hand hygiene audits.
- Drugs were stored securely and were kept at the right temperature.
- Staffing levels were good and plans were in place to fill the vacancies that there were.

Incidents

- There were a total of 191 incidents reported at the Conquest hospital in the period 1 July 2015 to 30 June 2016. Incidents were categorised by severity on a scale of one to five where five was the most severe and one was the least severe. 150 of the incidents were categorised at level one, 36 were categorised at level two, two were categorised at level three, one at level four and two at level five.
- Between August 2015 and July 2016 the trust did not report any incidents which were classified as never events for children and young people. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Serious incidents were recorded on STEIS in a timely way. Root cause analysis incidents were carried out with involvement of the directorate leads.
- All staff we spoke with and asked about incident reporting were familiar with the electronic reporting system, how to fill it in and what type of incidents should be reported.
- Senior staff told us that anything put on the electronic system went to the matrons, head of nursing and the service manager. The incidents were then investigated. After investigation the incidents would be rated in terms of the harm caused and the likelihood of it happening again.If incidents were rated as either moderate or high, they were discussed at the monthly clinical unit risk meeting.

- We were also told by a few staff that they believed that some incidents weren't reported as the reporting process took too long and that some people wouldn't speak up because they were concerned about repercussions.
- Data from the Patient Safety Thermometer, reported trust wide rather than hospital site specific, showed that there was one pressure ulcer, no falls with harm and no catheter urinary tract infections between July 2015 and July 2016. This meant the trust was providing harm free care within the children's services.
- Staff across services for children and young people had bi-monthly mortality and morbidity meetings. These meetings are held across the trust and not exclusively at the Conquest hospital. Minutes showed good presentation of cases by junior doctors to the consultants present. The review of individual children included both medical and social history alongside a chronology of the admission and investigations/ treatment to date. Safeguarding concerns were considered. There was good evidence of learning from case review.
- Separate perinatal morbidity and mortality meetings took place weekly. These reviewed the care of babies who were born in poor condition and perinatal deaths.
- We were told by staff how there had been an expected death on the Special Care Baby Unit (SCBU). This had been fully reviewed at a risk meeting and a full root cause analysis was carried out to ensure that if there was any learning from the incident then it would be taken.
- Staff we spoke with across the trust were familiar with their obligations regarding the duty of candour and the process they would need to follow was well embedded. We were also provided with an example where the team had followed the correct process through to conclusion, writing a letter to the parents explaining exactly what had happened.

Cleanliness, infection control and hygiene

- There had been one incidence of Clostridium Difficile (C.Diff) reported between March and June 2016. There had been no incidences of Meticillin-Resistant Staphylococcus Aureus (MRSA) reported between March and June 2016. These were reported trust wide and were not split by hospital site.
- The Kipling ward had readily accessible hand gels and Personal Protective Equipment (PPE) with a dispenser for each outside the bays and individual rooms. We saw signs on the doors of certain rooms explaining that PPE must be worn before entering the room.
- Cleanliness compliance on the Kipling ward for the month of the inspection was 94.82%
- Hand hygiene audits on Kipling ward in the period from March to July 2016 ranged from 88.89% in March 2016 to 100% in April 2016.
- The infection control audit on Kipling ward for the month prior to the inspection scored 96.47%. It was felt by staff that having the clinical orderly as well as regular cleaning by the house keeper had assisted with this. Housekeeping had devised a checklist to assist in keeping a clean environment and we saw this in use during the inspection.
- Hand hygiene compliance audits were carried out monthly. In the 8 months prior to inspection, the SCBU scored 100% in the hand hygiene audit.
- The SCBU had appointed a clinical orderly for cleaning and had devised a comprehensive cleaning schedule. This showed the areas that were cleaned, the frequency and how they should be cleaned.
- Patients on the Kipling ward were swabbed for MRSA on admission and at weekly intervals thereafter.
- The Kipling ward had five patients with cystic fibrosis who had open access. Open access meant that a child with a long term medical condition could arrive at the Short Stay Paediatric Assessment Unit (SSPAU) for treatment at short notice. The staff told us how they would try to keep those patients separated if they were in at the same time and provided them with their own room if possible, although this was difficult when the children were younger and more likely to want to move around. These children needed to be protected from specific hospital acquired infections and reduced contact with other children minimised the risk.

- Single rooms allowed for isolation of children who presented an infection risk to others or who were at increased risk of cross infection.
- Facilities were available for the sterilisation of baby feeding equipment.

Environment and equipment

- The Kipling ward at Conquest hospital had a bay that contained six beds. The area appeared very small for six beds as there was an immovable physical divide in the bay. One bed at the far end of the bay was placed against a wall. Piped oxygen was also right at the end, by the wall. In order for staff to get to the oxygen, they had to lean across the bed. Patients in this bay also had had parent beds placed next to or near the child's bed at night which meant that the ability for staff to access and care for children at night would have been severely restricted.
- A number of staff had highlighted this bay as being a concern to their managers and despite a number of attempts to get building work done to reduce capacity to four beds, this had not happened. The inspection team raised concerns about the situation in the bay to senior staff. National guidance for newly built or refurbishments is that that a bed space on a children's in-patient ward should measure a minimum of 3.4 metres by 3.5 metres.
- During our inspection we were told that as an interim measure, the bay had been reduced to three beds, pending building work to reconfigure it. Building work was due to commence late October / early November 2016. An unannounced inspection during the weekend of 15 / 16 October 2016 confirmed that the bay still only had three beds and the board at the nurse's station also showed that only three beds were available.
- A range of equipment across Kipling ward was checked by inspectors to see whether it had been regularly tested and was clean. Equipment checked included infusion pumps, 02 saturation monitors, a hoist, a weighing machine and a blood pressure machine. All the items checked had been completed and were in date with stickers showing when they needed to be re-tested. The resuscitation trolley was checked daily and had been signed and recorded to this effect. All equipment on the resuscitation trolley was in date.
- Equipment was stored in various places around the ward although much of it was kept in the ward corridor area which made it appear very cluttered. National guidance is that there should be adequate storage space over and above that for an adult ward as children's wards need to store child specific equipment such as highchairs, and buggies.
- Access to the Special Care Baby Unit (SCBU) was restricted. Entry was gained by the use of a swipe card for staff and had a 'buzz in and buzz out' system for visitors.
- The SCBU had 12 cots, six of which were located in a single bay. This meant that if the bay was full to capacity, there was a limited amount of space for parents that wanted to be with their baby.
- Storage for basic items on SCBU was limited and was reported by staff to be a persistent problem.
- Staff told us that the lack of space and general environment of the SCBU were on the trust's risk register.
- Outside the SCBU was a courtyard garden. This provided a small area for parents to use. The flooring in this area was suitable for small children to play although was overgrown. No provision was made for this area to be maintained and any maintenance was taken on by volunteers.
- Kipling ward had a playroom that also acted as a room for parents to use to have a drink. This posed a risk of scalding to young children who were running around and playing.
- The room itself had a range of toys which were cleaned every day.
- Nursing staff considered that there were not enough side rooms and told us that a lack of single rooms had caused the ward to close to new admissions on occasions as they could not accommodate those patients that needed their own room. There was no documentary evidence to support this claim.
- Housekeeping staff told how they had received training in Control of Substances Harmful to Health (COSHH)

- Flooring throughout the Kipling ward was old and showing signs of wear and tear. This carried a potential risk of infection to babies and toddlers who crawled around on the floor as the surface could not be cleaned effectively.

Medicines

- All drugs stored on the SCBU were stored securely. They were stored in glass fronted cupboards which allowed staff to look inside before opening.
- There were supply issues with vaccines and specials, for example (1mg in 10mL morphine injection, 1mg in 5mL (or similar) morphine oral solution, phenobarbital injection)
- Vaccines were prescribed and ordered but could take up to ten days to arrive, this had the effect of delaying discharge of medically fit babies
- Records seen showed fridge temperatures were within recommended temperature range
- The controlled drugs register was checked and all was in order.
- The keys for the controlled drugs cabinet were kept separately from the main keys to the drug cabinet.
- Staff told us during the inspection that occasionally medicines only used by the unit would expire and there would be a delay in obtaining new stock. This meant that they could be without certain drugs for a short period of time.
- Individual medicines records showed that there was appropriate prescribing and administration of medicines.

Records

- The special care baby unit (SCBU) used an electronic neo-natal patient record. There was also a lockable trolley for patient notes as well as a folder of all current documentation such as policies and guidance. We reviewed two sets of notes on the SCBU, both of which were of a good standard
- We were told by a medical staff that there had been occasions when the records for clinics in outpatients had arrived late. There had been 22 incidents formally recorded from outpatients It was believed that the real number was much higher, partly because some incidences were not being reported and missing records for a full clinic may only be recorded once.
- The hospital had started storing records off site and retrieval during the first months of operation had had a mixed reception. We were told that the expected turnaround time to get records ready for clinic was 10 working days. This meant that appointments that were arranged at short notice, two weeks in advance, would have difficulty in getting the records in time.
- The hospital had a children and young peoples' day surgery care pathway records sheet. This was a 12 page document that contained information about the patient, details of the procedure the patient would be having and details of next of kin. There were also sections that contained further personal details. Further details were entered on to the form as the patient followed the surgical pathway.
- We reviewed one patient surgical pathway and saw that the medical records had been completed but the surgical pathway document had not been fully updated. Records we saw showed that past family history, drugs or allergies were recorded. The PEWS score had been recorded in the medical records but not on the pathway record.
- In general, medical records were well completed and gave a comprehensive account of the child's medical and nursing care.
- An electronic observation recording system was in use across most of the adult services but had not yet been introduced to the Women and Children's Directorate as specialist modules needed to be commissioned. These were in the production stage and there was a 'roll out plan' in progress at the time of the inspection.

Safeguarding

- The Kipling ward had a specialist safeguarding nurse who assessed all attendances of children aged 16 and under in the emergency department (ED) to assess if there were any risks associated with the attendance and whether it triggered any alerts.
- Should any concerns be raised, the information was formally passed to social services to consider if any

further action or a home visit was necessary. If children of school age attended the hospital and there were any issues, this would be escalated to the local authority and subsequently to the school.

- The specialist safeguarding nurse provided a drop in for ward staff if they had any concerns.
- Level three child safeguarding training was provided by the specialist safeguarding nurse to all paediatric staff in ED, on the ward and in outpatients. Staff seeing children for dental work were trained to level three.
- Data provided by the trust showed the compliance with safeguarding training to be safeguarding children level two (82%) safeguarding children level three (82%) and safeguarding vulnerable adults (77%). This was worse than the trust target of 90%
- The topic of female genital mutilation (FGM) is covered in level three safeguarding training.
- A multi-disciplinary safeguarding meeting was held weekly across the ward and in the ED
- Staff told us that an alert will come up on the patient's records if there are any child protection concerns. They will then be able to link with the safeguarding lead
- Any child who failed to attend two outpatient appointments was always followed up from a safeguarding perspective.
- There was an automatic flagging system in the ED for children already known to have safeguarding risks and with local authority involvement. East Sussex County Council had a higher than England and South east average number of children with a safeguarding plan.
- The trust signed up to the multi-agency risk assessment conference (MARAC) Operating Protocol for domestic violence. The Named Nurse sits on the MARAC Quality and Audit Group which reviewed multi agency management of MARAC cases.

• The trust had a number of completed action plans relating to the Serious case Reviews(SCR's) and Multi Agency Request for Services (MARS). There were no outstanding actions from SCRs or MARS at the time of the inspection.

- Between April 2015 to March 2016 there were two East Sussex SCRs published. The overview report concluded that neither death was predictable nor preventable but learning was shared and disseminated by the Local Safeguarding Children Board.
- The Child Death Overview group reviewed 26 deaths of East Sussex children during 2015/16. Four were identified as having factors which may have contributed towards the death of a child and where action could be taken to reduce the risk of future deaths (not by the trust). As a consequence there have been two Safe Sleep training sessions delivered by the Lullaby Trust. These were well attended by trust staff. Champions/link professionals have been identified and established within SCBU, acute paediatrics, ED and health visiting services.

Mandatory training

- Topics covered during mandatory training included basic life support, blood transfusion, conflict resolution, deprivation of liberties, equality and diversity, fire safety, health and safety, infection control, information governance, mental capacity act, moving and handling, safeguarding level one and safeguarding vulnerable adults. The trust target for mandatory training was 90%.
- On Kipling Ward, Nursing and Midwifery staff met the 90% target in all areas except for conflict resolution (54%) equality and diversity (85%) health and safety (85%) information governance (88%)
- On the special care baby unit nursing and midwifery staff met the 90% target in all areas except for conflict resolution (73%) equality and diversity (82%) health and safety (86%).

Assessing and responding to patient risk

- The sister on duty on Kipling ward assessed the acuity of each patient every day and gave each a rating of red, amber and green (RAG) scale.
- Children requiring ward based care or level 2 critical care (high dependency) could be cared for at the hospital.
- Where a child required higher level critical care they were stabilised on site and managed until the retrieval team arrived to transfer them to a children's intensive care unit

- Mothers having babies who were likely to need intensive care were encouraged to deliver at a neighbouring hospital with appropriate support facilities.
- Neonates who became unwell after birth were transferred by ambulance. There was a service level agreement in place and good relationships with the neighbouring trust.
- PEWS were recorded in the patient notes and on the surgical pathway record. We saw one record where the score had not been recorded on the pathway record.
- PEWS scores were calculated and appropriate escalation action was taken where the score was raised outside of the set parameters.
- An electronic observation recording system was in use across the hospital and was due to be rolled out in children's services next. The system had been piloted in adult wards prior to hospital wide roll out and adaptation of the system for particular cohorts of patients.
- Children were accompanied back from theatre by a registered children's nurse.
- The 'Five Steps to Safer Surgery' checklist based on World Health Organisation guidance was used routinely in the operating theatres.
- A sepsis pathway had been developed which was being implemented at the time of the inspection.
- Children were not necessarily cared for by staff with specific training in the care of children whilst in the recovery area.
- Medical staff had created an online training module for staff on how to recognise a sick and deteriorating child. This had been done following learning taken from a mortality and morbidity meeting.
- The Board Assurance Framework (September 2016) showed that there had been an awareness raising campaign across the trust about the identification and management of sepsis. This had coincided with the launch of a new sepsis screening and management tool. Staff, including the executives, had spent the week wearing bright red and white striped socks and T shirts.
- Children with complex medical problems were cared for under 'shared care' arrangements with tertiary centres. Clear protocols and individual care plans were in place that enable children to be cared for locally with specialist input.

Nursing staffing

- There were five trained nurses (including the ward co-ordinator) and two healthcare assistants per shift on Kipling ward.
- The ED had paediatric nurse cover from 8am to 2am but no cover between 2am and 8am.
- The hospital used a modified Association of UK University Hospitals (AUKUH) tool which was adapted to meet the needs of children as there were very few specific paediatric acuity tools. This was then linked to the unit red, amber, green (RAG) rating which was discussed with the Head of Nursing and site bed management team throughout the day.
- Records of acuity were kept by the ward matrons as there was no accurate facility to measure staffing requirement based on the figures electronically.
- Planned staff for all shifts were six qualified and two unqualified for the day shift (Mon-Fri) and five qualified and two unqualified on Saturday and Sunday day shift
- Planned staff for nights was four qualified plus two HCAs (Mon-Sun)
- Nursing staff were invited to attend the doctors' handover at shift change.
- The nurse staffing numbers for June 2016 show that the Kipling Ward had 4.3 whole time equivalent vacancies. This amounted to 24% of the staff establishment.
- The nurse staffing numbers for June 2016 show that the special care baby unit had 1.1 whole time equivalent vacancies, this accounted for 5% of the total staff establishment.
- SCBU would have three registered band five nurses as well as a band six nurse. There was also one HCA on all shifts. The badger staffing tool was in use to arrange staff rotas.

- We were told how the improved information being collected on the badger system had allowed staff to be rostered to work together in various project groups. This in turn allowed staff the time to drive improvement.
- For short term staffing shortages the team would go to the nursing bureau that had a list of staff that could be called to fill a shift although some of the permanent staff would work overtime.
- There was the facility to go to agencies for staff and the team had preferred agencies for this purpose.
- SCBU did not use agency staff.
- The Short Stay Paediatric Assessment Unit (SSPAU) at the Conquest Hospital was staffed by 6 whole time equivalent nursing staff.
- Bank and agency staff went through the same induction as substantive staff as well as orientation to the ward and infection prevention and control training.

Medical staffing

- Medical staffing numbers were reported trust wide and were split into junior and senior medical staff.
- Across the trust there were 1.1 whole time equivalent vacancies among senior medical staff. This was a vacancy rate of 5% of the senior medical staffing establishment.
- Across the trust there were 2.2 whole time equivalent vacancies among junior medical staff. This was a vacancy rate of 11% of the junior medical staff establishment
- We were told by staff how some registrars had left to take up training posts but had not been replaced substantively and that these have been replaced by various locum doctors to mitigate the risk of not having the posts filled.
- The doctor from the SCBU attended the Kipling ward seminar room every day for handover at 8:30am. There were also handovers at 4:30 pm and 8:30pm.These meetings were attended by a matron / senior nurse.
- We observed the 8:30am doctors handover. It was noted to be efficient and the time available, usually 45 minutes, was managed well. The night registrar handed over the patients on Kipling ward as well as the patients on SCBU. The handover sheet was updated with the relevant blood results where available. The bottom of the handover sheet had relevant telephone numbers and contact details for the departments that were likely to have been needed for the day ahead.
- The night duty doctor on Kipling ward attended the nurse handover.
- The SCBU had one doctor in the level one unit. Level one is for babies who need continuous monitoring of their breathing or heart rate, additional oxygen tube feeding, phototherapy recovery (to treat neonatal jaundice) and convalescence from other care.
- There was a consultant of the week across the services for children and young people. Registrars would attend SCBU every day and consultants were able to review patients daily if required.
- The consultant of the week was also the on call consultant through the night. The consultant of the week rota covered Monday to Thursday and then would change from Friday through to Sunday.
- The ward had one registrar through the night and one SHO for the SCBU.
- In the period April 2015 to Mar 2016, the rate of use of locums fluctuated from zero to a high of 19.26% in August 2015 before falling back to 12.78%in March 2016
- The trust had introduced a consultant of the week who would carry a mobile phone so GPs could contact them to discuss children getting direct access. The consultant of the week would be available between 9am and 5pm, Monday to Friday.

Major incident awareness and training

- The trust had a Major Incident Response Plan for receiving casualties during a major incident. This plan covered a wide range of scenarios and ran to 104 pages. The trust also had a Business Continuity Plan. In the event of a major incident that required patients to attend, the Conquest hospital would have the role as a receiving hospital and the EDGH would have the role of a supporting hospital. Staff we spoke with were aware of the Major Incident Response Plan and the Business Continuity Plan.

Services for children and young people

Are services for children and young people effective?

Good

We rated effective as because:

- The trust had appointed a consultant who had dedicated time to review all National Institute for Health and Care Excellence (NICE) guidelines and implement them.
- Internal auditing was comprehensive and each audit was given a priority rating.
- A new fluid / feed balance chart had been devised which allowed staff to keep a more comprehensive record of patients nutrition and hydration.
- The practice educator had implemented a number of improvements and initiatives to ensure that all nursing staff and healthcare assistants had the competencies to undertake their role as well as providing them with opportunities for personal development.
- The short stay paediatric unit was open seven days a week allowing patients to attend for treatment without the need to go to the ED.

However:

- Some staff reported difficulties in getting jobs done through the estates department, primarily due to a lack of finance.

Evidence-based care and treatment

- The hospital was delivering care that was generally in line with the national guidance, "Standards for Children's Surgery (2013)'. There were dedicated children's surgical lists and a purpose designed unit. A consultant paediatrician was available at all times that children admitted for surgery were on the premises.
- The hospital was delivering care that was generally in line with the 'Getting it Right – National Service Framework for Children (2003). Parents were involved fully in the care of their children. Children were cared for in an appropriate environment by staff specifically trained to meet their needs.
- Staff on SCBU told us how, at the time of the inspection they were reviewing their guidelines. They decided to adopt the guidelines in place in a neighbouring trust's SCBU because babies were frequently transferred and this would allow for greater consistency. Guidelines in place were in the process of being replaced one by one and changes were stored on, and communicated through the intranet.
- The hospital followed the National Institute for Health and Care Excellence (NICE) guideline CG98 for jaundice in new-born babies.
- The trust had appointed a consultant who had dedicated time in their job role to review all NICE guidelines and implement them. Medical staff confirmed that all paediatric guidelines from NICE were adopted.
- The practice educator had dedicated time to work on changes to an implementation of new guidelines used across the SCBU.
- SCBU utilised their administrator to complete audits on the quality of the records. They checked that the paper records had been completed in black pen, signed, every page had an NHS number on it and were legible. Any trends identified in the standard of the records were fed back to the medical and nursing staff.
- The trust carried out a Surgical Consent Audit in June 2016. Of the four consent records audited, all areas regarding the documentation achieved 100% compliance.
- The trust completed a range of audits across services for children and young people. These were reported at trust level and were not site specific. Each audit was given a priority ranking between one and four with one being the highest priority and four the lowest. Each audit had a project lead, a planned start date and expected end date.
- Other audits were carried out at each priority level.
- The trust participated in the NHS National Clinical Audit and Patient Outcomes Programme (NCAPOP). This looked at performance in four areas. These areas were rated as high priority and were paediatric asthma, paediatric pneumonia, Neonatal Intensive and Special Care (NNAP) 2016 - 2017 data and Diabetes (Paediatric) (NPDA) 2016-2017.

Pain relief

- The practice educator had implemented a new pain chart for children under one and pre-school age. This involved a range of facial expressions that a child could recognise. Parents were involved in assessing the pain of their child. It was noted that these were always filled in at the beginning of a child's care but subsequently completion was variable.
- We were shown a range of ways the staff used to assess the pain the patients were in. These included smiley and unhappy faces, numbers from 1-10 and different colours.
- At the time of the inspection there was no auditing system in place to monitor the effectiveness of the pain tool.
- Parents of children were involved in the assessment of their child's pain if the child was not able to convey this.
- We observed that local anaesthetic cream was used on patients to assist with cannulation.
- In the CQC children's survey 2014 the trust scored 8.20 for the question 'Do you think the hospital staff did everything they could to help ease your child's pain?' This was similar to other trusts.

Nutrition and hydration

- Housekeeping staff provided the food for patients. Some food was available 24 hours a day.
- We spoke with one family who described how their child had special nutritional needs and required a diet of pureed food. They were always given options as to what food they could have.
- Staff on Kipling ward were made aware of patient's dietary requirements through the admission process. They asked specifically about any allergies such as cow's milk or gluten.
- During the inspection we were shown the new daily fluid / feed balance chart. There was space for the asset number of the pump used for intravenous fluids. The chart allowed for more detailed recording of intake.
- Pumps were available for mothers who wanted to express breastmilk for their babies.

Patient outcomes

- The Royal College of Emergency Medicine (RCEM), Vital Signs In Children Clinical Audit 2015/16 for Conquest Hospital showed that the hospital had performed better than the national median in four of the six standards. However, it had failed to meet the RCEM standard of 100% in all six standards.
- A clinical audit into bone age examination for patients attending the Conquest Hospital between 2011 and 2014 showed that from January 2013 to June 2014 the mean time frame for reporting on the examination from the actual test date was 31 days. This was a significant improvement on the mean time frame for reporting of 120 days in the period from January 2011 to June 2012. The maximum reporting time had also reduced from 537 days in the period January 2011 to June 2012 to 257 days in the period from January 2013 to June 2014. The hospital had an action plan in place to improve the reporting periods for bone age examinations.
- The trust had a total of ten priority one and two audits on-going at the time of the inspection. These included but were not limited to paediatric asthma, paediatric pneumonia and diabetes as well as re-audits of constipation in children, autism in children and young people to include recognition, referral, diagnosis and management and management of allergic reactions in children.
- There was also a re-audit underway entitled 'How effective is the CAMHs Pathway for Children and Young People attending Emergency Departments in East Sussex'. The original audit had identified that a risk assessment should be undertaken by the triage nurse when the patient presents at an Emergency Department. As a result a risk tool had now been put on the intranet to assist with triage.
- The most recent national Paediatric Diabetes Audit covering 2014/15 provided information that covered the whole trust and was not site specific.
- As recommended, 98.9% of patient had their HbA1c measured at least once a year. This was in line with the England average of 98.7%. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time.
- The trust scored better than the England average for 5 of the other 6 key care processes for those patients with diabetes.

Services for children and young people

- The only area where the trust performed worse than the England average was with eye screening. 27.5% of patients attended for eye screening against an England average of 64.9%.
- In the 2014/15 diabetes audit the trust performed worse than the England average. There were fewer patients having an HbA1c value of less than 58 mmol /mol compared to the England average and the mean HbA1c was similar to the England average.
- The trust participated in The Royal College of Paediatric and Child Health Neonatal Audit Programme 2015 (the audit).
- Retinopathy of Prematurity (ROP) scanning was completed on time in 94% of cases. This was in line with the England average of 93%
- The proportion of babies receiving breast milk at discharge was 14%. This was considerably worse than the England average of 33%.
- The proportion of parents that had a documented consultation within 24 hours of admission was 86%. This was broadly in line with the England average of 88%
- The proportion of babies that had received a documented follow up at two years gestational corrected age was 14%. This was considerably worse than the England average of 49%
- Between February 2015 and January 2016 there were fewer than six readmissions per specialty, as such no comparisons with the England averages can be made for elective readmissions within two days of discharge following elective surgery.
- Between February 2015 and January 2016 the percentage of the under 1 age group (3.8%) readmitted following an emergency admission was slightly worse than the England average (3.4%).
- The percentage of patients in the 1-17 age group (4.4%) readmitted following an emergency admission was worse than the England average (2.8%).
- **Competent staff**
- Staff in Kipling ward and across all services that care for children and young people had a monthly training session about diabetes. This was organised by the practice educator and run by one of three specialist diabetes nurses
- The practice educator attended 'super mentor' training following which any learning was cascaded down to other staff who act as mentors.
- Staff were given time to attend mentorship training course if they were senior band 5 or band 6 nurses, although assignments were done in their own time.
- The practice educator oversaw mandatory training across the trust for staff caring for children and young people. Compliance was good with all staff getting notification three months before any mandatory training was due.
- There was a central database that records the staff's compliance.
- Band three healthcare assistants (HCAs) were provided with a book of skills that they need to complete from the point they start in their role. The practice educator provides supervision to the HCA as they complete the book and gain the necessary skills.
- The practice educator arranged an infusion equipment device training away day relating to infusion pumps.
- The practice educator developed a portfolio of competencies and development for nursing staff to complete to assist in preparing for revalidation.
- Band six nurses had been seconded on to a two day training course that looked at leadership and self-education skills to assist with revalidation. HR kept a central record of information collected for the purposes of revalidation.
- A programme entitled 'sepsis six' was being rolled out across the department. At the time of the inspection the majority of staff had attended a session. A programme of training staff in tracheostomy care had also started.
- Staff on Kipling ward had been involved in the trust's sepsis week which was aimed to increase awareness of and knowledge about children's sepsis.

Services for children and young people

- Senior staff in the SCBU devised a programme of 360 degree feedback for band 6 nurses. This has created opportunities for staff to learn from and coach each other. It was anticipated that this initiative would also be rolled out to the mangers of the unit.
- Staff across SCBU were given opportunities to attend additional training courses as well as time to attend neo-natal network conferences. All band six nurses had attended neo-natal pathway training.
- Staff across services for Children and Young people talked of the need for more to be done to improve their knowledge and skills when dealing with and supporting CAMHS patients
- Staff we spoke with told us that they had had their appraisals and that access to their managers for supervision was good, and that they found those opportunities useful.
- The consultants have teaching sessions on weeks when all consultants can attend and discuss cases. This gave staff a feeling that the hospital was a 'good learning space' where they could talk through concerns.
- Nursing staff on the special care baby unit had a completed appraisal rate of 100%
- Figures for medical staff appraisal rates were reported trust wide and not hospital site specific. The appraisal rate for medical staff was 100%.
- Nursing staff on the Kipling ward had a completed appraisal rate for the period of April 2015 to March 2016 of 52%. This meant that a significant number of staff had not received an appraisal for this period. Appraisal rates were discussed with senior staff who explained that they had now either completed appraisals for staff or had booked time for the appraisal to take place.
- The hospital provided equality and diversity training to enable staff to be more aware of the needs of different groups of patients and increase their self-awareness as to how their behaviours can be interpreted.

Multidisciplinary working

- We were told by medical staff how the communication between the special care baby unit (SCBU and Kipling ward worked well although it could be difficult logistically to work between SCBU and Kipling ward due to the distance between the two wards.
- Senior staff involved in the care of children and young people met monthly to consider, as a whole team any existing or emerging risks. This included staff from the SCBU, Kipling ward and the SSPAU.
- The head of nursing for Children's services attended the Child and Adolescent Mental Health Services (CAMHS) transformation meetings. These were held with the recently appointed CAMHS nurse in accident and emergency.
- Staff told us that they had a good relationship with the safeguarding and community nurses who often worked on the ward. This made staff feel that the service was integrated.
- We were told how the team had built good relationship with the oncology team and that they always meet the golden hour. The golden hour is a time period that children should start antibiotic within an hour of the development of neutropenic sepsis following chemotherapy.
- Kipling ward had a dietician on the ward who also had a deputy.
- Kipling ward had access to a respiratory and orthopaedic physiotherapist who could attend every day, if needed.
- As per the trust operational policy all children from birth to their 16th birthday are treated by the paediatric ward. From their 16th birthday onwards, young people were referred to or admitted to the adult services, unless
  - They had a long-term condition and are under paediatric outpatient follow-up, up to their 19th birthday
  - They have a learning difficulty and are under the care of a community paediatrician up until their 19th birthday.
- There was no formalised transition pathway to adult services for the children who remain under the care of paediatric services until their 19th birthday. Children with long-term conditions such as CF, Diabetes & Epilepsy are transitioned by their Community Specialist Nurse.
- The Kipling Ward staff communicated with the Learning Disability lead for adult services as required to discuss transition.

Services for children and young people

Seven-day services

- The Short Stay Paediatric Assessment Unit (SSPAU) opened Monday to Friday from 7:00am until 7:30pm. The unit had started to trial opening at weekends to mirror the service offered at EDGH. However, the number of attendances had, to the point of the inspection, been low.
- Staff on the Kipling ward had good access to physiotherapists, occupational therapists and speech and language therapists out of hours.
- Radiology support was good and they could transfer images to specialist children's hospitals 24 hours a day, seven days a week.
- The consultant of the week covered the hours 8:30am to 6:00pm. Outside of these hours they had an on call consultant who attended the hospital in person if required.

Access to information

- Trust policies were available on the trust intranet and could be easily accessed by all staff.
- The trust provided both acute and community children's services and communication between the two staff groups was good, with a shared line management and governance structure that allowed for dissemination of information.
- A letter was sent to the GP of every child that attended the hospital as either an inpatient or outpatient.
- The SCBU had a board with the names, job roles and photographs of all ward staff on the wall. This enabled parents and visitors to identify the person they needed to speak to.
- On discharge from the SCBU a letter was sent to the GP, health visitor, community midwife and parents. If the discharge was more complicated, the team also liaised with the community paediatric team. The hospital did not offer an outreach service

Consent

- The trust had a consent policy that made explicit to staff the expectation that informed consent would be obtained prior to any intervention.
- The hospital used standard NHS consent forms and had different version for use in specific circumstances
- Parents, or those with parental responsibility, were involved and asked to sign consent prior to surgery where the child was younger than 16 years of age. Young people with capacity who had reached their 16th birthday signed their own consent forms.
- Children under the age of 16 years who were able to understand the implications, risks and benefits of the procedure could sign the consent form themselves if they refused to involve a parent, as they were deemed 'Gillick competent'. In practice this rarely happened as most children were accompanied by a parent of carer.
- Staff did seek verbal consent from both children and their parent prior to providing any care or treatment. We observed proper explanations being given by staff before any care was provided.
- We saw that consent was obtained and recorded in accordance with the published professional guidance.
- Consent was rechecked on the day of surgery before the child was taken to theatre and then again in the operating theatre by the anaesthetist.

Are services for children and young people caring?

Good

We rated caring as good because:

- We observed compassionate care from all staff who had interaction with both children and their families
- Families and children were complimentary about the caring nature of the staff when they attended the hospital
- Staff told us they had won an award for buying presents for a patient receiving palliative care.
- We heard an example and witnessed children of varying ages being cared for in an age appropriate way.

Compassionate care

Services for children and young people

- We were told staff on the Kipling ward had been given an award for buying presents and treats to make the birthday of a patient receiving palliative care special for them and their family.
- We spoke with seven parents and family members who were complimentary about how helpful the staff had been and how they had made a point of introducing themselves, were kind and that staff were approachable.
- Staff told us how they had used money from their tea and coffee fund to buy presents for children that had to stay in hospital over the Christmas period. The fund came from asking parents to make a voluntary donation 50 pence when they had a cup of tea or coffee.
- One parent told us that prior to admission, they had reservations about their child being treated at the hospital. They wanted to tell us that they had been very happy with the care that had been given and how the staff had all treated their child age appropriately.
- The trust's Friends and Family Test performance (% recommended) was generally better than the England average between September 2015 and August 2016. In the latest period, August 2016 trust performance was 96.8% compared to an England average of 95.2%.

Understanding and involvement of patients and those close to them

- Nursing staff told us that they believed the team were good at engaging children in their care and take the time to explain everything that was going on. We also heard staff took the time to speak with parents to provide any support they needed and also to seek their views. They discussed the plans for the care of the child and talked in depth about the child's condition(s)
- We were told by one parent that had attended the hospital on a number of occasions that sometimes communication was not good, particularly early in the morning as it was sometimes difficult to find the right staff to ask questions of.
- A parent told us they had been allowed to stay overnight with their child and had been offered a sandwich and hot drink at night. They also told us that they had been kept up to date at all times with what was happening and that their stay on the ward been a good experience.
- Another parent told how when they had attended A&E and were being triaged, they were given frequent updates as to what was going on, they spoke with their child at their level and how they couldn't fault the communication from the staff.
- Another parent told us how the care their child had received had been beyond their expectations. Staff in recovery had been attentive, kind and were willing to answer any questions they had and generally couldn't have done more. They also commented on how their child had been treated age appropriately.
- We saw staff giving explanations to both children and parents before providing care or treatment.
- A survey carried out for children's services had specific questions for children and the parents of children who visited the department. The information was not site specific so applies to both EDGH and the Conquest Hospital. Parents were asked four questions about their child's stay at the hospitals and asked to give a score out of 10. The average score for answers to these questions was 9.12 out of 10. Children aged 8-15 are also asked if they felt safe on the ward. The average score in response to this question was 9.39 out of 10.

Emotional support

- We saw posters across Kipling ward that gave details of local support groups for parents of children suffering with cancer
- There were notices around Kipling ward with contact details of the local police for those who wanted to report or needed advice regarding childhood sexual exploitation.
- The Kipling ward had regular visits from a group of musicians who could play music and / or sing with patients. It was the patient's choice if they wanted to listen or participate. Staff told us that this had been a great help to some patients.

Are services for children and young people responsive?

Requires improvement

We rated responsive as requires improvement because:

Services for children and young people

- Outpatient waiting times were excessive with 79 of 1106 patients waiting over 18 weeks for their appointment.
- The Kipling ward had been closed to new admissions on a total of 21 occasions in the year prior to the inspection
- There was no play specialist to lead and develop play services at the hospital. The outside play area was not able to be used due to the type of flooring. The equipment available had also been left for so long that it was not fit for use.
- There was no formal transition planning for children with complex needs approaching adulthood.
- There was no parents room that could be used to have private and / or difficult conversations

However:

- The parent's kitchen on the SCBU had recently been refurbished and provided parents with a clean and comfortable area to prepare and consume food and drink.
- Work in the SSPAU, along with the appointment of a consultant of the week had been effective in keeping children out of hospital or had allowed them to get back home quickly.

Service planning and delivery to meet the needs of local people

- The trust worked closely with commissioners, local authorities, and other partners to plan and deliver services that met the needs of their local population in conjunction with other care services. The Chair of the trust also chaired 'East Sussex Better Together' an initiative to bring together health and social care providers and commissioners to plan the most effective use of resources across the county.
- The Women and Children's Health directorate had a clear set of priorities for 2016/17. The priorities were set out and included ensuring the sustainability of community children's services by acquiring increased investment and continuing to be provider of choice.
- Among the performance targets was a commitment to improving access to a community paediatrician, where waiting times were long. There were no delays in the delivery of acute care.
- There were clearly stated objectives around the improvement of mandatory training uptake and staff recruitment.
- However, the main focus of the directorate strategy was on the maternity and gynaecology services which were rated 'inadequate' following our inspection visit in March 2015.
- Paediatric outpatients consisted of four consulting rooms where three clinics would run. Two of the clinics were general clinics and the other was a clinic run for children with developmental needs. There would typically be 10 patients per day for the general clinics and three for the developmental clinics.
- The trust operated its services for children and young people in both hospitals as one service. A number of staff work cross site and services are planned accordingly.
- The Board Assurance Framework (September 2016) showed that the trust was planning to meet the needs of children and young people with mental health needs. There was joint work with the local mental health trust to support an appropriate pathway for children and young people admitted in mental health crisis to acute children's and adult wards. An ED liaison nurse had been recruited to Conquest Hospital. The HoN had requested an 'impeach' programme and daily ward visit from a CAMHS specialist. This was on-going but the children's services had already established daily access to a liaison nurse.
- The ward had access to a CAMHS liaison link practitioner Monday-Friday between 9am and 5pm for advice and to arrange urgent CAMHS assessments for young people who had been admitted to the ward. Outside of these hours advice and arrangements for assessments was obtained through the out of hours CAMHS service (weekday 17:00-20:00 and 10:00- 18:00 Sat & Sun).
- At all other times a CAMHS Consultant could be contacted via switchboard for a telephone consultation.
- Young people were admitted to the unit awaiting assessment by CAMHS following a risk assessment carried out by A&E staff and the ward staff observe these

admissions following the guidance available through the special observations policy. Children aged 16 years and over remained in A&E until assessed by a member of the CAMHS team.

- At the time of the inspection discussions about creating a business case to move towards providing individualised care rooms on SCBU had started. Preparations had started to show the model of care that they would like to provide to meet the local demographic.
- The SCBU parent's kitchen had been refurbished in March 2016, funded with money from the charity, BLISS. This meant that parents could prepare and consume meals and drinks on site in a comfortable environment

Access and flow

- The Short Stay Paediatric Assessment Unit (SSPAU) at the Conquest Hospital is open for admissions from 7am to 7pm. The unit would then close at 9:30pm as the patient would then need to be discharged or admitted.
- The SSPAU had developed a service where a patient's GP could phone through to notify them of a child's attendance. This patient would then be taken on by the consultant of the week
- Paediatric outpatients consisted of four consulting rooms where three clinics would run.
- In the month prior to the inspection there were 584 patient attendances in outpatients across the trust. However, in the same period, 190 patients did not attend their appointment. This represented approximately 18% of all appointments.
- It was acknowledged by senior operational staff that outpatient waiting times were too long. At the time of the inspection there were 1106 patients waiting for an appointment. The waits varied with 360 patients waiting less than three weeks but 79 had waited over 18 weeks. Ten of these had been waiting between 27 and 51 weeks.
- The booking process for outpatient's appointments was on the trust's risk register. The trust were considering overbooking clinics due to the high rate of non-attendance although at the time of the inspection, this hadn't happened.
- Data was collated on patients that did not attend their appointments. The policy on patients that did not attend stated that they would only be offered one more appointment, if they failed to attend that, then they would be referred back to their GP.
- Kipling ward kept a book to record patients who had open access to the SSPAU or the ward itself. This included 14 oncology patients and four patients with cystic fibrosis. Patients with diabetes also had open access.
- Patients that had been assessed at EDGH and needed to be admitted to the Kipling ward would be transferred by emergency ambulance.
- For elective surgery the patients will come for pre-assessment where they will go through topics such as allergies and weight and will also discuss the fasting policy.
- There were 12 level one neonatal cots in the Special Care Baby Unit (SCBU)
- We spoke with a range of staff on Kipling ward and the SSPAU. All spoke of the how effective the short stay assessment units are in getting patients in, assessed, treated and back home where possible.
- A parent described to us how they had brought their child to the walk in centre, then on to A&E where they saw the triage nurse. They explained that they were geared up to deal with small children, were well informed and were able to transfer their child straight to the ward.
- CAMHS patients that are medically fit were not admitted without consultant approval. When the CAMHS patient went to the ward a full risk assessment would be completed by the nursing staff.
- We were told by senior staff that there were no escalation or bed management problems in children's services. In the event of a 'surge' of very sick children the trust would transfer to another children's hospital nearby. However, at the time of our inspection Kipling Ward had to be closed at 9pm as there were no beds available. This resulted in an eight month old child having to be transferred from accident and emergency to another NHS hospital at 2am. The ward was able to re-open early the following morning.

Services for children and young people

- In the year October 2015 to September 2016, Kipling Ward had to close to patients admissions on 21 occasions. All closures were for less than 12 hours. 11 of the closures related to their not being sufficient beds to admit patients. The other 10 closures were due to nursing levels or the acuity levels of the patients already admitted.
- The children's service manager created a report for all patients that had been waiting for over 40 weeks for an outpatient's appointment. This report would then be reviewed by a consultant to assess the risk of harm from the delay.
- We were told how the outpatient department had introduced a text alert system for patients to say that they were expected to attend along with an explanation of what failure to attend would cost the NHS. This had not been received well by parents and the feedback was that they believed they would be charged this amount if they failed to attend.

Meeting people's individual needs

- Getting it right - The National Service Framework for Children (2003) states that "Children visiting or staying in hospital have a basic need for play and recreation that should be met routinely in all hospital departments providing a service to children. This applies equally to the siblings of patients, and so is also a consideration for neonatal units. It has been recommended that all children staying in hospital have daily access to a play specialist. The use of play techniques should be encouraged across the multidisciplinary team caring for children, including in A&E, with play specialists taking a lead in modelling techniques that other staff can then adopt."
- The hospital did not have a play therapist or play specialist
- There was no formalised transition pathway to adult services for the children who remained under the care of paediatric services until their 19th birthday. Children with long-term conditions such as CF, Diabetes & Epilepsy were transitioned by their Community Specialist Nurse who worked with staff in the acute services and local authority to co-ordinate the transfer.
- Outside the playroom was a play area with some pieces of equipment for children to play on. However, these were no longer in use and had become very dirty and unusable due to the inappropriate flooring in the area.
- There were two parents' rooms on the SCBU that were used by parents in the period preceding discharge. These rooms were private areas where the parents would have time to spend with their baby to bond and learn to feed.
- The ward allowed parents to remain with their child 24 hrs a day (generally one parent overnight but if necessary two parents or occasionally a sibling could be accommodated overnight).There were no separate sleeping facilities but parents were offered a fold-away bed beside their child.
- There were no separate bathroom or toilet facilities but parents had unrestricted access to the ward bathroom and toilets.
- Staff told us that while they did have provision for parents to stay overnight, they had limited beds due to the difficulties storing them on the ward
- Parents were able to make themselves breakfast (cereal / toast) and obtain hot drinks throughout the day from the ward kitchen.
- The hospital did not routinely provide main meals to parents (with the exception of breast-feeding mothers). They could, however, access the hospital restaurant or coffee shop which also sold sandwiches etc. The coffee shop visited the wards with a trolley of sandwiches, crisps and cakes that parents could purchase once a day Monday-Friday.
- Kipling ward had no designated parent area other than a small room where parents could wait with their children. Difficult conversations with parents were held either in the seminar room or in matron's office. Discussions with Child and Adolescent Mental health Services (CAMHS) would also have to take place in the seminar room or matron's office.
- Medical staff explained how they believed they needed more input from the CAMHS team to assist with the care of patients on Kipling ward. Consequently they did not believe that children and adolescents with mental health problems were being appropriately cared for.

Services for children and young people

- At the time of the inspection the Kipling ward had Child and Adolescent Mental Health Services (CAMHS) for its topic of the month. Topic of the month was an initiative introduced to give staff a focus of a particular subject.
- A new phototherapy unit in the SCBU was available to improve the quality of care provided for babies being treated for jaundice and their families. This allowed a baby to be held or fed while continuing to receive phototherapy treatment. This promoted tactile interaction and enhanced parent – infant attachment as the baby could be fed or held without compromising the amount of phototherapy being delivered.
- Staff had access to interpreters that could be brought into the hospital to provide their service. They also had access to telephone interpreters, as well as the equipment to have three way conversations to avoid the need to keep handing telephones around. This meant that the staff, parents and patients would be able to engage in conversation.
- Staff on Kipling ward used Makaton, communication with patients when necessary.
- The parents of a child who required a pureed diet explained how the kitchen was always able to provide suitable food with a range of options.
- Kipling ward offered children and parents some basic toiletries including toothpaste and soap.
- The Kipling ward had recently taken delivery of a water cooler for patients and parents to use.
- Kipling ward had a number of games consoles available for children to use as well as a range of DVDs.
- One member of staff told us how their previous experience of end of life care had been used and they had introduced an advanced care plan tool. This included understanding the family's wishes about where they want to be in the event of their child becoming very unwell.
- The Kipling ward were able to makes some provision for those patients with sensory loss. This included fibre optic lights, DVDs and calming music.
- The trust published a wide range of information on its website both for patients and parents visiting the hospital. The trust also signpost patients and parents to the Patient Advisory Liaison Service (PALS).
- Information regarding the hospital's performance was displayed prominently in the ward areas. This included NHS Safety thermometer information as well as performance in relation to cleanliness.
- Information providing advice to parents regarding their child's condition was also available from the ward.

Learning from complaints and concerns

- The trust has devised a complaint satisfaction survey which was implemented from September 2016. It is sent to all complainants (with the exception of bereavement cases) four weeks from the date of the Trust's response to their complaint. The results will then be analysed on a monthly basis and included within the Patient Experience reports. In addition the trust has worked closely with Healthwatch East Sussex to review the complaints process. As part of the weekly and monthly monitoring the Trust monitors the number of internal re-opened complaints and those upheld or partially upheld by the Parliamentary and Health Service Ombudsman.

Are services for children and young people well-led?

Good

We rated well-led as good because:

- The SCBU was, at the time of the inspection looking to get family friendly accreditation from the charity BLISS. The Bliss Family Friendly Accreditation Scheme (BFFAS) recognises and rewards neonatal units across the country caring for premature and sick babies, where they deliver consistent high quality family-centred care.
- The matron on Kipling ward was able to complete audits on a hand held tablet. This tablet was also available for those wanting to complete a friends and family test.
- New staff reported how they had felt supported when they started, how they had had an induction to the ward as well as role specific training.
- Safety huddles, which started at Eastbourne SSPAU and on the SCBU were introduced on the Kipling ward in August 2016

- We heard how the culture across the ward was supportive, praising and caring which promoted close working relationships across the teams.
- There was a board level children's lead.

However:

Some staff felt that there needed to be more done to promote an open culture with regards to incident reporting.

Vision and strategy for this service

- The vision for the service reflects the vision for the trust as a whole. They want to be the provider an employer of choice for patients and staff.
- Safe patient care was the trust's highest priority. They aimed to provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
- There was a published strategy for the Women and Children's Health Directorate with clear priorities and measurable performance indicators.

Governance, risk management and quality measurement

- Services for children and young people were headed by a Clinical Unit Lead. Below the Clinical Unit Lead was a General Manager, a Head of Nursing and Heads of Service and Service Managers.
- The trust Risk and Quality Delivery Strategy made explicit that all members of staff had an individual responsibility for the management of risk and quality and that they should be aware of and comply with the trust's Risk Management Policy and Procedure. This included taking personal responsibility for maintaining a safe environment and complying with the Incident Reporting and Management Policy by reporting all types of incidents and near misses through the appropriate processes.
- All levels of management were required to understand and implement the trust strategy and comply with trust policies. They were tasked with ensuring that adequate resources are made available to provide safe systems of work.
- The Head of Governance was responsible for the central governance team which provided specialist support and advice on the implementation of the Risk Management. The central team ensured that there was support, advice and systems in place for incident management, risk management, clinical effectiveness, health and safety and patient experience.
- The Associate Director of Governance had overall responsibility to ensure the central governance team and functions were effective and supporting the Division to deliver their quality and risk responsibilities.
- The operational staff working at ward and department level reported data and risks such as complaints, incidents and local dashboards to the Divisional Governance meetings, risk meetings and speciality meeting.
- The Divisional leads reported to the executive team via the Integrated Performance reviews and Executive led meetings.
- Information from the Divisional Governance meetings was fed up to the committees that make up the Governance Framework through the executive directors reports and directly to the sub committees of the Board.
- We were provided with the paediatric risk register. Each risk was scored and given a red, amber or green rating (RAG). This register had identified the paediatric triage and outpatient clinic as the biggest area of risk. It was recognised that the referrals process for paediatric triage and on-going referral and ensuing appointments within the paediatric outpatient department was inefficient. This lead to duplication of work, delayed and unorganised appointments and inconsistent care.
- We saw evidence of monthly children's risk meetings, which were attended by a range of medical and nursing staff. These meetings covered topics such as incidents, root cause analysis into serious incidents and lessons learned and the risk register.
- We were also provided with minutes from the paediatric morbidity and mortality meetings. The minutes demonstrated that complex issues were tackled and learning from previous practice was happening. This meeting was attended by a range of medical and nursing staff.
- The service had three incidents where they had to follow their requirements under the duty of candour. All staff had received duty of candour training and were clear as

to what they needed to do. We saw an example of a letter that had been written to the parents of a child clearly explaining what had happened in a particular case. We also saw that this letter had been translated into another language to ensure the recipient could fully understand what had happened.

- Executive directors did Quality Walks where they visited different areas and spoke with staff and patients. We saw from Board meeting papers that the feedback from the Quality Walks was discussed and led to improvement action.

Leadership of service

- The service was led by and Interim General Manager and a Clinical Lead.
- The Head of Nursing reported to the General Manager. They line managed the matrons for all children's services across the trust including the children's wards, community services and children's outpatient services.
- The medical services were led by the Clinical lead for Women and Children's Services, who line managed both the paediatric specialist lead and the community paediatric lead.
- There was a Board level children's lead.
- There was a cross over between the acute children's services and the community services through the directorate management structure. This allowed for clear communication and improved transition arrangements for individual patients.
- Staff across a range of roles were enthusiastic about the changes that had occurred at the most senior levels in the trust. Managers reported how they felt they now had the support they needed to provide a better service to the patients.
- The majority of staff we spoke with reported good relationships with their immediate line managers.
- We were told by staff how members of the executive team and senior managers had been supportive to their colleagues when managing performance
- A few staff also felt that more could be done by managers to promote an open culture with regards to incident reporting.

Culture within the service

- Kipling ward had a board where staff could place post it notes about things that they had done to make them feel proud. We were told that these were collected monthly to enable senior staff to review and feed back to others positive information. However, when we checked the board, we found that some of the comments dated back to June and July 2016. This meant that the opportunity for positive messages to feed back to staff had been delayed and could have lost some of the impact it could have had.
- We heard from senior staff on SCBU who described how they felt supported by their own line manager and the senior staff across the trust.
- During the inspection we had the chance to speak to newer members of staff and discuss their experiences when they started. We were told that they felt supported and that they had had an initial induction to the ward as well as specific training relevant to their role.
- The culture amongst staff was described as caring and praising which promoted close working relationships across the teams.
- We spoke with a range of staff specifically about the duty of candour across the trust. Those staff we spoke with were aware of what duty of candour meant and had received appropriate training. We were also provided examples of when the hospital had complied with the duty of candour.

Public engagement

- The trust had engaged with large corporate firms to provide the children with Christmas presents. They received donations of colouring and reading books for the children. Local schools had also donated toys for the children to use. A local pub also gave the hospital chocolate eggs at Christmas.
- At the time of the inspection staff were actively looking at ways to get support for parents with the provision of some basic toiletries and clothes for those parents that were unable to get home to change their clothes. They had written to a number of large supermarket chains to see if they would be prepared to make any donations of essentials like underwear and clothes.

Staff engagement

- Staff told us how the practice educator had devised a new daily fluid balance / feed chart to be used across both the Conquest and EDGH hospitals. In doing this, they had involved all staff in the final design to ensure that it was fit for purpose. A copy of the new chart was provided to the inspection team.
- Housekeeping staff described how they felt part of the team and that there was a positive culture on the ward.
- Staff on the acute wards reported improvement in the organisational culture. They felt they could speak to the DoN directly, if they had serious concerns.
- The Board has a specific work stream that focussed on staff engagement and cultural improvement

Innovation, improvement and sustainability

- The SCBU was, at the time of the inspection working to get family friendly accreditation from BLISS. The Bliss Family Friendly Accreditation Scheme (BFFAS) recognises and rewards neonatal units across the country caring for premature and sick babies, where they deliver consistent high quality family-centred care. This is an approach which places parents at the centre of their baby's care. The Bliss Family Friendly Accreditation Scheme stems from the Bliss Baby Charter, a toolkit developed by Bliss, to help hospitals caring for premature and sick babies self-assess the quality of family-centred care they provide and identify areas for improvement.
- Staff told us how having a permanent ward clerk had made a huge improvement to the running of the ward. From greeting patients and their families on arrival at the ward, to doing their best to ensure notes are available for the staff that needed them
- Kipling ward had introduced a tablet computer to record friends and family tests scores. This tablet was also able to be used by the matron to complete their audits. The tablet could also be used by staff to look at patient details such as their care plan, drug charts, details of any allergies and details of consent.
- Safety huddles, which started at Eastbourne SSPAU and on the SCBU were introduced on the Kipling ward in August 2016

End of life care

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

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life, likely to die within the next 12 months and following death.

East Sussex Healthcare NHS Trust provides an end of life care service at the Conquest Hospital, Eastbourne District General Hospital and community services. The community services were not observed on this inspection because at the last inspection they were rated good.

Conquest Hospital had 876 in-hospital deaths between April 2015 and March 2016. During this period 346 referrals to the palliative care team were recorded. Of these 221 (64%) were cancer, 53 (15%) non-cancer and 72 (21%) did not have a diagnosis recorded.

The end of life care service provided by the trust is working under a new format since April 2016. The service consists of a medical director, end of life care team, specialist palliative care team, ward staff, chaplaincy, mortuary services and bereavement support.

The end of life care team is responsible for the governance of the service, including policies and strategy and works with the specialist palliative care team to provide end of life care education.

The specialist palliative care team delivers a service between 8.30am to 6pm Monday to Friday. Out of hours consultant telephone advice is available from the local hospice. The palliative team delivers services to all clinical areas and works cohesively with all areas involved in the care of patients who are on the end of life care plan.

At the Conquest location we visited a variety of wards across the hospital including wards: Tressell, Gardner, Baird, emergency department, acute admissions unit (AAU), clinical decisions unit (CDU), Wellington, Macdonald, Egerton and Newington. We also visited the mortuary, Patient Advice and Liaison (PALS) office, bereavement office, and hospital chapel and prayer room. We reviewed the medical records and drug charts of 15 patients at the end of life and 25 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records.

We spoke with 39 members of staff and observed the care provided by medical, nursing and support staff in the departments visited. We spoke with two patients receiving end of life care and seven of their relatives. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital and trust.

Following our inspection visit of September 2014, we rated end of life care services at the Conquest Hospital as 'Requires Improvement' overall with all domains except 'caring' (Safe, Effective, Responsive and Well led) also rated as requiring improvement.

Specific concerns identified included poor incident reporting and investigation systems with no ability to track incidents relating specifically to end of life care. There was also limited senior clinical oversight of complaints management and responses. We found the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms were poorly completed and that staff lacked an understanding of the trust policy and national guidance relating to DNACPR forms. There were no individualised care plans in use

although, at the time, they were being discussed. Patients approaching the end of their life were rarely able to be cared for in single rooms because of poor patient flow management and these patients not being identified as part of the bed management processes.

Summary of findings

Overall we rated the end of life care service at the Conquest Hospital as 'Requires Improvement'. This was because:

- The service did not have a programme of regular audits for end of life care.
- The trust provided formal training for some staff in end of life care. However, junior staff told us they were not confident at recognising an end of life care patient.
- The trust did not meet the requirements of the key performance indicators of the National Care of the Dying Audit (NCDAH) 2016.
- The trust had not implemented the standards set by the Department of Health and National Institute of Health and Care Excellence's (NICE) guidance.
- There were inconsistencies in the documentation in the recording of spiritual assessments, Mental Capacity Act assessments and recording of ceilings of care for patients with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form completed.
- Patients did not always have access to a specialist palliative support for care in the last days of life, as the trust did not have a service seven days a week
- We found the service did not have clarity in its leadership. It was disjointed without a clear line of objectives that the staff could understand or follow.
- There was no formal referral criterion for the specialist care team for staff to follow.
- The risk register for the service was insufficient and did not reflect the needs of the service.
- The trust did not collate service user's views with a patients or bereaved relatives' survey.

However:

- The specialist palliative care team were a dedicated team who worked with ward staff and other departments in the hospital to provide holistic care for patients with palliative and end of life care needs in line with national guidance.

End of life care

- Staff recognised that provision of high quality compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team and end of life care guidelines.
- Staff at the hospital provided focused, dignified and compassionate care for dying and deceased patients and their relatives. Most of the clinical areas in the hospital had an end of life care link staff member.
- Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.
- The hospital had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines.
- Areas we visited were visibly clean, tidy and fit for purpose. The environment was light, airy and comfortable.
- Medical records and care plans were completed, contained individualised end of life care plans and contained discussions with families. The DNACPR forms were all completed in accordance with national guidance and the trust policy.
- The hospital had sufficient supplies of appropriate syringe drivers and staff were trained in their use.
- Out of hours telephone support for palliative medicine was provided by the local hospice.
- A current end of life care policy was available and a steering group met regularly to ensure that a multidisciplinary approach was maintained.

Since the inspection visit in September 2014 there have been a number of improvements to the end of life care provided at the Conquest Hospital. There are still areas where further improvement is needed but greater consideration was being given to identifying and meeting the needs of this group of patients. Some significant changes to the safety of the service that were evident included much better understanding of the rationale for reporting incidents and a more robust investigation process. We saw evidence across the hospital that there was now a commitment to sharing learning when things went wrong. The trust now had a single type of syringe driver for use with patients.

Patients with an end of life care plan were now identified at bed meetings and there was a commitment from senior staff that these patients should be cared for in single rooms, without being moved around, whenever possible. We attended the bed meetings and saw this happened in practice.

Completion of DNACPRs was now good. The records showed that there had been discussion with the patients and/or their relatives. There was consultant review of any decision made by a more junior doctor regarding resuscitation. Work still needed to be done to support staff around 'ceiling of care' discussions but overall there were significant positive changes in practice relating to the identification of people approaching end of life, the use of DNACPRs.

End of life care

Are end of life care services safe?

Good

At our last inspection, we rated the service as requires improvement for safety. On this inspection, we have changed the rating to good because we have seen significant changes in key areas such as staffing levels, new facilities and the way incidents and safeguarding concerns were monitored.

- The trust provided us with the incidents relating to end of life care at the hospital with evidence of learning achieved and the resulting changes in practice that took place. The trust used an electronic incident reporting system. Staff gave us examples of how they reported incidents and the feedback they received. Staff informed us that they were encouraged to report incidents to enable learning as an organisation.
- There were robust systems and processes to ensure that a high standard of infection prevention and control were maintained throughout the hospital. Staff in all departments used appropriate hand hygiene techniques and complied with the trust's policies and guidance on the use of personal protective equipment.
- The hospital was using an appropriate syringe driver (a device which helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin). They were readily available across the hospital to support end of life care patients. Staff reported they did not have any problems with obtaining them when required.
- We reviewed 15 medical records and care plans relating to end of life care patients. We observed the appropriate prescribing of medication for patients who were end of life. The palliative care team documented changes in patient care needs and the management of their medications in the records.
- We saw the documentation used in the mortuary for recording patients details and the bereavement officers explained the systems to process death, burial and cremation certificates.
- The hospital had sufficient numbers of appropriately trained staff to provide safe care to patients. The majority of staff had completed the provider's mandatory training programme.
- Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

However

- There were inconsistencies in the documentation and recording ceilings of care for 'do not attempt cardio-pulmonary resuscitation' (DNACPR).

Incidents

- The trust did not report any never events between August 2015 and July 2016. Never events are serious incidents that are wholly preventable where guidance or safety recommendations that provide strong protective barriers are available at a national level, and which should be implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the end of life care directorate reported no serious incidents (SIs) which met the reporting criteria set by NHS England during August 2015 and July 2016.
- The trust had an incident report writing policy and used an electronic incident reporting system. Permanent nursing and medical staff, porters, mortuary and administrative staff gave us examples of how they reported incidents and they received feedback. We saw incidents were discussed at team meetings. Staff told us the trust encouraged them to report incidents to help the whole organisation learn.
- We saw 20 incidents relating to end of life care patients had been reported at Conquest Hospital between July 2015 and June 2016. Each incident had a description, action taken including investigation and date of closure. The incidents were graded for severity between one and four, with four as the highest. Twelve incidents were graded as one and eight incidents were graded as level two.
- Sixteen of the incidents were reported across the wards and one was reported in the pharmacy. There were five incidents reported about patient discharges and transfers and three incidents regarding admissions and referrals of end of life care patients. There were two incidents reported regarding medicines; the pharmacy

was delayed in providing medication and one ward experienced a faulty syringe driver. This meant end of life care patients may have been at risk of not receiving the appropriate medicines prescribed.

- Two incidents were reported regarding the mortuary. A member of staff had sustained a needle stick injury and the other incident related to a deceased patient not being labelled correctly regarding infectious diseases.
- Minutes seen of the terms of reference for the end of life care steering group showed clinical incidents were to be discussed in future meetings and actions identified.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The trust apologised and informed people of the actions they had taken.
- Staff said the dissemination of information was through electronic communications and their attendance at staff meetings. We also reviewed a sample of trust wide clinical incidents, patient's notes. We looked at the root cause analysis for the level four incident reported for an end of life care patient and saw evidence that staff had applied the duty of candour appropriately.

Cleanliness, infection control and hygiene

- We saw the hospital was visibly cleaner and less cluttered than at our last inspection. Scores for cleanliness audits against the National Specification for Cleanliness in the NHS showed high levels of compliance with audit scores of above 97% on all wards we visited.
- We saw ward and departmental staff who were caring for patients with an end of life care plan complying with the trust's policies and guidance on the use of personal protective equipment (PPE). We observed staff were bare below the elbow, sanitised their hands between patient contacts, and wore aprons and gloves when they delivered personal care to patients.
- We saw there was PPE available for use by all staff handling deceased patients in the mortuary. The trust had standard operating procedures for the management of a patient's body following their death with a suspected or confirmed infection. This had clear guidelines about the potential risk from body fluids and specific advice for all staff when transporting a body. We were told and saw staff were encouraged to incident report any situation where a known transmittable disease had not been communicated appropriately, and could have put them at risk.
- The National Specifications for Cleanliness in the NHS by the National Patients Safety Agency and the Human Tissue Authority (HTA) standards of practice relevant to mortuaries define the cleaning regimes required by mortuaries. The HTA premises, facilities and equipment standards PFE2 state: 'Environmental controls are to be in place to avoid contamination with documented cleaning and decontamination procedures and documented cleaning schedules and records of cleaning and decontamination'.
- We saw the mortuary at the hospital was audited by the HTA in December 2015 and June 2016. HTA regulates organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public. The HTA audit found the hospital was compliant in all areas except it highlighted there was a lack of documentation to show when cleaning of the mortuary had been performed.
- The cleaning of the post mortem room and other clinical areas was the responsibility of the mortuary staff. Since the HTA audit we saw cleaning schedules had been introduced. We saw the cleaning records for August and September 2016 which showed the areas were cleaned on the days a post mortem had taken place and all the appropriate areas performed.
- The trust had a decontamination and cleaning of the mortuary procedure for Conquest Hospital. The procedure was reviewed every two years. The procedure stated the cleaning of the changing rooms, post mortem viewing gallery, viewing room, bier (a moveable frame for transporting a coffin or corpse) room, relatives reception areas, housekeeping cupboard and internal corridors were to be cleaned three evenings a week by hotel services department.
- We observed that all areas of the mortuary, including the viewing area were visibly clean. However, staff told us that housekeeping services do not clean the non-clinical areas on a regular basis. We saw the cleaning schedules posted in the waste disposal cupboard were blank and not completed as per

guidelines. This meant there was no guarantee the non-clinical areas of the mortuary were cleaned as per national legislation. This was highlighted to the management of housekeeping services during the inspection. The manager provided assurances and we saw actions had been taken. We saw the audits and cleaning schedules for March 2016 to September 2016 and saw the target of 95% was achieved each month. Since our original conversation the mortuary had been deep cleaned and we were assured it would be cleaned three evenings a week as per the procedure.

Environment and equipment

- The trust used an appropriate syringe driver which fulfilled the safety guidance by the National Patient Safety Agency Rapid Response Report (2010). Syringe drivers (a device which helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin) were maintained and regulated by the equipment services and stored in the equipment library. Staff told us these were readily available.
- We saw there were no issues around securing the necessary equipment for end of life care patients, for example pressure relieving mattresses. End of life care patients requiring an air mattress received this promptly, to prevent the development of pressure sores.
- The HTA inspection audited the suitability of equipment, traceability of bodies and tissue traceability. The HTA found the mortuary to be suitable in accordance with the requirements of the legislations.
- We saw and were provided with the up to date servicing and maintenance records for all the equipment used in the mortuary.
- The mortuary was secured by closed circuit television and access was controlled by a key lock. Porters were provided with keys for the duration of their shift, which they returned to the porter's office at the end of each shift. Any external agencies requiring access to the mortuary out of hours had to go to the emergency department and provide identity documentation in order to obtain the key.
- All the fridges in the mortuary were alarmed with local and remote alarms. If an alarm was triggered out of hours the switchboard staff called the engineers to investigate.
- The mortuary used slide sheets to assist in the safe handling and transfer of bodies from trolleys to the fridge trays.

Medicines

- The trusts 'General guidance for symptom control and prescribing for adults' contained clear escalation guidelines for symptom management for patients at the end of their life. The guidelines were for prescribing anticipatory medication. The prescribing of anticipatory medication is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. Staff were encouraged to ensure end of life care patients were prescribed anticipatory medication whether the patient had symptoms or not. All the records we saw showed patients had been prescribed anticipatory medication and this was administered in a timely manner.
- The guidelines also advised on the appropriate use of a syringe driver, a portable battery operated device to help reduce symptoms by delivering a steady flow of injected medication continuously under the skin. It is useful way of delivering medication for an end of life care patient when they are unable to take medication orally. Guidelines directed staff to review the prescription daily as the doses may need to be altered if symptoms were not controlled or if multiple doses of anticipatory medication had been needed. Staff were encouraged to ask advice and guidance from the palliative team, pharmacy or hospice advice line. At the time of inspection no patients were receiving medication through a syringe driver.
- The trust had a drug dispensing chart which was to be completed by an authorised prescriber for the dispensing of medications for use in patients going home for end of life care. The chart clearly defined the drugs to be used for a syringe driver and anticipatory injections. This was to be completed with the 'drug instruction chart' for community instructions on drug titration.
- The hospital audited the ordering, documentation and availability of midazolam (a medication regularly given as a subcutaneous bolus injection to reduce agitation in the last hours or days of life). The audit assessed the hospitals compliance with National Patient Safety Agency (NPSA) recommendations and to establish any resulting impact on patient care. The audit identified the majority of patients with anticipatory midazolam

did not have a sufficient high strength ordered and available for use. As a result of the audit the trust changed local practice and highlighted this issue nationally to other trusts. Staff we spoke with confirmed the appropriate strength of midazolam was available for end of life care patients.

- The trust audited the accuracy and turnaround time of controlled drug prescribing for patients being discharged home with anticipatory medications in 2015. This allowed the trust to see the impact of the new dispensing chart used and compare this to old practice. The results of the audit showed a significant improvement with medication clinical errors reduced to 14%. However, the audit identified other issues to be resolved. Recommendations were for stock levels to reflect demand, segregation of certain medicines for end of life dispensing, document all dispensing errors and address trend appropriately, resolve associated template issue and continue to train junior doctors who joined the trust annually. The audit had an action plan which included the actions required, action by date, person responsible and comments and action status.

Records

- All patients care records were hand written and managed in line with trust policy.
- Patients receiving care from the specialist palliative care team had their documentation updated when reviewed. This gave information around changes in patient care needs and medicines management. Staff on the wards then implemented the changes required, such as applying a syringe driver or changing medication. We observed that the specialist palliative care team provided a holistic assessment on their first visit to a patient and subsequent visits were documented in the patient's medical notes.
- The trust had a guidance chart for the dying patient. This assisted healthcare professionals in assessing and managing physical symptoms in dying patients. Its aim was to support the provision of consistently high quality care tailored to dying patient's individual needs in the last few days or hours of their life. The chart gave clear guidelines for nursing staff to assess the patient every four hours and escalation prompts as required. Staff told us the chart was user friendly with helpful prompts.
- Across the wards we visited we reviewed 15 medical records and nursing notes. All records were completed appropriately, recording evidence of discussions with patient or family and assessment of individual symptoms. However, apart from one record, none of the records contained evidence of the patient being assessed for their psycho-spiritual care.
- Following the withdrawal of the Liverpool Care Pathway and the release of 'One Chance to Get it Right' 2014 by the National Leadership Alliance for the Care of the Dying Person (LACDP), the trust generated 'Key elements of care, last days/hours of life documentation'. The end of life care team had updated this and the 'Last days of life personalised care plan' was introduced in June 2016. This was to ensure patients who were identified as dying experienced transparent and open communication and compassionate care from all health care professionals. The plan was designed to move with the patient and the hospital kept a copy. The personalised care plan had recently been introduced by the trust and had not been widely initiated across the wards and we were told this was due to be piloted on James ward.
- Until the new documentation was widely implemented, staff continued to use key elements documentation. This was based on the five priorities for care of the dying person recommended by LACDP which focuses on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care wherever that may be. Of the 15 medical records we reviewed, six patients were recognised to be in the last days of life and were on the key elements of care documentation. We saw these were completed appropriately.
- On visiting the bereavement office we saw there were systems to process death, burial and cremation certificates. An officer showed us the process and explained what the role involved.
- The mortuary staff told us that effective systems were in place to log patients into the mortuary. They explained the process and showed us the ledger record book that contained the required information. We observed that the book was appropriately completed.
- While visiting ward areas we checked medical records and we viewed 25 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. However, the forms were inconsistent with recording the patients ceiling of care. Only two records had a ceiling of care recorded. This guides staff, who did not know the patient, to know the patient's previously expressed wishes and/or limitations to their treatment. This is best practice in hospitals to

provide continuity of care and good communication. Staff we spoke with, including management told us the recording of ceilings of care was poor across the hospital.

Safeguarding

- The trust had a safeguarding for adults and children policy 2016, to ensure that appropriate action was taken to protect all from any form of abuse. All staff undertook mandatory safeguarding awareness training. The policy contained contact information for staff in the event of suspected abuse.
- The specialist palliative care team were not compliant with the trust training target for safeguarding adults and children with only 75% of the team having completed the appropriate level of training.
- Trust wide the assistant director of nursing was executive lead for safeguarding. Adult safeguarding, including the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was managed by a separate manager.
- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable people and knew who the safeguarding lead was. The relevant local authority and social services numbers were available for staff.

Mandatory training

- There was a trust wide induction programme for permanent and temporary staff with the required mandatory and statutory training plan which involved classroom and e-learning. We saw the trust wide workforce induction pack for registered nurses and health care assistants. The induction pack did not mention palliative or end of life care. However, it did mention the guidelines for the use of the appropriate syringe driver.
- The chaplaincy and bereavement office teams told us they were involved in the induction programme. The chaplaincy team educated staff about spirituality/ religion/faith. The bereavement team taught about care after death and gave specific training for clinical staff regarding the appropriate packing of a patient's property to respect privacy and dignity and be in line with infection and property guidelines.
- The specialist palliative care team was trust wide and had achieved the target of 95% for most of mandatory and statutory training. Subjects included basic life support, conflict resolution DoLS, MCA, fire safety, and infection control and information governance. The subjects the team was not compliant in were equality and diversity (67%) and safeguarding adults and children (75%).
- Training for the use of syringe drivers was mandatory for permanent nursing staff and was provided by the medical device educators. The trust provided us with lists of names of staff across all departments, trust wide, who had attended the course between April 2014 and August 2016. We saw 524 staff had completed this between April 2014 and August 2016. We saw the training records of registered staff on Baird and Wellington wards who had completed the training.
- We saw the completed induction forms for housekeeping and portering staff, including agency, which was specific to their role and responsibilities. Staff had annual refresher training which was entered onto a database register and we saw this was monitored by managers.
- Guidance from Hospice United Kingdom for staff responsible for care after death clearly states education and training on all aspects of care after death should be included in induction and mandatory training programmes. For porters this should include safe handling and transfer and preparation for transferring of the body. We saw the records which indicated this training was part of the induction process and annual training for porters, except agency staff.
- The chaplaincy, patient affairs and bereavement officers provided evidence that they were up to date with their mandatory training.

Assessing and responding to patient risk

- The clinical needs of patients were monitored through regular nursing, medical and therapy reviews. Guidance from NICE CG50 Acutely Ill Patients in Hospital, recommends the use of an early warning scoring system to identify patients whose condition may be deteriorating. The hospital used the National Early Warning System (NEWS) and we saw this was routinely used for inpatients where appropriate.
- The trust had introduced an electronic observation recording system which allowed discussions around the management of deteriorating patients to take place at an early stage. We were told between April 2015 and September 2016 the percentage of observations which resulted in additional scrutiny and support had

improved from 77% to 91%. This data referred to all patients across the trust and specifically to end of life care patients. Observations resulting in a NEWS score of five or more triggered a review by the critical care outreach (CCO) team. This also resulted in the completion of a sepsis screen.

- The active involvement of the CCO team supported conversations with patients and their families about ceilings of care and the futility of active treatment. We were told the recognition of dying patients had improved and this had allowed for care to be provided in a more appropriate environment. However, staff on the wards told us the electronic observation recording system was not revised regularly to enable them to receive updated information and identify end of life care patients appropriately.
- The practice development nurse explained to us they printed a list of end of life care patients on a daily basis from the electronic observation recording system. This was only for patients who were no longer having regular observations (for example, blood pressure and temperature) documented. They recognised this list might not have been accurate, updated in a timely manner and a true measure of recognising an end of life care patient.

End of life care staffing

- Staff relevant to end of life care included a trust wide executive, a clinical lead for end of life care, a lead cancer manager, and a Macmillan lead cancer nurse. Staff specific to Conquest Hospital included one full time practice development nurse and the specialist palliative care team. The team was made up of one palliative care consultant, who worked one clinical session a week and 2.6 whole time equivalent (WTE) clinical nurse specialists. The specialist palliative care team did not have administration support.
- The chaplaincy team had one WTE chaplain who was supported by a large team of ward based volunteers from a variety of faith traditions and on call representatives of a variety of faith and belief groups from the immediate area.
- The bereavement office was staffed by two WTE officers, one WTE administrator and led by one WTE trust wide manager.
- The Patient Advice and Liaison (PALS) office was staffed by two officers. Both staff worked all day Monday to Thursday and a member of the team worked on their own on a Friday.
- There were two WTE members of staff employed in the mortuary. There were no arrangements for covering annual leave or sickness. This was organised and covered by the mortuary staff.
- During our inspection, we asked ward managers about their staffing levels and whether they felt there was adequate staff on the wards when caring for patients on an end of life care plan. A few ward managers we spoke with raised concerns with the level of staffing.

Major incident awareness and training

- The hospital had a major incident plan (2016) which set out a framework for ensuring that the trust had appropriate emergency arrangements which were in line with the Civil Contingencies Act 2004 statutory duties. Staff were able to explain to us this was accessible on the internal computer system.
- Mortuary staff were aware of the major incident plan. The Mortuary had sufficient storage space and one overflow temporary fridge that contained 10 spaces in the event of a major incident.

Are end of life care services effective?

Requires improvement

At our last inspection, we rated the service as requires improvement for effective. On this inspection, we have kept the rating as requires improvement because:

- The trust did not meet the requirements of the key performance indicators of the National Care of the Dying Audit (NCDAH) 2014. They did not have access to specialist palliative support, for care in last days and hours of life, as they did not have a service seven days a week. Also they did not have a formal feedback process regarding capturing bereaved relative's views of delivery of care.
- The results of the NCDAH (2016) benchmarked East Sussex Healthcare NHS Trust against other national

hospital trusts The trust performed worse than the England average for three of the five clinical indicators and the trust only provided two of the eight organisational indicators of the NCDAH.

- The trust had implemented only five of the 16 standards as set by the National End of Life Care Strategy 2008 published by the Department of Health, NICE End of Life Quality Standard for Adults (QS13) and 'One chance to Get it Right' 2014 by the National Leadership Alliance for the Care of the Dying Person.
- The service did not have a programme of regular audits for end of life care. The end of life care lead confirmed that a robust audit programme was not in place.
- The trust provided formal training for some staff in end of life care. However, junior staff told us they were not confident at recognising an end of life care patient.
- Patients did not have access to a specialist palliative support, for care in the last days of life in all cases, as they did not have a service seven days a week
- Staff voiced their concerns as they were confused about the difference between the end of life care team and the specialist palliative care team. They were unsure of each team's specific roles and who to refer patients to. Staff on the wards were unclear who to contact for advice out of hours.
- There were inconsistencies in the documentation in the recording of Mental Capacity Act (MCA) assessments.
- Staff had a limited understanding of Deprivation of Liberty of safeguards (DoLS), its rationale and process.

However:

- Alternative end of life care guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway. The trust generated 'key elements of care, last days/hours of life documentation'. The end of life care team had updated this and the 'last days of life personalised care plan' was introduced in June 2016. Patients on the care plan were prescribed appropriate medication by medical staff.
- Patients' pain, nutrition and hydration needs were monitored in accordance with national guidelines. The palliative care team supported and provided evidence-based advice to health and social care professionals from other wards and departments.
- The chapel and prayer room were accessible 24 hours 365 days of the year. The chaplaincy team provided a 24 hour on call service for all faiths via the switchboard.
- Out of hours telephone support for palliative medicine provided by the local hospice.
- The DNACPR forms were completed for appropriate patients.

Evidence-based care and treatment

- The National End of Life Care Strategy 2008 published by the Department of Health, sets out the key stages for end of life care, applicable to adults diagnosed with a life limiting condition. National Institute for Health and Care Excellence's (NICE) End of Life Care Quality Standard for Adults (QS13) sets out what end of life care should look like for adults diagnosed with a life limiting condition. The 16 quality standards define best practice within this topic area.
- Five of the standards had been achieved with the provision of a specialist palliative care team, an operational policy, after death care, timely verification and certification of death and emotional and spiritual support to those affected. The trust was working towards being compliant with the remaining standards. There was a trust wide end of life care strategy 2016-2019, action plan and progress tracker which incorporated all standards.
- The trust had responded to the withdrawal of the Liverpool Care Pathway (LCP) and the publication of 'One Chance to Get it Right'. The trust generated 'Key elements of care, last days/hours of life documentation'. The end of life care team had updated this and the 'Last days of life personalised care plan' was introduced in June 2016. However, it was not in use but was due to be piloted.
- The trust's report for end of life quarter four, dated March 2016, stated end of life care audits were to be completed by August 2016. We saw only 50% had been achieved.
- We saw that some audits were being performed. The practice development nurse audited the records of end of life care patients on a monthly basis and this was started in June 2016. The records were for patients who were not having their observations (for example, blood

pressure and temperature) documented. The records were audited against a series of defined questions including recognition of dying and appropriate medications prescribed.

- However, we did not see a planned programme of regular audits for the end of life care service. The end of life care lead confirmed that a robust audit programme was not in place.
- We saw evidence across the wards we visited that the specialist palliative care team supported and provided evidence based advice when caring for patients reaching the end of life. Guidance and instruction was given regarding complex symptom control and individualised care of the patient.
- During our visits to the wards staff demonstrated how they were able to access national and local end of life care information on the hospital's computer system.

Pain relief

- Effective pain control was an integral part of the delivery of effective end of life care and was supported by the specialist palliative care team and the acute pain team.
- The trust had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). There were guidelines for prescribing using NICE guidance on opioids (a strong pain killer) for palliative care.
- The trusts 'general guidance for symptom control and prescribing for adults' supported the effective management of pain in the dying patient. Guidelines included prescribing anticipatory pain relief alongside guidance for other common symptoms.
- We reviewed 15 patients' medical records and drug charts and saw that patients had regular assessments for pain and appropriate medication was given frequently and as required.
- Staff told us that doctors were good at increasing medication for pain if required and anticipatory medication was always available.

Nutrition and hydration

- Risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a nutritional screen assessment tool which identified patients who were at risk of poor nutrition, dehydration and or those who experienced swallowing difficulties. It included actions to be taken following the nutrition assessment scoring and weight recording. The 15 care plans we observed across the wards contained the nutritional screening assessment and showed where patients had been referred to the dietician.
- The trusts 'general guidance for symptom control and prescribing for adults' had clear guidelines for the assessment of mouth care, hydration and nutrition. The end of life care records we observed showed that these were being completed and updated by staff.
- The personalised care plan included prompts to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- We saw staff on Newington ward assisting end of life care patients to eat in an appropriate and gentle manner.
- Staff provided good mouth care for end of life care patients; this was actioned in a timely manner and was documented.

Patient outcomes

- The trust did not meet the requirements of the key performance indicators of the National Care of the Dying Audit (NCDAH) 2014. They did not have access to specialist palliative support, for care in last days and hours of life, as they did not have a service seven days a week. In addition they did not have a formal feedback process regarding capturing bereaved relative's views of delivery of care.
- The trust told us that they were committed to continuing to embed best practice in care of the dying patient. This was to be achieved with a comprehensive education programme, modelling of a gold standard of care by senior clinicians, monitoring performance with an internal audit programme and benchmarking themselves against national standards by participating in the bi-annual NCDAH.
- The results of the NCDAH (2016) benchmarked East Sussex Healthcare NHS Trust against other national hospital trusts to encourage investment into changes to consolidate good achievements or to rectify weaknesses. The trust performed worse than the

England average for three of the five clinical indicators: recognition the patient would die imminently, this had been discussed with nominated person important to the patient and their needs asked. The trust scored better than national average for documented evidence the patient was given an opportunity to have concerns listened to and a holistic assessment of the patient needs regarding individual plan of care in the last 24 hours of life.

- The trust stated they had achieved two of the eight organisational indicators of the NCDAH. They sought bereaved relatives views and had a practice development nurse. The trust answered no to: trust board representation for end of life care; training which included communication skills for care in the last hours or days of life for medical staff,registered and non-registered staff and allied health professionals; access to specialist palliative care for at least 9am to 5pm seven days a week. Since the audit the trust had board representation.

Competent staff

- Most of the clinical areas in the hospital had at least one end of life care champion known as 'link staff'. The links were central to disseminating end of life care education and support to their local multidisciplinary team.
- The role of the link nurse had been reinstated by the trust in September 2016 and according to the end of life care lead, 40 members of staff trust wide had applied for the role. We spoke with the link persons on Wellington, James, AAU, Tressell and Gardner wards. However, the clinical decision unit (CDU) and Egerton wards were not aware of the link role.
- In line with the NICE end of life care quality standards (2011) and Ambitions for Palliative and End of Life Care (2015) the trust recognised the need for a workforce skilled to provide end of life care, care after death and for staff to have the ability to have honest and sensitive conversations with patients and their families.
- The National Care of the Dying Audit 2014 recommended that staff received mandatory training in the care of the dying. Information we received before the inspection showed us end of life care education consisted of study days, induction programme, e-learning, workshops for clinical staff and medical staff. End of life care education was provided by both the practice development nurse and specialist palliative care team based at Conquest Hospital.
- However, junior doctors and staff we spoke with on four of the 10 wards we visited (Baird, CDU, Egerton and AAU) told us they had not received any formal training in end of life care from the trust. Junior staff told us they were not confident at recognising an end of life care patient.
- We were told education for end of life care for all staff, except medical, was not mandatory. The trust had introduced a specific training programme in April 2016. The training was for a whole day and alternated each month between Conquest and Eastbourne Hospitals. The content of the course included, but was not limited to advance care planning, symptom control and verification of death. The trust had focused on staff who worked closely with patients and their families/ carers. At the time of inspection the trust told us 133 of staff had attended the training.
- Education in end of life care was included in the corporate induction for medical staff. Additionally foundation doctors attended a three hour session as part of their centralised teaching programme. All medical staff were required to complete a mandatory e-learning module on end of life care. We saw the records which indicated 161 trainees out of 168 (96%) had completed the module at the time of inspection.
- We saw the training and induction records for housekeeping staff. This included the relevant training for the cleaning of the non-clinical areas of the mortuary as per the trust's procedures.The relevant staff had all received training related to cleaning techniques in pathology. This incorporated the appropriate cleaning solutions approved by Health and Safety Executive guidelines to be used in the area.
- We were told the critical care outreach team offered all nursing staff, including agency staff, training in the use of the electronic observation system and the management of deteriorating patients. Staff were offered workshops and study days which included sepsis recognition, escalation processes for deteriorating patients and early

intervention. In some areas health care assistants had been appointed as observations champions. On one ward, the level of compliance with observation timings had improved by 5% in one week.

- We saw the annual report of the trust wide Schwartz rounds which were started in May 2015, and met on a monthly basis. Schwartz rounds provide a structured forum where all staff, clinical and non-clinical, meet together regularly to discuss the emotional and social aspects of working in healthcare. The rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend the rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. There had been 324 attendees at the meetings in the previous 12 months and feedback provided showed the rounds to have a positive effect. Staff we spoke with told us the rounds had been beneficial to their practice.
- The trust had an appraisal policy to ensure that all staff understood their objectives and how they fit with the departmental and hospital objectives and vision. Trust wide the appraisal rate for the specialist palliative care team registered nurses, April 2015 to March 2016, was 33%. The data showed between April 2016 to July 2016, 25% of staff had received an appraisal.
- Staff in the specialist palliative care team we spoke with confirmed they did not have regular one to one meetings with their management or had appraisals planned.
- All the staff we spoke with in other departments had received an annual appraisal. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with the NMC.

Multidisciplinary working

- The specialist palliative care team held weekly multidisciplinary meetings at the hospital on Thursdays with doctors, nurses, chaplaincy and members of the extended team. The meeting covered all aspects of patient's medical and palliative care needs. The outcomes of the meeting were recorded and shared with the extended team.
- The specialist palliative care team had formed close, and mutually helpful working relationships with the local hospice and other clinical teams in the hospital. For example, the acute pain team, bereavement officers, chaplaincy and the discharge team.
- Staff told us the hospital overall worked as an effective multidisciplinary team recognising when a patient was approaching the end of life. Medical staff told us that the specialist palliative care team were very supportive in assisting medical staff to have sensitive conversations with patients and their families regarding end of life care.
- Staff we spoke with across the hospital voiced their concerns as they were confused about the difference between the end of life care team and the specialist palliative care team. They were unsure of each team's specific roles and who to refer patients to.

Seven-day services

- The specialist palliative care team was not staffed or funded to provide a seven day week visiting service. The specialist palliative care team was available Monday to Friday 8.30am to 6pm, except bank holidays. Out of hours telephone advice was available from the local hospice.
- Staff we spoke with in four of the wards were unsure who to contact for advice for an end of life care patient out of hours.
- The acute oncology manager said the lack of end of life care education caused a lack of confidence in nurses and doctors. The oncology department received calls from wards requesting symptom management for end of life care patients.
- The hospital pharmacy dispensary provided a service Monday to Friday. The service was available in the mornings of Saturdays and bank holidays. There was a clinical pharmacy service which was ward based and was available Monday to Friday only.
- The chapel and Muslim prayer room were accessible 24 hours a day every day of the year. The chaplaincy team provided 24 hour on call service and were contactable via the switchboard.
- The mortuary was staffed 7am to 5pm Monday to Friday. Within these hours collections were possible and

viewing appointments were available to families. A member of the mortuary staff at Conquest Hospital was on call 4.30pm to 9.30pm Monday to Friday and 10am to 6pm Saturdays, Sundays and bank holidays. They were contacted via the switchboard. Out of hours access to the mortuary was obtained by contacting the emergency department and the site manager.

- The bereavement office was open Monday to Friday 8am to 5pm.
- The Patient Advice and Liaison (PALS) office was open Monday to Friday 9am to 3.30pm.

Access to information

- The trust's clinical intranet site was available for all staff. This intranet resource provided easily accessible and easy to read information for all aspects of end of life care. Staff showed us it contained information for care of the dying patient, guidelines and prescribing advice for palliative patients.
- The wards provided bereaved relatives with a trust wide information wallet specific to the hospital. This contained contact details for bereavement support, contact details, the process for collecting the death certificate and registering the death.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust's Policy and Procedures for the Management of Resuscitation 2016 incorporated the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) guidelines. Medical staff we spoke with understood the DNACPR decision making process and described decisions with patients and families. They told us they provided clear explanations to ensure that the decision making was understood.
- While visiting ward areas we checked medical records and we viewed 25 DNACPR forms. All the forms were kept in the front of the patients' notes; all decisions were recorded on a standard form and signed by a senior clinician. The rationale for DNACPR was documented with evidence of discussion with the patient and or their relative if appropriate.
- The trust had a Policy and Procedure for Consent, 2015. This set out the standards and procedures relating to consent that the trust expected staff to follow in order to comply with the law and best professional practice requirements. It included the Mental Capacity Act (MCA 2005) and Human Tissue Act 2004.
- The Guidance for Staff on the Implementation of Deprivation of Liberty Safeguards (DoLS) 2015, directed staff on the practice and procedures that should be followed when an individual who lacked mental capacity and may have to be temporarily or permanently deprived of their liberty in their best interests. This was to ensure that staff were at all time able to work within the parameters of the MCA. Training for MCA and DoLS was part of mandatory training for all clinical staff.
- Of the 25 DNACPR forms, nine were recorded as the patient not having capacity and were on a mental capacity care plan. However, none of these patients had a completed formal mental capacity assessment documented. Staff had a limited understanding of what constituted a formal mental capacity assessment and staff told us this was the responsibility of the social worker or doctor.
- Additionally, none of the records we saw showed evidence of a DoLS assessment. We spoke with staff about their understanding of the appropriate assessment and documentation for DoLS. Staff on Macdonald ward were not able to explain the process and had limited understanding of the rationale.
- The chaplaincy team provided a leaflet which explained its services, contact details and special events. Details were advertised on the chaplaincy notice boards and available on the hospital's web page.
- The end of life care team provided each ward with a resource folder known as a 'purple box'. The box contained bags for patient's valuables, general guidance for symptom control, free car parking for relatives, advance care planning information, and leaflets for coping with dying, the hospice and rapid discharge process. The box contained the contact numbers for the specialist palliative care team but did not specify the team's names. We saw the boxes on the wards we visited (Baird, Wellington, Gardner, Tressell, Egerton and Macdonald).

End of life care

Are end of life care services caring?

Good

At our last inspection, we rated the service as good for caring. On this inspection, we have kept the rating as good because:

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life. We were told about and shown evidence of collaborative working across the teams to provide exceptional care for end of life care patients.
- On the wards we visited we observed compassionate and caring staff that provided dignified care to patients who were at the end of their lives. We spoke with patients and relatives who were complimentary about the care they had received.
- Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support and patience from staff.
- Emotional support was provided by the hospital. Staff knew who to signpost relatives to for bereavement care. There was an on call service with access to chaplaincy staff and other multi faith leaders who supported families in times of loss and grief.

Compassionate care

- Staff on all wards we visited said end of life care was a vital part of their role and they enjoyed the relationships they formed with patients and their relatives. During our inspection we observed end of life care that was sensitive, dignified and caring by all staff.
- Staff on James ward told us they were proud of delivering individualised care for end of life care patients. They provided us with two examples of this. They had organising a wedding for a patient on the ward supplying flowers, bunting and decorating the garden for the service. The other example was of a husband and wife who were patients on the ward at same time. Staff encouraged and supported their family to care for them both.
- Staff on the wards told us that the specialist palliative care team were helpful and responsive. Consultants were good at talking to end of life care patients and their relatives. They were honest and work well with the ward team.
- Staff in the mortuary showed us their individual folders which contained cards and emails from bereaved families and departments thanking them for the professional service received. Comments included: “You have gone above and beyond” and “Professional care you provided”.
- The chaplaincy team gave us examples of compassionate care provided for end of life care patients. In the event that a patient wished to marry their partner the chaplaincy team contacted the local registrar to conduct the ceremony and the chaplaincy team performed a blessing if required. We were told of an example where this happened recently. The ceremony had taken place on the same day that the dying patient had decided they wished the ceremony to take place.
- The bereavement officers told us that if a patient who had died did not have any next of kin the hospital would arrange the funeral with the assistance of the chaplaincy team. They provided us with examples of this.
- We saw 12 examples of cards and thank you letters displayed in the PALs office. Comments included: “Your intervention much appreciated” and “Big thank you for listening to me”.
- We were told the trust did not have a specific bereavement survey. However, since May 2016 the bereavement office collated feedback from bereaved relatives when they visited their office. We saw comments noted were generally concerning excellent nursing care of the deceased and compassion and consideration of relatives while on the wards. Conquest Hospital received 33 comments in May 2016 and one of these was negative. In June 2016, 14 comments were received and one was negative. Negative comments received across the trust concerned lack of communication on the wards, loss of deceased property and inappropriate transfer of patients who were dying.

End of life care

- The bereavement officers asked those making the comments if this information, positive and negative could be passed to the ward's matron to be disseminated to staff.
- The hospital measured national survey information, for example the Friends and Family test (FTT), and used all patient feedback to guide investment plans, treatments offered and the overall patient experience. The FFT scores for the medical wards we visited were 100%.

Understanding and involvement of patients and those close to them

- We spoke with two patients and seven of their relatives. They told us staff providing end of life care were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and that their questions were answered in a way they could understand.
- We observed staff introducing themselves to patients and their relatives.
- Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with mouth care and personal care.

Emotional support

- Staff provided emotional support for end of life care patients. We observed occasions when this occurred on the wards.
- Bereavement support was not specifically provided by the hospital. Relatives were signposted to the relevant agencies that could support them. A relative told us they had been provided with information on who to contact if they required emotional support.
- All GPs were informed within one working day of a patient's death so they could provide appropriate community centred bereavement support if required.
- The chaplaincy team were involved in supporting families in times of loss and grief. Relatives of end of life care patients told us that they had been offered chaplaincy support and a member of the team had visited them promptly.

Are end of life care services responsive?

Good

At our last inspection, we rated the service as requires improvement for responsive. On this inspection, we have changed the rating to good because we have seen significant changes in key areas such as the bed management arrangements had been revised for end of life care patients. Movement of these patients was restricted and made only when all other possibilities had been considered.

- The specialist palliative care team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive to patients, relatives and other members of the multidisciplinary team. This was demonstrated with their specialised advice and knowledge.
- The specialist palliative care team responded promptly to referrals to assess the patient and plan care.
- The hospital had facilities for relatives and we found staff supported relatives to stay with end of life care patients. Patients and their families were offered side rooms dependant on availability and suitability.
- The wards provided an information pack for bereaved relatives which advised them about collecting the death certificate from the bereavement office. The pack contained the contact details for contacting the mortuary for a viewing if required.
- The mortuary viewing area was visibly clean and welcoming for relatives.
- The chapel accommodated all faiths as well as no faith. Staff respected the cultural, religious and spiritual needs of patients.
- The trust had worked collaboratively with the local hospice to provide a rapid discharge service for local patients.
- There were a variety of mechanisms to provide psychological support to patients and their supporters. This range of service meant that each patient could access a service that was relevant to their particular needs.

End of life care

- There were systems to ensure that patient complaints and other feedback was investigated, reviewed and appropriate changes made to improve treatment care and the experience of patients and their supporters.

However:

- There was no formal referral criterion for the specialist care team for staff to follow.

Service planning and delivery to meet the needs of local people

- During the inspection we observed that the specialist palliative care team was involved in all clinical areas of the hospital. Staff on the wards told us that the team was professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals.
- The trust told us 73% of patients were seen within 24 hours of a referral to the palliative care team.
- There was no clear referral criterion for the specialist palliative care team. Staff told us they were confused who to refer an end of life care patient to, the end of life care team or the specialist palliative care team.
- The specialist palliative care team at Conquest Hospital told us they receive between five and 12 referrals every day.
- We saw during the reporting period April 2015 to March 2016, 346 referrals had been recorded by the palliative care team. Of this figure 221 (64%) had a diagnosis of cancer, 53 (15%) were non-cancer and 72 (21%) did not have a diagnosis recorded. We were told between December 2015 and April 2016 only one part time palliative clinical nurse specialist was working at the hospital. The provider acknowledged that during this period referrals may not have been recorded on the computer system.
- The trust collected data of patients who were end of life care and had achieved their preferred place of death. We saw the data referred to the trust wide locations and were not split into individual sites. Between September 2015 and August 2016, there were 1131 patients and 323 of these records were incomplete. The remaining 808 records showed 81% patients were discharged to their preferred place of death. The majority of these patients (67%) had a primary diagnosis of cancer, 10% were non-cancer and 23% a primary diagnosis was not recorded.
- We saw the chaplaincy team had access to the computer system which allowed them to identify on a daily basis, patients and their families who might require additional input from the team in the last hours and days of life. The chaplaincy team did not record their visit on the patients individualised care plan. We were told this was being considered for the future.
- Conquest Hospital recorded the referrals received from the palliative care team to the chaplaincy team for end of life care patients. Between October 2015 and September 2016 there were 165 referrals recorded.
- We observed across all the wards that we visited that staff supported relatives to stay with end of life care patients. We were told and observed when a patient was recognised as in the dying phase all wards would offer patients and their family's side rooms dependant on availability and suitability.
- Relatives of end of life care patients were provided with free car parking, open visiting and encouraged to use the facilities on the wards. James ward had a relatives room and told us relatives could also use a flat in the nurse's accommodation.
- The emergency department had two relatives' rooms and recliner chairs which they shared with the acute admissions unit (AAU).
- The emergency department had four cubicles that could be used for dying patients that offered privacy and where the lights could be dimmed. They told us they preferred to not have dying patients in the emergency department and tried to transfer to AAU, but sometimes this was unavoidable.
- The mortuary had a viewing suite where families could visit their relatives. They were escorted by the bereavement officer who would stay with the relatives in the waiting area during the viewing for as long as they required.
- Guidance and support was offered after death from the bereavement office. Contact numbers were provided to relatives within a trust wide information wallet. The bereavement office advised relatives on the process

around the death of a patient. The office issued death, burial and cremation certificates. The staff in the bereavement office told us they were aware of whom to signpost relatives to if they required additional support.

- The PALS office was a spacious office located off the main corridor and contained a separate seating area to accommodate confidential and private conversations. The PALS officers told us they would visit patients on the wards if required.

Meeting people's individual needs

- The hospital had access to translation services for face to face and telephone interpreting. This could be booked through a centralised booking system.
- Patients living with learning disabilities or dementia were supported by the hospital. A blue butterfly flagging system on the notes identified the patients who required extra assistance.
- The hospital chapel was multi faith. The Muslim prayer room had separate washing facilities which met the needs of the local community. The chapel was a space for patients and families to have a quiet time.
- The chaplaincy service offered access to multi faith worship 24 hours a day. There was an on call service with access to chaplaincy staff and other multi faith leaders.
- The hospital ensured that the faith needs of the community were met. The chaplaincy team offered spiritual, religious or pastoral support to people of all faiths and beliefs, religious and non-religious. The chaplaincy team was assisted by a group of volunteer visitors. They were able to contact community faith leaders who represented the major world religions.
- The chaplaincy team had produced a leaflet relevant to the hospital for patients to explain their service. The leaflet listed the services available in the chapel, how to contact the team and was produced in a handy book mark design.
- The hospital provided facilities for patients with a very high body mass. We saw Wellington ward had two large single rooms with private bathrooms which were fitted with a tracking hoist. Each of the rooms was furnished with a bariatric (severely obese) bed, chair and mobile hoist.
- The officers in the bereavement office supported all bereaved families with the paperwork and processes for care after death. All doctors were supported and guided by the Medical Examiner (ME) in the completion of the medical certificate of cause of death certificate where appropriate. This enabled the certificate to be completed in a timely manner.
- The trust recognised the mortuary had restricted facilities and time available for viewing of a deceased person following bereavement. The facilities were not suitable for washing of the body or incense burning. Therefore viewings were usually held in the funeral directors premises after release. However, the staff told us this did happen occasionally and they could facilitate this. They were able to walk us through the process involved.
- Access to the mortuary viewing room was obtained through a private fenced off pleasant garden which was maintained by the mortuary staff. The viewing room had two seating areas. It was visibly clean and provided facilities for relatives such as seating, tissues and access to drinking water. The room was neutral without religious symbols which allowed the suite to accommodate all religions. The mortuary staff arranged fresh flowers in the areas.
- The mortuary had a storage area with 89 fridge spaces and spaces which could be converted into a freezer if required. The mortuary had a dedicated specific block of fridges for babies and pregnancy remains. We saw there was an additional temporary storage unit but we were told this was rarely used.
- There was accommodation space for bariatric patients in the mortuary. There was a specific area which could be transformed to accommodate a bariatric or multiple bodies while still respecting dignity and privacy.
- James ward had a garden area that was maintained by volunteers. Bereaved families were encouraged to visit the garden. We were told some returned regularly and left flowers as part of their grieving process.
- The trust had an advance care plan which supported a patient to develop their wishes and preferences.

Access and flow

- The hospital had a twice daily bed meeting which looked at immediate concerns in the emergency

department and predicted bed needs. We were told that the site managers were aware which patients had been identified as end of life care and those living with dementia and these patients were protected from moves.

- All patients on an end of life care plan were discharged from hospital with anticipatory medication which ensured that streamlined care was maintained.
- The trust had worked collaboratively with the local hospice to provide a rapid discharge service for patients who were registered with a GP within Hastings and Rother areas. The service began in May 2016 and assisted health professionals with patients, who required end of life care, who had been admitted to the emergency department, medical/ surgical and acute assessment units in Conquest Hospital. If the patient was deemed to be in the last few weeks or days of life the hospice team would assess the patient within 60 minutes. If it was the patient and family's wish they would facilitate a discharge home before a decision was made to admit to the hospital.
- A representative from the rapid discharge service and the end of life care practice development nurse visited the departments weekly to promote the service. We were told the service had managed to get one patient home to die since the service had started and on the day of inspection, there were no appropriate patients requiring the service.
- The hospital had one discharge nurse who told us they did not have time to complete the fast track continuing healthcare paperwork. We were told there were delays in successfully enabling patients to be discharged to their preferred place of death due to lack of care agency staff.
- The GP's within the trust catchment area had an identified Gold Standards Framework Local Enhanced Service where patients were identified as being in the last 12 months of life. On admission to the trust this information was available and could be accessed via the computer system. We were told all staff in the emergency department had access to this information. Once admitted to the wards the computer system used to identify patients who were in the last days and or hours of life so adequate resources and expertise could be targeted to those areas to support care delivery. However, the use of this had not been audited or evaluated at the time of inspection.
- The chaplaincy team saw all newly admitted patients within 48 hours of admission to hospital regardless of diagnosis. The nature and purpose of the chaplaincy service was explained and patients were advised the service was available for patients of all faiths (including no faith). Every attempt was made to ensure that patients felt at ease in discussing any particular issues and needs they may have, and the patients were asked if they would like regular visits.
- The trust had an emergency out of hour's viewings and access to the mortuary policy dated 2014. This gave clear guidelines and processes to follow for all staff to follow with directions specific to each hospital. It contained a decision making flowchart and an out of hours viewing checklist which was the responsibility of the site manager to complete.
- At the time of inspection, James ward staff told us there were delays in transferring patients to the local hospice. This had recently reopened after a fire accident. The ward told us they had good support from the hospice at home team and district nurses.
- The trust had a system in for discharge planning for a patient being discharged home with a syringe driver. The community teams returned the drivers once they had replaced it with their own.

Learning from complaints and concerns

- The trust recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure.
- Complaints could be made verbally or in writing directly to the organisation, via the website or by NHS Choices. Information on how to make a complaint was available in leaflet form or on the website. Staff were aware of how to direct patients who would like to raise a complaint or concern.

End of life care

- The chief executive was the executive lead for patient experience and complaints. This responsibility was delegated to the director of nursing during periods of absence. The medical director and director of nursing were responsible for the governance function including patient experience and reporting information on complaints to the trust board and meet with complainants as required.
- The Board and non-executive led Quality and Safety Committee received a patient experience report at each main board meeting. There was also an annual complaints report for the trust. Departments were responsible for monitoring their complaint actions and received information on complaints as part of the governance report that was reviewed on a monthly or alternate month basis depending on the department.
- The chief executive received copies of all complaints relating to clinical treatment and care. These were discussed at monthly meetings with the head of patient experience, PALS and complaints to discuss actions arising, themes and learning.
- The patient experience lead was responsible for managing the complaints function. The complaints and PALS manager was responsible for the day to day running of the complaints team. They also collated the outcome of the investigation from the relevant clinical unit to then draft the response for the chief executive to review.
- The trust's complaints policy set out the relevant timeframes associated with the various parts of the complaint response process. A full response was required within 30 working days or 45 days for a complex complaint. We were told the trust had responded to 47% of complaints within the required timeframe for July 2016.
- If a complaint was escalated to a further stage the complainant was given the information of who to take the complaint to if they remained unhappy with the outcome, for example the NHS Ombudsman.
- We saw complaints were to be discussed as part of the terms of reference by the end of life care steering group. However, in the minutes of the two meetings we saw there was no evidence of complaints being discussed.
- The trust had received several complaints regarding end of life care at Conquest Hospital. Two of these had also been shared directly with CQC. The Director of Nursing had been personally involved in overseeing the response to the complainants and had arranged meetings with the relatives to try and seek resolution. We looked at a sample of 15 complaints relating to end of life care received by the hospital between August 2015 and July 2016. All the complaints referred to the lack of compassionate care received for patients by medical and clinical staff on the wards.

Are end of life care services well-led?

Requires improvement

At our last inspection, we rated the service as requires improvement for well-led. On this inspection, we have kept the rating as requires improvement because:

- We found the service did not have clarity in its leadership. It was disjointed without a clear line of objectives that the staff could understand or follow. The end of life care team was not working in partnership with the specialist palliative care team.
- The service had an ineffective governance structure. They did not have a clear audit plan and the risk register for the service was insufficient and did not reflect the needs of the service. Entries identified on the register as 'high risk' had no planned actions or timeframes recorded. This may suggest an ineffective approach and poor oversight of risk management in the end of life care service.
- Out of 43 actions findings of the previous CQC inspection relating to end of life care, the trust had only completed seven actions at the time of this inspection.
- An improvement tracker for the service was started in April 2016 and had 20 issues listed. At the time of inspection none of these had been completed.
- Staff we spoke with on the wards were confused about the change in the service. They were not aware of, or the role of the end of life care team.
- The leadership of the end of life care service recognised that they needed to identify the dying patient earlier and keep end of life care as the focus.

End of life care

- The service had reinstated the trust wide steering group in July 2016. However, representatives from chaplaincy, bereavement, pharmacy and the mortuary were not involved.
- The trust did not collate service user's views with a patients or bereaved relatives' survey.

However:

- The trust wide end of life care strategy was underpinned by a clear action plan. The vision, values and strategy were being developed in line with all who were involved in the end of life care steering group.
- The service had a clinical lead and a board member.
- The senior management team of the trust were highly visible and accessible across the hospital. The trust culture encouraged candour, openness and honesty. Staff told us that they were actively encouraged to express their views which could help to develop services.
- All staff we spoke with demonstrated a positive attitude toward caring for the dying person. They described how important end of life care was and how their work had an impact on the quality of care for dying patients.

Vision and strategy for this service

- There was a trust wide clear vision for the future and had been circulated to all staff as a pocket booklet titled 'outstanding by 2020'. We saw the trust's values were displayed across the buildings and appeared on the reverse of staff identification badges.
- There was a trust wide end of life care strategy, action plan and progress tracker. The end of life care strategy 2016-2019 was influenced by national frameworks and local recommendations.
- We were told the trust's vision for end of life care was to deliver high quality care for all people in the local area at the end of life. This would be supported by effective decision making, encouraging personal choice and the provision of responsive services equipped to meet individual needs. This would be achieved by collaborative work between other agencies such as clinical commissioning groups, local hospices, and the volunteer sector to widen improvements in end of life care provision.

Governance, risk management and quality measurement

- Since April 2016 the structure of the end of life care service had changed.
- The end of life care team reported to the clinical outcomes group which covered mortality. The end of life care steering group fed into the patient quality and safety group. The end of life care steering group met alternate months and was chaired by the assistant director of nursing. We were told the group was overseeing the various improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also meeting the National Institute for Health and Care Excellence's (NICE) end of life guidance.
- We saw the minutes for the first meeting held in July 2016 and the following meeting in September 2016. The minutes showed the group discussing aims and plans for the future but did not discuss risks, incidents and complaints relevant to the service.
- The attendees of the steering group were a multi professional group and included members of clinical staff trust wide. However, representatives from chaplaincy, bereavement, pharmacy and the mortuary were not involved.
- The service had an ineffective governance structure. They did not have a clear audit plan or adequate risk register.
- The trust had incorporated the findings of the previous CQC inspection into an action plan 2016/17. The overarching actions were allocated to teams with specified timescales. Out of 43 actions relating to end of life care, the trust had completed seven actions at the time of inspection. These included a robust incident reporting system, safe prescribing and documentation of patient medicine administration, improving the profile of end of life care and ensuring the use and training of a specified appropriate syringe driver.
- The trust's report for end of life quarter four, dated March 2016, updated the board on the actions developed from CQC's previous inspection recommendations and observations. This was fed into the trust's '2020 programme highlight report' dated August 2016, where the progress of the end of life care

service was recorded, since June 2016. The service had an action plan with four items that had due by completion dates. The four items were: audits due to be completed by August 2016; policies were to be reviewed and relaunched by October 2016; increase the end of life care training for clinical staff by October 2016; and strategy to be approved by July 2016. The only item that had been fully achieved was the strategy.

- We were shown the improvement tracker for the end of life care service. This had 20 issues listed and outcomes to be measured. The tracker was started in April 2016 and documented its progress up to September 2016. However, none of the issues had been completed. Issues rated as high risk included: reviewing end of life care policies and ensure they were available to staff, labels used on the syringe drivers and further clinical and administrative support for the specialist palliative care team. At the time of the inspection all policies needed to be ratified and uploaded onto the internal computer system and syringe pump labels were still in the design process. The administration posts had been advertised and business case was to be agreed for palliative clinical support.

Leadership of service

- The end of life care team reported to the clinical outcomes group, who reported to the quality and safety committee who reported directly to the trust board. The medical director was the executive lead for end of life care.
- The assistant director of nursing was the clinical lead for end of life care and was also the clinical lead for other areas in the trust including dementia.
- We were told the end of life care programme was being developed further with the support from the senior management team. It was allocated as a project in its own right in the trust's quality improvement programme.
- However, we found the service did not have clarity in its leadership. It was disjointed without a clear line of objectives that the staff could understand or follow. The end of life care team was not working in partnership with the palliative care team. The palliative care team worked with the chaplaincy team; however the chaplaincy team had little contact with the end of life care team.

Culture within the service

- All staff spoken with told us about the visibility of the executive team. Particular mention was made of the chief executive, finance director and chairperson all visiting clinical areas and listening to staff. Staff told us the chief executive had given a clear message that all staff, of all grades were valued and inappropriate behaviour towards others would not be tolerated. We were given an example by staff on the wards of a consultant who was disciplined for shouting at staff in front of patients.
- The executives all took part in a 'walking in your shoes' programme where they shadowed individual members of staff to see what their job entailed and how the hospital felt from the perspective of different staff. We were told examples of this.
- We were told by staff and the senior team that the trust culture encouraged candour, openness and honesty.
- All staff we spoke with demonstrated a positive attitude toward caring for the dying person.They described how important end of life care was and how their work had an impact on the overall service.
- Nursing staff we spoke with demonstrated a commitment to the delivery of good quality end of life care; they felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- We found staff had a 'can do' attitude. Staff were patient-centred and wanted to deliver good care though good training and support.
- However, the specialist palliative care team did not feel part of the end of life care strategy. Additionally staff we spoke with on the wards (CDU) were not aware of, or the function of the end of life care team and this was echoed by the junior doctors we spoke with. The emergency department told us the change in end of life care service had left a gap in the support and advice that previously was freely available.
- A trust wide end of life care newsletter was produced and the first edition was published September 2016. The two page document explained the definition of end of life care, contact details for the specialist palliative care team, the risks, resources available, shared learning

themes and trends, improvements achieved and areas still needed to improve. Photographs and names of the end of life care team were printed in the newsletter but not the specialist palliative care team. We asked managers why the photographs or names of the specialist palliative care team were not displayed and we were told there was not enough room.

- We asked managers about the disconnection of the service between end of life care and the specialist palliative care team. They agreed with our observation and we were told there needs to be a review of investment and expansion.
- As at August 2016, Conquest Hospital reported a 86.2% turnover rate, 3.3% sickness rate and no vacancies for nursing staff in the specialist palliative care team. There were no vacancies or staff turnover and 15.6% sickness rate for medical staff in the same period.

Public engagement

- The trust did not have an official bereavement or end of life care patient satisfaction survey which would enable the trust to capture feedback from bereaved relatives. Management told us consideration needed to be given to future audits on the best way to capture patients' experiences of their service.

Staff engagement

- Staff told us that they were actively encouraged to express their views which could help to develop services.
- The specialist palliative care team told us they were encouraged to report any concerns regarding wards that may affect the care of an end of life care patient. For example, staff shortages that could affect the care of end of life care patients and identified training issues.
- The trust acknowledged and awarded staff to celebrate the work they achieved.
- The team of porters were joint winners in the May 2016 trust annual awards in the working behind the scenes category. The trust recognised the work porters accomplished to keep the services running. They were an integral part in looking after patients and their carer's and were often the first hospital staff they met. The trust said 'this is a team who really do go the extra mile'.
- The trust thanked 31 volunteers at the annual volunteer's celebration event and presented them with certificates in recognition of their length of service. A chaplaincy volunteer said 'it is a great team to be part of and rewarding in so many ways'.
- The trust held monthly awards which recognised the efforts of staff and to say thank you. The award was presented to a team or an individual. Staff spoke positively about the awards; we saw certificates displayed in ward areas.

Innovation, improvement and sustainability

- We saw there was commitment from staff to develop end of life care services through innovation and best practice.
- The end of life care service was in the process of making provision changes and utilise quality improvement methodology and frameworks. This would support the delivery of the service provided for patients and those closest to them.
- A specially made stained glass window was commissioned for Conquest Hospital to commemorate colleagues who had passed away.
- The service had developed an initiative about starting conversations with patients about exploring their wishes at the end of their life. They had secured funding to purchase a game designed to help patients find out what is the most important things for them at the end of their life. The team had used them in a training day and aim to use with patients when it seems appropriate.
- We saw the risk register for the trust wide end of life care service, August 2016, which had two risks listed. These related to end of life care education and audit, and the recognition and diagnosis that death is imminent. Both risks were assessed as high risk and had planned actions to be taken. However, the planned actions were not documented.
- The risk register was not robust as it did not reflect the issues listed on the improvement tracker or failures in service provision recommended by national guidance, for example National Care of the Dying Audit (NCDAH) 2014 and 2016. This meant the service had not

anticipated or recognised the appropriate risks which would or could affect the provision of the service. The service did not recognise the effects this could have on the health and well-being of both patients and staff.

Outpatients and diagnostic imaging

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

Information about the service

Conquest Hospital provides outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up are required. The hospital has medical and surgical specialty clinics, as well as paediatric and obstetric clinics. There were 190,373 outpatient attendances at the hospital in the between April 2015 and March 2016.

The outpatient clinics are located in different speciality areas, this included a women's health clinic, eye clinic, blood test clinic, general outpatients, orthopaedics and a clinic for ear, nose and throat.

The diagnostic imaging department carries out routine x-rays, magnetic-resonance imaging (MRI), computerised tomography (CT), mammography and ultrasound. Between April 2015 and March 2016, 117,623 patients used this service.

Prior to inspection more than 250 members of staff from across the trust attended focus groups and shared their experiences of working at the trust.

During the inspection, we spoke with 43 members of staff, which included managers, nurses, administrative staff and allied health professionals. We spoke with 18 patients and their relatives. We visited outpatient areas, the booking centre and all areas of diagnostic imaging.

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital.

During our last inspection, we found that the condition and availability of patient's health records was inadequate and confidential information was not stored securely. Tracking of records was poor and large numbers of records were unavailable for clinic. At this inspection, we saw the trust had implemented a bar code and scanner tracking system. Over the last 12 months, less than 1 % of medical records were unavailable for clinic. We saw records were being stored securely in all areas.

During our last inspection, we found the outpatient department was not being cleaned in line with the national specifications of cleanliness. At this inspection, we saw all cleaning audits were in line with these specifications. Scores for cleanliness audits showed high levels of compliance in all areas.

At our last inspection, the trust was not able to evidence that they were meeting with referral to treatment (RTT) NHS standard operating procedures across all specialties for either 2 week or 18 week targets. The trust had maintained the standard since July 2015, but had failed to meet it since March 2016. At this inspection, 12 of the 16 speciality groups were better than the England average for incomplete pathways (18-week targets) and four were worse than the England average for incomplete pathways. The trust had seen an improvement in their performance over time against the two-week standard for urgent GP referrals and data suggested the trust met the 93% operational target with performance of 96.1%.

Outpatients and diagnostic imaging

At our last inspection we saw the diagnostic imaging department did not provide space and privacy for patients in gowns to maintain their dignity. The department had been redesigned so this issue had been resolved.

During our last inspection there were vacancies across all areas of diagnostic imaging. These vacancies remained a problem during this inspection and staff described the pressure they felt due to poor staffing levels.

Summary of findings

We found the outpatient and diagnostic imaging services at Conquest Hospital to be requires improvement. This was because:

- At the time of the inspection there were 22,000 xrays that did not have a radiology report. However , the xrays were available for review by the clinician that had requested the examination. Radiologists had reviewed examinations of the chest, abdomen and pelvis to ensure there had been specialist input. A risk assessment had been carried out and an action plan to address the backlog of remaining xrays implemented.
- Staffing numbers in the diagnostic imaging department were 33% below the numbers required to cover all examinations and the on call rota.
- The trust referral to treatment time (RTT) had fallen below the 92% standard from March 2016 onwards, but had been the same as the England average since July 2015.
- The trust was performing much worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.
- Morale was low in the diagnostic imaging department. Staff felt they were not consulted on changes in the structure of the department and that there was disconnect between staff and managers.
- The outpatient department had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines.
- Areas we visited were visibly clean, tidy and the environment was light, airy and comfortable.
- A wide range of equipment was available for staff to deliver a range of services and examinations.
- Medicines were stored in locked cupboards and administration was in line with relevant legislation.
- Staff kept medical records accurately and securely in line with the Data Protection Act 1998.

Outpatients and diagnostic imaging

- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- The outpatient services had sufficient numbers of appropriately trained competent staff to provide their services.
- Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- Staff interacted with patients in a kind, caring and considerate manner and respected their dignity. Patients told us they felt relaxed when having their treatment.
- The hospital was responsive to the needs of the local populations. Appointments could be accessed in a timely manner and at a variety of times throughout the day.
- Staff in the outpatient department felt their managers were visible, approachable and effective.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement for the outpatient and diagnostic imaging services. This was because:

- At the time of the inspection there were 22,000 xrays that did not have a radiology report. However , the xrays were available for review by the clinician that had requested the examination. Radiologists had reviewed examinations of the chest, abdomen and pelvis to ensure there had been specialist input. A risk assessment had been carried out and an action plan to address the backlog of remaining xrays implemented.
- There were 33% less staff in the diagnostic imaging department than there should have been.

However;

- Staff in outpatients had a good understanding of the incident reporting process. Staff discussed incidents regularly at departmental and governance meetings.
- Patients were cared for in a visibly clean environment that was well maintained. There were arrangements to prevent the spread of infection and compliance with these was monitored.
- There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use.
- Staff demonstrated good medicines storage and management. There were systems to ensure patient's medicines were given safely and were stored securely as per national guidelines.
- Records were accurate, legible, complete and were stored securely. The outpatient service was in the process of centralising its records store and planned to scan all paper records onto an electronic system.
- The outpatient service had sufficient numbers of appropriately trained staff to provide safe care to patients.

Incidents

Outpatients and diagnostic imaging

- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between April 2015 and March 2016, the trust reported no incidents, which were classified as never events for outpatients and diagnostic imaging.
- In accordance with the Serious Incident Framework 2015, the outpatients department reported no serious incidents (SIs) which met the reporting criteria set by NHS England between April 2015 and March 2016.
- The hospital used an electronic incident reporting system. During the 12 months prior to inspection the hospital recorded 390 incidents using the system.
- Staff we spoke with had a good understanding of how to report incidents using the electronic reporting system. Staff were able to give us examples they had reported and the feedback they received. We saw that staff discussed incidents at the daily safety huddle, which was documented. We saw documentation which indicated this was occurring. Staff told us they shared learning from incidents at the daily huddles.
- Staff were aware of the duty of candour; they were able to describe the reporting procedure for all incidents. The duty of candour regulation requires providers of health services to be open and transparent when things go wrong. This includes some specific requirements, such as providing truthful information and an apology. At the service, if a patient was involved in an incident, they would be informed of what had happened and given an apology. Staff would inform the head of department and complete an incident reporting form. Staff gave examples of where they had given an open and honest apology to patients following an incident. Staff we spoke with had not experienced discharging duty of candour.
- At the time of inspection, two reports had been made to CQC in line with ionising radiation (medical exposure) regulations (IR (ME) R, 2000) in the last 12 months.
- Staff in diagnostic imaging had a good understanding of the incident reporting process. They explained if a patient received an unintended dose of radiation or a wrong body part was X-rayed, they would contact the radiation protection advisor (RPA) for advice. They documented the outcome of the advice on the incident reporting system and we saw examples of this occurring.
- In the last 12 months, data indicated 21 incidents were recorded on the electronic reporting system which related to unintended exposure to X-ray or wrong body part being x-rayed.

Cleanliness, infection control and hygiene

- All the areas we visited in the outpatients and diagnostic imaging departments were visibly clean and tidy and there were good infection control practices in place.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations.
- We saw chemicals were stored in cupboards in line with Health and safety at work regulations.
- We saw sharps bins were available in treatment areas where sharps may be used. This demonstrated compliance with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area.
- Staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene', from the World Health Organisation (WHO) guidelines on hand hygiene in health care. Information was displayed demonstrating 'five moments for hand hygiene' near hand washing sinks.
- The most recent hand hygiene audit scored 100% for both departments.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. Information was displayed demonstrating the 'five moments for hand hygiene' near hand washing sinks.
- We saw hand sanitiser available in entrances to waiting areas and staff used it as they entered and exited departments.
- We saw appropriately completed cleaning checklists in every treatment and clinic room. All checklists were

complete. We saw all cleaning audits were in line with national specifications of cleanliness. Scores for cleanliness audits showed high levels of compliance with audit scores of above 97% in all areas.
- We saw disposable curtains in treatment areas which had been changed within the last six months in accordance with hospital policy.
- Equipment had stickers on it to indicate it had been cleaned recently and was ready for use.
- All consulting and treatment rooms were in line with hospital building note (HBN 00-09 Infection control in the built environment. The flooring in all clinical areas was seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant which was in line with HBN 00-10 Part A (flooring).
- Toilets in waiting areas were visibly clean and had cleaning checklists, which were complete.
- Some areas of outpatients used endoscopes (an instrument used to examine the interior of a hollow organ or cavity of the body); These were delivered to the department, sterile, in a covered, solid walled, leak proof container in line with health and safety executive standards for endoscope reprocessing units. Used scopes were covered and sent to the sterile services department at the end of the morning or afternoon.
- Staff told us, if they had an infectious patient, a member of the housekeeping team carried out a deep clean, removed and replaced the disposable curtains immediately following the patients appointment.

Environment and equipment

- The was a main outpatient waiting area, leading to separate waiting areas for specialist clinics.
- There was clear signage from the main reception area to direct patients to the separate outpatient areas.
- We saw tidy and spacious waiting areas.
- Individual consulting rooms were available in all outpatient areas. Each consulting room was equipped with a treatment couch and trolley for carrying the clinical equipment required. Rooms had equipment in to provide physical measurements, in privacy. This was line with Hospital Building Note (HBN) 12 (4.18) which recommends a space for physical measures be provided so this can be done in privacy.
- A variety of disposable items of clinical equipment was available in treatment rooms. All items we checked were in date.
- We saw equipment was serviced regularly and stickers on equipment indicated it had been serviced within the last 12 months. Electrical equipment had electrical safety stickers on it, which indicated it had been tested and was safe to use.
- Resuscitation trolleys were available in outpatient areas. We saw the checklists were completed daily for the last two months. We saw appropriate equipment was available and all equipment was in date.
- The diagnostic imaging department had been very recently redecorated and rearranged. There was a main waiting area and separate waiting areas for specific examinations.
- Quality assurance checks were carried out on diagnostic imaging equipment monthly. We saw the results of these checks which were kept in individual examination rooms.
- We saw diagnostic imaging equipment servicing sheets, saved on the computer system with engineer details and confirmation they were safe to use. Copies of servicing sheets were also kept in each room, which we saw.
- We saw annual equipment reports from the radiation protection advisor (RPA), which were completed annually and complied with ionising radiation regulations, 1999.

Medicines

- The trust had a policy for the safe and secure handling of medicines. The policy ensured that medicines were prescribed, stored, administered and managed safely according to current best practice.
- Some prescription medicines were controlled under the Misuse of Drugs legislation 2001 and called controlled drugs (CDs). We examined the CD cupboards and found that storage was appropriate with no other items in the cupboards. The CD registers on the wards had been appropriately completed and checked daily.
- Staff prescribed medicine using FP10 prescription forms and hospital prescription forms. The member of staff using them signed the forms in and out. Staff kept a record of serial numbers of prescriptions issued, which indicated the system was secure. This is in line with NHS Protect, Security of prescription forms guidance, 2013.

Outpatients and diagnostic imaging

- Drug cupboards we saw in the outpatients department were locked. Only registered nursing staff held keys to the drug cupboards. This was in line with National Institute for Health and Care excellence (NICE) guidelines, MPG2.
- Patient Group Directions (PGDs) provide a legal framework that allows the supply and/or administration of a specified medicine, by a named, authorised, registered health professional. We saw PGD's were in place and in date in the outpatient department. This indicated staff administered medicines in line with professional guidance and legal requirements.
- Minimum and maximum medicines refrigerator temperature records provided assurance that medicines requiring refrigeration were kept within their recommended temperature ranges.

Records

- The number of temporary records was monitored daily using the clinical administration dashboard. The trust had a target of 1% of temporary records being created for outpatients appointments every day. On average over the last 12 months 1% of patients were seen without their full record being available, which indicated the trust met the target.
- Data from the clinical administration dashboard indicated, over a 6-week period the number of temporary notes created for outpatient was almost 5%, which was worse than the target. Managers explained the number of temporary records had increased during the relocation of records to the central store. The dashboard demonstrated that the number of temporary records had increased at the start of the relocation and was decreasing.
- The trust had an escalation process, in the event a record could not be found. Staff could explain this process to us.
- Staff told us records were transferred from the central facility to a medical records processing area. They were then distributed to the various outpatient clinics and stored in secure areas.
- We saw records were available in outpatient areas. We saw records stored securely in locked trolleys or in rooms with key pad access only.
- We looked in five sets of patient records. We saw records were complete, legible and signed. They contained referral letters, results of diagnostic tests and discharge letters.
- In diagnostic imaging, records were stored on a patient arriving communication system (PACS). Only staff with a passcode could access them. Only staff authorised to have access had a passcode.
- We saw confidential waste areas available in administration areas, which indicated confidential waste was managed appropriately.

Safeguarding

- Staff who dealt with children had safeguarding level one and two training, in addition to this a trained children's nurse was available in the department when children attended.
- Nursing and diagnostic imaging staff demonstrated a good awareness of what to do if they had safeguarding concerns. They could explain what to do if they had concerns and who to contact.
- Staff knew who the safeguarding lead was for children and vulnerable adults and areas we visited had safeguarding link nurses.
- We saw data which indicated 87.5% of outpatient staff had attended level one and two safeguarding children training and vulnerable adult safeguarding training, which was worse than the trust target of 90%.
- We saw data which indicated 80% of diagnostic imaging staff had attended vulnerable adult safeguarding training and 74% had attended safeguarding children training, which was worse than the trust target of 90%.

Mandatory training

- Staff we spoke with told us they had access to mandatory training and they received reminders of when it was due.
- Data indicated 91.5% of outpatient staff had attended mandatory training, which was better than the trust target of 90%.
- We saw 86% of diagnostic imaging staff had attended mandatory training, which was worse than the target of 90%. Staff told us they had to cancel training to cover for lack of staff in the department.

Outpatients and diagnostic imaging

Assessing and responding to patient risk

- Staff carried out essential care rounds every hour. Essential care rounds involved a senior member of nursing staff carrying out a series of checks to ensure patients were well and had not been waiting a long time. Staff kept records of these checks and we saw the records, which indicated this was occurring.
- Patients on a cancer pathway had a dedicated booking team in the booking centre. All referrals were received electronically and an email was sent to the GP to indicate it had been received. The booking team could escalate concerns about appointments to service managers. Weekly cancer patient tracking list meetings provided clinical oversight of patients on two week pathways.
- If a patient did not attend their appointment, they would be referred back to their referring doctor, who could follow this up. A record of all patients who had not attended their appointment would be printed out the following day and sent to medical secretaries and GP's.
- Staff had received training in basic life support. They told us that a staff member would tend to the patient, one would get the emergency equipment and another would call the emergency team. The patient would then be transferred to the emergency department. Staff told us this had happened recently and they felt the response of all staff involved was swift.
- We saw emergency call bells available in treatment and clinic rooms.
- Some eye treatments can be carried out using light amplification by stimulated emission of radiation (Laser) therapy. We saw the Laser was used in a designated room, with warning signs and light which activated when the Laser was in use. This was in line with Laser safety guidelines (BS EN 60825-1: 2007. Safety of laser products: Part 1. Equipment classification and requirements).
- The department had a trained Laser protection supervisor. The Laser protection advisor, based at another location, oversaw the use of Laser and local rules.
- There was also a Laser in the diagnostic imaging department. We saw warning lights and signs in line with guidelines.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in areas we visited. Diagnostic imaging staff had a clear understanding of protocols and policies. Staff had access to protocols and policies, which were stored on a shared computer file. Staff demonstrated their knowledge of where policies were kept.
- We observed good radiation compliance as per policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. There was key pad entry to examination rooms and only authorised staff knew the code.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with ionising regulations 1999 and regulations IR (ME) R, 2000.
- Departmental staff also carried out regular Quality Assurance checks. This indicated equipment was working, as it should. These mandatory checks are in line with ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R 2000). We saw records of these checks.
- Lead aprons were available in all areas of radiology for children and adults. Regular checks occurred of the effectiveness of their protection. We saw checks occurred regularly and equipment provided adequate protection.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging departments in line with best practice.
- The five steps to safer surgery is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. It is for use in any operating theatre environment, including interventional radiology. Staff audited the use of this monthly to ensure all steps were followed. An audit of the checklist completed in August 2016, scored 100%.
- A safety questionnaire was completed prior to examinations being undertaken, this checked a patient's identification, previous scans, the dose of the scan required and a check on PACS to see if there had been other images. The completed questionnaire was then

scanned onto the computer system to ensure it was completed. We saw an example of this which indicated it was occurring. Staff told us they double checked forms to ensure identification checks had been completed before they were scanned onto the system.

- We saw pause and check signs in all examination rooms to remind staff to check a patient's details.
- If something unexpected was noted on a patient scan, an alert was set up on the computer system, which went straight to the referring doctor. This was in line with Royal College of Radiologists standards for the communication of critical, urgent and unexpected significant radiological findings.
- Staff felt there were not enough of them to manage the new waiting room arrangement. We saw a patient alone, on oxygen in the sub-waiting area of the department. When we asked if someone should be with her, we were told a member of staff should have come from the ward, but did not. There were not enough staff in the department to stay with the patient.
- There was one radiology department assistant available for ultrasound, so although consultants always had a chaperone, radiographers did not. This was not in line with the trusts chaperone policy.
- Staff told us there was no receptionist available at the main waiting area after 5pm. This meant patients were alone in the waiting area from then until the department closed at 8pm. If someone became unwell, staff would be unaware until they went to call the next patient in.
- Staff told us out of normal working hours there was no patient archiving communication system (PACS) staff available. If a patient's image was put into the wrong electronic folder, there would be a delay until the next working day in getting it put into the right folder. This could be two days or more, if it was a bank holiday weekend. This was a big cause of concern for staff and would be a big problem if, for example a patient had to be transferred to another hospital for treatment. In the last 12 months, data indicated there were 21 occasions when images had to be corrected on PACS because of being put into the wrong folder. This was not in line with Royal College of Radiologists Standards for providing a seven day acute care diagnostic radiology service, Standard 8. Which states :Radiology information systems (RIS) and picture archiving and communication systems (PACS) support should be available seven days a week.
- At the time of inspection, there were 22,000 x-rays waiting to be reviewed by a specialist in order to make a diagnosis. Managers told us they had risk assessed this back log. Managers were cross checking computer systems to see if any of the patients had, re attended the hospital and a systems-based analysis was to be done by the end of October to ensure none of the waiting patients came to harm. The trust later confirmed this had been completed.
- The x-rays were available for review by the clinician that had requested the examination. Radiologists had reviewed examinations of the chest, abdomen and pelvis to ensure there had been specialist input. A risk assessment had been carried out and an action plan to address the backlog of remaining xrays implemented"
- We asked to see the most recent radiation protection advisor (RPA) audit. Staff and managers were unable to locate the last one and were unsure of when the last one was. This was not in line with the Ionising Radiations Regulations 1999, the Ionising Radiation (Medical Exposure) Regulations 2000 or Health and Safety Executive guidance.

Nursing staffing

- Nursing staffing in the outpatients department was determined through a review of clinic numbers and competencies of nurses required to support these clinics.
- A registered nurse was available at each area of outpatients. There were a mixture of registered nurses and health care assistants (HCA's). The department did not use agency staff.
- Senior nurses told us they over recruited staff at lower bands, and then developed their staff in to higher band roles.
- The hospital's own staff and nursing students who had attended a placement at the hospital worked as bank staff when required. We saw a nurse staffing rota for a four week period, which indicated there were always registered staff available in each outpatient department.

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Medical staffing

- The trust employed six interventional radiologists and seven radiologists provided reports on examinations. There were adequate staff to cover on-call rotas.
- The trust also used an external company to provide reports for examinations, which meant extra help was available for providing reports for examinations.

Diagnostic imaging staffing

- The diagnostic imaging department had only two thirds of the staff they were established for. They should have 36 staff, but had only 26. Managers were going through an overseas recruitment process, which was taking some time. Some of the staffing shortages were covered with agency staff, who had worked at the hospital for a number of months. Staff told us some agency staff had expressed an interest in becoming a permanent member of staff, but could not during the overseas recruitment process.
- They provided an on call service for CT, interventional radiology, emergency department and theatres. They told us that although they had managed to cover the on call rota so far, there were gaps for the rota throughout November.

Major incident awareness and training

- The hospital had a business management continuity plan which had been reviewed in August 2016. Staff we spoke with were able to show us where this was located.
- Staff gave an example of a major incident, which happened recently, where a chimney collapsed within the hospital. Although it did not affect the outpatient department, staff activated the plan in preparation that their help might be needed. They had a clear understanding of who to contact and what their role would be.
- The physiotherapy department practised an emergency evacuation of the hydrotherapy pool annually.

Are outpatient and diagnostic imaging services effective?

We inspected but did not rate effective, as we do not currently collect sufficient evidence to rate this. However, we found:

- The hospital had an on-going, comprehensive audit programme, which monitored areas for improvement regularly.
- Treatments offered to patients were in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Staff were competent to perform their roles and were encouraged to develop their skills further.
- Health professionals worked together to provide services for patients.
- The diagnostic imaging department provided an on call services, 24 hour a day seven days a week.
- Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff were able to explain what steps were taken to ensure relevant legal requirements were met.

Evidence-based care and treatment

- The outpatient and diagnostic imaging departments participated in a variety of local and national audits to comply with best practise, professional standards and National Institute for Health and Care Excellence (NICE) guidelines.
- The outpatient department had carried out a health records audit in line with professional standards, which demonstrated the standards were being met.
- Local audits included hand hygiene audits and the assessment for competency of staff using glucose meters. These demonstrated staff were following standards, guidelines and operating procedures.
- We saw staff in dermatology followed NICE guidelines. Psoriasis: assessment and management, Clinical guideline (CG153).

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- The diagnostic imaging department demonstrated following, clinical guideline (CQ95), Chest pain of recent onset: assessment and diagnosis.
- The department also contributed to the Royal College of Radiology, national audit of radiology systems alert for critical, urgent and unexpected findings.
- They attended multidisciplinary meetings regularly and audited their function in line with professional guidelines.
- The diagnostic imaging department also audited the accuracy of reporting on a variety of scans.
- Staff in the ultrasound department, performed regular checks of scans in line with set criteria. They have modified practise in response to this audit. In addition to this, they grade the quality of reporting every three months. They offered extra training, if required, in response to these checks.
- The department met professional standards for the prevention of contrast induced acute kidney injury in adult patients as they checked blood test results within three months of the examination.
- We saw some protocols available had been reviewed in March 2016.

Nutrition and Hydration

- Staff told us that if a patient experienced a delay in their appointment, they offered them a drink.

Pain relief

- If pain relief was required in the outpatients department, a patient would be given a prescription which they could take to the pharmacy department within the hospital.
- We saw nursing staff recorded pain scores when patients had waited as a result of transport delays. This was to identify any pain relief requirements.
- Staff gave us a detailed example of dealing with a patient approaching the end of their life, who had attended an outpatient appointment. The management they described was in line with the faculty of pain medicine's, core standards for pain management (2015)
- In diagnostic imaging, staff would contact the ward if an inpatient was in significant discomfort. This was in order to return them to the ward as soon as possible and inform ward staff pain relieving medication was required.
- We saw a variety of pillows and pads were available to make patients as comfortable as possible whilst undergoing an examination.
- The physiotherapy department provided acupuncture for pain relief, which they offered to appropriate patients..

Patient outcomes

- Patient outcomes recorded on the computer system indicated if a patient had another appointment or had been discharged. The reception manager checked all patients had an outcome every day. Heads of departments discussed patient outcomes daily and we saw this was a daily agenda item. Service managers would be contacted if a patient did not have an outcome.
- The physiotherapy department recorded a variety of patient reported outcome measures, which indicated if a patient had improved because of a treatment intervention. This was in line with best practise and professional standards.
- In the reporting period April 2015 to March 2016, the follow-up to new rate for the Conquest Hospital was similar to the England average. The latest site figure in May 2016 of 2.3% was very similar to the England average.

Competent staff

- Staff told us that additional staff were available during the induction process so that sufficient time was allocated to get to know the area they were working in. New staff were also allocated a buddy. Staff were moved through different clinical areas for a period of two weeks. There was a system for assessing the competency of staff in several skills. We saw copies of competency certificates.

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- There is a set of standards that social and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new workers. We saw a number of health care assistants had care certificates.
- Staff were moved through different clinical areas to maintain their competency in a variety of skills. This was part of a clinical skills development programme. Staff were developing a competency skills framework which would be signed off by a trained nurse.
- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the nursing and midwifery council (NMC). Managers supported their staff through the revalidation process.
- The electronic rostering system kept a record of registered nurses. If registration had lapsed, it would not allow a nurse to be booked on a shift.
- Staff told us they were able to access funding for external training and that this was positively supported.
- Staff in outpatient areas had specific areas of responsibility, for example health and safety, dementia, learning disabilities and safeguarding. They had accessed additional training and supported other staff in these areas.
- We saw data, which indicated 89% of outpatient and diagnostic imaging staff had attended an appraisal in the last 12 months. This was worse than the target of 90%.
- Staff told us following their appraisals they received continued support to progress their careers and access postgraduate courses.
- We saw that all employed radiology staff were registered with the Health Care Professions Council (HCPC). Managers checked the registration of their staff regularly.
- Staff had dedicated professional development time in order to maintain their registration.
- Agency staff completed an induction prior to starting work in the diagnostic imaging departments. We saw copies of these checklists to indicate inductions were complete. Agency staff had worked in the diagnostic imaging department for several months, so were very familiar with the environment and equipment.
- Eighty two percent of all diagnostic imaging staff had an appraisal in the last year, which was above the trust target of 75%.
- Some staff working in diagnostic imaging could give medicine to patients for certain diagnostic tests. We saw certificates which confirmed staff were competent to do so.
- The department kept a record of non-medical staff that could refer a patient for a diagnostic imaging test on their shared computer drive.

Multidisciplinary working

- Staff told us they worked well together and had good communication with other health professionals and administrative staff. We saw staff engage in a professional and courteous manner.
- Matrons from different clinical units provided support for each other.
- The clinical team worked with the administration team to develop slips of paper for patients to indicate which waiting area they should go to when they first booked in.
- Staff in the women's health clinic told us they had a weekly multidisciplinary videoconference meeting with other members of the team at other sites. This meant different staff groups worked together in planning the service and the delivery of care.
- Diagnostic imaging staff attended multidisciplinary meetings, which is in line with guidelines for clinical radiologists, November 2014.

Seven-day services

- Radiology consultants worked seven days a week, on a rota basis. The radiology department provided a seven day, on call service.

Access to information

- The computerised radiology information system (CRIS) stored patient data and was used for booking appointments.

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- A patient archiving computer system (PACS) was used for the storage of diagnostic imaging tests. Authorised staff throughout the trust could access the results of diagnostic tests through PACS with an individual passcode.
- Policies, procedures, service records and meetings of minutes were stored in a shared folder on the trust intranet. We saw staff could access this information with ease.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw signed consent forms in medical records, which indicated patients had consented to treatment, in line with the hospital's consent policy.
- The trust completed a consent audit from June 2015 to February 2016. They found 100% of records had a signature by the patients and a competent member of staff in all cases carried out the consent process.
- Staff had training in Mental Capacity Act (MCA), 2005 and Deprivation of Liberties Safeguards (DoLS).
- Staff described the process of dealing with a patient who may not have the capacity to consent to treatment. They were aware of who to contact if they required further advice. They could explain best interest decisions and discussions.
- The consent audit showed 71% of records demonstrated evidence of a formal capacity assessment and a best interest meeting, when consent was applied using the Mental Capacity Act.
- Staff told us the safeguarding training day included MCA and DoLS training. MCA advice and additional information was also cascaded via a learning disability link group. However, 87.5% of outpatient staff had attended level one and two safeguarding children training and vulnerable adult safeguarding training, which was worse than the trust target of 90%.
- We saw data, which indicated 80% of diagnostic imaging staff had attended vulnerable adult safeguarding training and 74% had attended safeguarding children training, which was worse than the trust target of 90%.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring for outpatients and diagnostic imaging services as good. This was because:

- Staff treated patients in a kind, considerate and professional manner.
- Staff supported patients to cope emotionally with their care and treatment as needed. Specialist support was available, when required.
- Patients overwhelmingly commented positively about the care provided from all staff they interacted with.
- Patients felt well informed and involved in their procedures and care.
- Patient's surveys and assessments reflected the friendly, kind and caring patient centred ethos and our observations of care confirmed this.

However;

- In the diagnostic imaging department, staff told us they were not always enough staff available to provide a chaperone.

Compassionate care

- A friends and family test (FFT) completed in August 2016 indicated 96% of patients would recommend the outpatients department and 1% would not .This was better than the national average of 92% who would recommend and three percent who would not recommend a service. One thousand one hundred and nineteen of an eligible 23,829 patients completed the survey which is 5% of all patients who attended the outpatient department.
- We saw staff greet patients in a kind and considerate manager. Members of staff introduced themselves by name and explained what their role was.
- We spoke with patients new to the hospital and those that had been attending for a number of years. They were happy with the care they received and told us they could not fault the service.
- Patients told us they had plenty of time allocated and doctors and nurses always provided detailed explanations.

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- We saw written feedback from patients to staff praising the care they had received.
- Patients we spoke with in the diagnostic imaging department, told us they were treated with dignity and respect.
- Entrances for inpatients and out patients had been separated. There were individual bays for inpatients to wait on beds, with screens, to preserve dignity. There was a separate waiting room for outpatients.
- From the main waiting area, patients were taken through to separate waiting areas, dependent on the scan required. Patients waiting in gowns could not be seen.
- Patients told us they felt it was a proper waiting area and staff felt the redesign offered more dignity for patients and the department was no longer a throughfare
- Some patients told us the new changing area was more private than before. We saw separate cubicles for patients to wait in gowns.
- We saw that viewing areas could not be overlooked by anyone in corridors or passing by.
- Staff told us, because of staffing shortages, they were not always able to provide a chaperone during examinations. This was not in line with the trust's consent policy.

Understanding and involvement of patients and those close to them

- We saw a variety of health-education literature and leaflets produced by national bodies. Some of this information was general in nature while some was specific to certain conditions. This literature was available in all waiting areas of the outpatient departments.
- Some patients we spoke with felt the environment in the diagnostic imaging department was better than it used to be, atmosphere nice, bright and clean. However, some patients in the diagnostic imaging department were unhappy their relatives could only wait with them in the main waiting area and could not wait with them in the sub waiting area.

Emotional support

- Macmillan information and specialist nurses were available to support clinic staff when breaking bad news.
- Staff told us they had the time to spend with patients and their families, when needed.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement. This was because;

- The trust referral to treatment time (RTT) had been the same as the England average since July 2015 but had fallen below the 92% standard from March 2016 onwards.
- The trust was performing much worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.
- The diagnostic imaging department did not monitor their waiting times or reporting times.

However;

- The diagnostic imaging department had redesigned its waiting areas to maintain patient's dignity.
- The trust has seen an improvement in their performance over time against the two-week standard for urgent GP referrals.
- Rapid access services were available for patients with suspected cancer.
- Staff gave us examples of dealing with people living with dementia and had link nurses within the service.

Service planning and delivery to meet the needs of local people

- The outpatient department was open from 8am to 6pm Monday to Friday and evening clinics ran four nights a week. Nursing staff had changed their rota in order to accommodate evening clinics.
- Some clinics occurred on Saturday mornings on an ad hoc basis.

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- The service provided rapid access services for patients referred by their GP who suspected them of having cancer and referred patients under the two week wait rule. This included all suspected cancer specialities.
- There was also an ophthalmology clinic for patients requiring urgent attention.
- There was a main outpatient reception area, with an area for patients to wait whilst queuing to speak to a receptionist. Reception staff had desks separated with a divide and conversations between staff and patients could not be overheard.
- We saw comfortable looking waiting areas with refreshments and magazines available for waiting patients.
- We saw adequate seating available at a variety of heights and space available for patients to wait in wheelchairs. The hospital had several wheelchairs available for patients to use if required.
- Staff displayed clinic delays and waiting times on white boards.
- Although staff did not record clinic overruns in the outpatient department, the senior nursing team carried out essential care rounds. This meant staff responded to patients' concerns and needs regularly.
- A quiet room was available for breaking bad news or if a patient living with learning disabilities or dementia preferred to wait in a quieter area.
- The diagnostic imaging department was open daily from 8am until 8pm and weekend sessions were provided as required.
- A direct access service was available for patients referred for an X-ray from their GP.
- The layout of the diagnostic imaging department had been changed and still had work to be done. Separate waiting areas had been provided for waiting inpatients and outpatients.
- The inpatient waiting area consisted of individual, curtained bays to improve patient dignity and respect.
- There was a main outpatient waiting area, which had a variety of seating available and space for wheelchairs. Patients then went through to a separate waiting area, were they could wait for their examination.
- Although some patients told us they experienced delays at clinic, they were always kept informed of the reasons why. They told us staff offered an apology and a drink. We saw staff explaining delays and offering patients drinks.
- The diagnostic imaging department was open from 8am to 8pm five days a week and would open at weekends to deal with the waiting list.

Access and flow

- Between October 2015 and September 2016 the trust's referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance. The most recent data from September 2016, showed 78.3% of this group of patients were treated within 18 weeks, which was worse than the England average of 90%. The overall trend in trust performance had been downwards since February 2016.
- Dermatology, Geriatric Medicine and Cardiology specialties were above the England average for non-admitted RTT.
- Thirteen specialties were below the England average for non-admitted RTT (percentage within 18 weeks). Gynaecology at 76.6% was worse than the England average of 95.3%.
- The trust's referral to treatment time (RTT) performance for incomplete pathways has been below the England average overall performance since March 2016. The latest figures for September 2016 showed 86.7% of this group of patients were treated within 18 weeks. The trust has fallen below the 92% standard from March 2016 onwards..
- Ten of the 16 speciality groups were better than the England average for incomplete pathways and five were worse than the England average for incomplete pathways. The RTT's for Gynaecology, ENT, Thoracic medicine, Trauma and Orthopaedics were worse than both the standard and the England average.
- The trust had seen an improvement in their performance over time against the two week standard for urgent GP referrals and datafrom September 2016, suggested the trust met the 93% operational target with

performance of 97%. There had been a steady increase from a performance of 88.6%. This increase in performance was in conflict to a national downward trend.

- The trust was performing better than the 96% operational standard for people waiting less than 31 days from the diagnosis to first definitive treatment.
- The trust was performing much worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance had been deteriorating over the last three quarters compared to both the standard and the England average and was at 76% in quarter two, 2016-17 compared to the England average of 82.4%.
- From April 2015 to March 2016 the trust cancelled 5% of clinics with more than six weeks' notice.
- The number of clinics cancelled with less than six weeks' notice over the same period was 7.5%, which was better than the trust's target. The main reason given for cancellations was junior doctors strikes, which accounted for 3% of clinics cancelled.
- Paper referrals were received into the outpatient appointment centre. Staff gave them to the speciality staff group, who scanned them onto a computer system. Staff took the referrals by hand to consultant secretaries for consultants to triage. The target time for this was 48 hours. In the six weeks prior to inspection, the target time was achieved 86% of the time, which was better than the trust target of 80%.
- The triaged referral was scanned onto the system and an appointment booked.
- All letters are sent out via an external company. Staff told us the relevant information leaflet would be sent out at the same time.
- A dedicated team managed referrals for patients with suspected cancer. GP's faxed the referral to a dedicated fax number which transferred the referral in to an electronic one. Staff emailed the GP to indicate the referral had been received. The patient was then contacted by phone and offered and appointment. Data indicated the six weeks prior to inspection 99% of patients received an appointment within two weeks.
- On average, the numbers of calls received in to the booking office was 2,404 each week. A display in the booking office enabled staff to see how many callers were waiting, so staff could assist one another in managing the calls. The clinical administration dashboard allowed managers to monitor closely the call handling data and manage their service accordingly.
- The diagnostic imaging department did not routinely monitor their waiting times, thought they did record six week diagnostic waits for CT, MRI and non-obstetric ultrasound. Neither did they monitor their reporting time.
- The most recent data from September 2016 indicated 2.5% patients had a diagnostic test within six weeks, this was worse than the standard of 1%.
- The diagnostic imaging department recorded the proportion of stroke patients being scanned within certain timeframes. The most recent data indicated they were above the national average for this data.
- In diagnostic imaging, paper referrals were received on paper into the department. The same day, referrals were taken by hand to the relevant clinician for coding; this would indicate whether a patient was acute or urgent. The patient was then booked an appointment at the relevant time. If a patient was urgent or on a cancer pathway, this was indicated with a blue dot sticker, so it was easily identified. The booking team had dedicated appointment slots, reserved for these patients.
- The diagnostic imaging department were in the process of introducing an electronic requesting system.
- There was a backlog of 22,000 x-rays to be reported on at the time of inspection. Managers were undertaking a risk assessment of these x-rays to ensure no patients came to harm. Managers told us they could outsource reporting to an external reporting company. In addition, some radiologists could access the computer system from home and could provide reports out of hours.

Meeting people's individual needs

- We saw that the outpatient department had a vulnerable patient pathway and mission statement. There was additional support for patients with impaired memory and those living with dementia. Staff told us they would fast track patients living with learning

difficulties or dementia. They encouraged patients living with dementia to carry a booklet they can use to tell staff about their needs, preferences, likes, dislikes and interests.

- The outpatient department had dementia and learning disability link nurses.
- Staff highlighted patients living with dementia by placing a blue butterfly on their medical records.
- Any individual needs could be indicated on the patient administration system or the electronic document manager and staff demonstrated this to us.
- Staff received training in making every contact count, an approach to healthcare that encourages all those who have contact with the public to talk about their health and wellbeing. It encourages health and social care staff to use the opportunities arising during their routine interactions with patients to have brief conversations on how they might make positive improvements to their health or wellbeing.
- Staff used a graphic visual analogue scale for patients to indicate their pain level if they had difficulty with the written word.
- If patients living with dementia attended clinic a designated nurse could attend clinic with them. There was a dementia champion in the department, who had attended specialist training and could support patients, families and other members of staff.
- We saw a range of equipment which was suitable for bariatric patients attending outpatient departments. Staff told us further equipment was available from the bariatric ward, if required.
- All documentation could be provided in alternative formats including braille, audio and large print. Patients requiring communication assistance were asked at time of booking an appointment whether they required communication support, staff then requested appropriate interpreters or adjusted any environmental factors. Physical support could be provided for patients who required assistance around the hospital.
- The hospital had a service level agreement (SLA) with an external company which provided interpretation. Staff told us it was easy to book interpreters and they provided telephone interpretation to patients. Cordless phones were available throughout outpatient departments to assist this.
- We saw disabled toilets were available in waiting areas.

Learning from complaints and concerns

- From August 2015 to July 2016 43% of all complaints received by the trust were in relation to the outpatient departments.
- The chief executive was responsible for the complaints procedure, for the review and completion of complaint responses. This responsibility was delegated to the director of nursing during periods of absence. The medical director and director of nursing were responsible for the governance function including patient experience and reporting information on complaints to the trust board and meeting with complainants as required. There was a patient experience lead responsible for managing the complaints function. The complaints and the patient advice liaison service (PALS) manager was responsible for the day to day running of the complaints team. In the complaints team there were two customer liaison support staff who were responsible for administrative duties and logging all complaints on the database. The customer liaison leads were responsible for triaging new complaints; act as contact for complainants and liaising with the investigating clinical unit. They also collated the outcome of the investigation from the relevant clinical unit to then write the response for the chief executive to review.
- Patients and/or relatives were encouraged to raise any concerns at the time to the staff providing their treatment. Staff told us they were confident in dealing with patients who had raised a concern or complaint.
- Patients could also contact the PALS team to see if concerns could be resolved informally. The trust website provided details of how patients could raise concerns. We saw information on how to complain was available in outpatients' areas we visited.
- Once a complaint was received, the customer liaison lead triaged the complaint, identified the issues for investigation and if a telephone number was provided, agreed these with the complainant. The complaint was

then sent to the relevant clinical unit for investigation and was sent to the head of nursing and service manager of the area being complained about. Once the information had been received from the clinical unit, a draft letter was written and sent to managers for review. Following this, the response and complaint file was sent to the Chief Executive for final authorisation.

- The trust aimed to respond to complaints within 30 working days or for complex complaint within 45 working days. In July 2016, the trust responded to 47% of complaints within the agreed timeframe; there was work underway to improve this, by implementing a clear escalation process. There had been a historic backlog of complaints with a high number overdue the response period however the trust was working hard to reduce the backlog and the trend was moving in the right direction.
- We reviewed five complaints and there was evidence that these processes were being followed in line with trust policy. Face to face meetings were being offered, response letters were personal and clear, with apologies, if necessary.
- Each clinical unit reviewed and discussed complaints and was responsible for disseminating the learning from complaints.
- Monthly governance reports included a section which reviewed complaints and identified learning and trends. Which saw minutes of these meetings which indicated this was the case.
- This information was shared at unit meetings and we saw minutes of these meetings which indicated this was occurring.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement for the outpatient and diagnostic imaging services. This was because:

- The radiology manager did not have a clear understanding of reporting incidents under IR (ME) R. There was no plan or system in place to monitor diagnostic imaging waiting times or reporting times.
- At the time of the inspection there were 22,000 xrays that did not have a radiology report. However , the xrays were available for review by the clinician that had requested the examination. Radiologists had reviewed examinations of the chest, abdomen and pelvis to ensure there had been specialist input. A risk assessment had been carried out and an action plan to address the backlog of remaining xrays implemented
- At the time of inspection, there was no formal strategy for the diagnostic imaging department. Managers told us they planned to invite stakeholders to a strategy-planning meeting at the start of 2017.

However;

- The outpatient department had made considerable improvements to the department and processes since the last inspection.
- All staff were proud of the work they did at the hospital. They had a good understanding of the vision for the development of their services.
- There was a clear leadership structure which staff were aware of. Outpatient staff told us their managers were visible and approachable.
- The executive team engaged regularly with all staff and communication was clear and consistent. Staff spoke positively about the executive team.
- Governance processes were clear and effective from departmental to executive level.
- Staff were driven to deliver quality care in their departments and ensure patient experiences were good ones.

Vision and strategy for this service

- The trust combined community and hospital services through the East Sussex Better Together programme. The aim was to provide safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex.
- The trust had developed ESHT 2020, which was a framework of objectives and actions in order to make

the trust into the high-performance organisation they wanted it to be by 2020. It involved the vision and strategic objectives published in 2015 and brought these up to date.

- As part of ESHT 2020, the clinical administration team had identified keys areas for improvement. This involved reconfiguration of the outpatient booking services which included the two week pathway. An improvement of the working environment and improved staff engagement and morale. Completion of an electronic tagging of medical records, centralisation of health records storage and the implementation of an electronic management system. This supported the vision that people who used services would have the best possible support and experience.
- Staff understood the vision of the trust and hospital and they could demonstrate how this was implemented in practice. They told us they were proud to put patients first in everything they did and they strived to provide the best possible services to the local community.
- At the time of inspection, there was no formal strategy for the diagnostic imaging department. Managers told us they planned to invite stakeholders to a strategy-planning meeting at the start of 2017.

Governance, risk management and quality measurement

- Clinical units held quarterly risk and clinical governance meetings, where incidents, serious incidents, complaints, the risk register, safeguarding and infection control were discussed as regular agenda items. We saw minutes of these meetings which indicated this was occurring.
- These meetings fed into clinical governance reports which were produced quarterly and helped with the delivery of the trust strategy. We saw examples of these reports.
- The clinical governance report was presented to the quality and safety board subcommittee, which fed into the trust board.
- The clinical administration dashboard provided measurement of quality of across the directorate. It measured a range of key performance indicators weekly, which were discussed at a daily multidisciplinary call to highlight any areas of potential problem. We saw there was a set agenda for the daily calls and weekly meetings.
- Booking leads monitored breaches and escalated to speciality service managers for action.
- We saw a variety of risk assessments, which included assessments of equipment, environment and substances hazardous to health. Staff had received appropriate training to carry them out and the health and safety lead ensured everyone had read them and signed to indicate they had. We saw signatures of staff to indicate this had occurred. We saw risk assessments about medication, equipment and waiting area for children.
- Radiology risk meetings discussed incidents, the risk register, lessons learnt and trends. This occurred every two months and we saw minutes of these meetings which indicated this was occurring. This was available for all staff to see on the shared computer drive and hard copies were available in the staff room, which we saw.
- A structured audit programme supported the clinical units and departments within those, to ensure patient safety was at the forefront of service provision. Actions were monitored locally and within sub-committees and clinical governance meetings. These ensured lessons could be learnt and actions had been completed.
- The diagnostic imaging department did not have a clear plan in place to monitor performance. The radiology manager did not know waiting times for different examinations, although the radiology booking lead did. This meant there was no leadership view of how the department was performing over time.
- The radiology manager did not have a clear understanding of reporting incidents under IR(ME)R, nor did they know when the last radiation protection advisor (RPA) report was, where the report was or when the next one was due. This meant there was no assurance the department was working as it should . there appeared to be no knowledge of whether any actions had arisen from the last RPA audit or if any had been completed.

Leadership of service

Outpatients and diagnostic imaging

- Staff overwhelmingly spoke positively about the executive leadership team. They felt they were visible and staff were positive about improvements occurring throughout the trust.
- The outpatient's service sat within three separate clinical units; specialist medicine, surgery and women and children. In each clinical unit, staff reported to a matron, who worked across site. The matrons reported to and met regularly with the heads of nursing, who reported to general managers. General managers reported to clinical unit leads.
- There were clear lines of management responsibility and accountability within the outpatient's department. Staff in all areas stated they were well supported by their managers. They were visible and provided clear leadership.
- Radiographers and radiography department assistants reported to leads for individual examinations. The leads for individual examinations reported to the radiology manager, who reported to the senior general manager.
- Some staff in diagnostic imaging told us they felt their managers were 'invisible'. Other staff told us they had not met their service manager, who had been in post for a year. They felt they had not been consulted or kept updated with regard to the considerable structural changes that had occurred within the department. They told us they had raised concerns around building work, but felt they had been ignored.

Culture within the service

- All staff we spoke with were very proud of their work and services they provided to the local community. They were focused on providing a good experience for patients who visited their department. Staff and managers told us there was an open culture and they felt they could express their opinions and were listened to by the management. Local teams worked efficiently and staff were supportive to one another.
- Staff working in the outpatients department were overwhelmingly positive about changes made within the department over the past 12 months and felt this was sustainable.
- Outpatient managers were proud of their staff and the work they did.
- The outpatient nursing staff supported and promoted the '6C's' of nursing, which are care, compassion, competence, communication, courage and commitment
- Doctors, nurses and allied health professionals told us the communication between the different professionals was "excellent" and that it helped to promote a "positive working environment."
- Staff we spoke with told us they felt able to raise concerns and discuss issues with the managers of the department.
- The trust had introduced a 'Speak up' guardian. We spoke with staff who gave examples of when this was used and were confident the matter was dealt with fully.
- In the diagnostic imaging department some staff reported a disconnect between staff on the ground and middle managers. They told us they never saw senior members of the management team.
- Morale in the department was low and staff reported feeling tired and 'stretched to breaking point'. They reported teamwork was good and they felt supportive of each other. They were proud they were managing despite low staffing levels, but did not feel this was recognised by their managers.
- They told us they were unable to have regular staff meetings because of staffing, yet they had one prior to inspection, we saw there was only one set of staff meeting minutes available on the shared drive.

Public engagement

- The patient experience steering group provided a report to the patient safety and quality group. The report gave an overview of information on patient experience from the patient advice and liaison service, friends and family test and volunteer services.
- The out of hospital team engaged with local Healthwatch and held public engagement events to help shape the services being developed.

Staff engagement

- Staff in outpatients felt engaged and involved with their work in local departments and throughout the trust.

- They had a daily safety huddle and the key points discussed were displayed for staff working later in the day to see and be informed of.
- Although the outpatient nursing staff were in separate clinical units, they supported one another and carried out regular peer reviews.
- Staff spoke positively about the monthly staff awards, we saw certificates displayed in outpatient areas recognising award winners.
- The clinical administration team developed 'you said, we did' in response to staff feedback, for example; staff told managers they did not feel valued and their work was not recognised. Managers responded by participating in the Unsung Heroes celebrations, monthly and annual trust awards.
- A networking study day had led to the idea of a safety information board where safety advice and information was displayed.
- Staff in diagnostic imaging had a daily briefing, which they had been doing for a long time, weekly staff meetings and monthly staff meetings. Their daily briefing key points were documented on a white board daily and at the end of the day, those points were written into a book. This was to share discussions with staff that had not attended the briefing.
- In summer 2016 there was a roadshow organised by the managers to enable the staff working within the out of hospital unit to know who the senior team was and what they were doing. We were shown the presentation from this roadshow.
- Staff told us they received and read an electronic newsletter from the chief executive.

Innovation, improvement and sustainability

- A health care assistant had introduced a 'rebalance programme' which encouraged patients to lose weight and had won an award.
- An outpatient nursing team had put forward an abstract to the Royal College of Nursing about the development of their health care assistants and at the time of inspection were waiting on an outcome.
- Nursing staff were developing and implementing the standardisation of nursing practise across the trust.
- The clinical administration team developed a weekly performance dashboard, which was used, alongside daily operational calls to monitor performance and areas of concern across the service. This included reception, health records, inpatient and outpatient bookings and medical secretarial services.
- There was a collaborative programme to agree standard operating procedures and specialty booking rules which resulted in more effective clinic utilisation, less errors and consequently improved patient experience.
- A business case had been prepared to implement, a new function within the patient administration system to reduce dependency on paper records of appointment outcomes. This aimed to support more accurate and timely capture of data to support patient pathways.
- The team have implemented a major health records improvement project which was still underway at the time of inspection. In Autumn 2016 the plan was to start a programme of electronic document management to further improve access to and quality of health records.
- In diagnostic imaging a, consultant radiologist, received a trust award for support in audit / research, nominated by the foundation doctors at the trust foundation awards event.
- The department were introducing an electronic requesting system, which would remove paper requests for in and outpatient diagnostics.
- The clinical unit called the out of hospital team is the team supporting all allied health professionals working in the hospital and developing services with the support of the CCG in the community as well. The unit worked with the CCG in the development of 'East Sussex better together' strategy and has launched initiatives such as the Crisis response service that provides urgent assessment and provision of community nursing care in the patient's own home.
- Services were co designed with the commissioners of health services to shape the care in the community and avoid unnecessary hospital admissions. It included all intermediate care units, pharmacy and all community-nursing teams.

Outstanding practice and areas for improvement

Outstanding practice

- Positivity and engagement of staff in the outpatient department. A commitment to deliver high quality care and develop their own staff.
- The trauma nurse service coordinator had coordinated a complex international repatriation with an acquired brain injury (ABI) specialist nurse from the clinical commissioning group, a general practitioner and an ABI non-profit organisation. The trauma nurse acted as a single point of contact for the patient's family and in the process identified the need for an ABI pathway that included scope for international collaboration and repatriation. As an interim measure, information for international patients and relatives was made available on the trust's website and the trauma nurse planned to develop this pathway as part of their work to improve rehabilitation services.
- A dedicated multidisciplinary team had established a five year plan to establish an innovative rehabilitation care plan as part of an out of hospitals services transformation programme. This programme included staff from multiple specialties and enabled ED staff to work with colleagues from across the trust and in the community to develop future services, including an ambulatory rehabilitation unit and a rapid access care service. The programme planned to introduce nurse practitioner roles for frailty, crisis response and proactive care who would provide an integrated rehabilitation service alongside hospital and community-based specialists. This programme would significantly improve working links between the trust's hospitals and local authority social care services and enable rehabilitation services to be provided more responsively to avoid the need for hospital admissions. There was significant support and infrastructure for staff to develop this programme and they had been invited to present their plans and work so far at a national health and social care awards ceremony.
- Innovative service developments to meet the individual needs of specific patients were being encouraged. These included providing keepsake boxes for bereaved parents and including the use of knitted comfort bands to reduce the likelihood of patients with dementia tugging at IV lines.
- The recent maternity review was effective and considered the views of users alongside staff. It resulted in quick improvements to the service and a more positive culture amongst staff.
- Women received a further risk assessment upon entering the labour suite by a lead midwife. This change came about following a series of incidents involving missed opportunities for early intervention.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that consultant cover meets the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine.
- Must develop play services in line with national best practice guidance.

Action the hospital SHOULD take to improve

The surgery directorate should ensure completion of anaesthetic machine logbooks

- The surgery directorate should ensure compliance with: inadvertent perioperative hypothermia, NICE guidance clinical guideline CG 65.
- The surgery directorate should ensure accurate record keeping of controlled drugs in theatres.
- The surgery directorate should improve the quality, content and outcomes of mortality and morbidity meetings.

Outstanding practice and areas for improvement

- The surgery directorate should ensure compliance with the guidance contained in venous thromboembolism (VTE) in adults: reducing the risk in hospital QS3.
- The surgery directorate should ensure compliance with National Patient Safety Alerts regarding safer spinal and epidural needles.
- The surgery directorate should ensure a consistent governance structure across the two surgical directorates.
- Review all maternity policies and procedures that are outside their review date and take action to ensure all policies reflect current national and evidence-based guidance.
- The hospital should discuss and record ceilings of care for patients who have a DNACPR.
- The trust should have a defined regular audit programme for the end of life care service.
- The trust should record evidence of discussion of an end of life care patient's spiritual needs.
- The trust should implement a formal feedback process to capture bereaved relatives views of delivery of care.
- The trust should ensure that all staff received regular mandatory training for end of life care.
- The trust should provide a formal referral criterion for the specialist care team for staff to follow.
- The trust should define and streamline their end of life care service to ensure staff are clear of their roles and who to contact.
- The trust should develop a rapid discharge process for end of life care patients to be discharged to their preferred place of death.
- The trust should extend the Palliative care team service to provide support and advice over the full seven days. As the hospital did not currently have this provision, some patients did not have access to specialist palliative support, for care in the last days of life in all cases.
- Work towards meeting the requirements of the key performance indicators of the National Care of the Dying Audit (NCDAH) 2016.
- Continue to consider ways to improve staff recruitment and retention such that it meets the national recommended levels.
- The trust should ensure incidents occurring in the ED are investigated thoroughly and all staff are included in the dissemination of the outcomes.
- The trust should ensure nurse to patient ratios in the ED are managed in relation to the individual needs of patients based on acuity.
- The trust should ensure that RTT is met in accordance with national standards.
- The trust should ensure that standard for patients receiving their first treatment within 62 days of an urgent GP referral is met.
- The diagnostic department should ensure all policies and procedures are up to date.
- The diagnostic imaging department should ensure they have a recent audit from their Radiation Protection Advisor.
- The diagnostic imaging department should monitor their waiting times and reporting times.
- The diagnostic imaging department should ensure staff attend mandatory training in line with the trusts target.
- The maternity services should ensure medication locks are suitable and do not allow unauthorised patient access.
- The maternity services should ensure there is a clear procedure documented for pool evacuation.
- The trust should consider improving the environment in the Day Assessment Unit waiting area as flooring could be a trip hazard and the room is unwelcoming.
- The maternity services should a robust mechanism is in place to monitor and audit abortion HSA4 notification completion.

Outstanding practice and areas for improvement

- The maternity services should ensure resuscitation trollies are fully stocked with items that are in date, at all times.
- The maternity services should ensure cleaning schedules are adhered to and audit is appropriately used to monitor this in the obstetric theatres.
- The children's service should address the lack of storage space and cramped conditions on the Kipling ward.
- The children's service should develop transition planning for children with long term conditions approaching adulthood.
- The children's service should improve efficiency of appointment and clinic booking systems to avoid long delays in accessing paediatric review and to improve efficiency.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The trust must ensure that consultant cover meets the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine.** **The trust must appoint a play specialist to lead and develop play services at the hospital.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...