

East Sussex Healthcare NHS Trust

# Eastbourne District General Hospital

## Quality Report

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Date of inspection visit: 4, 5, 6 October 2016  
Date of publication: 27/01/2017

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 Eastbourne 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.

# Summary of findings

- 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.
- 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.

## CARING

- All services inspected were rated as good for caring.
- Data and our observations confirmed the very positive feedback received from patients with respect to the caring nature of staff.
- Staff treated patients with dignity, respect and kindness. Patients felt supported and said staff cared about them. Patients and staff worked together to plan care and there was shared decision-making about care and treatment

# Summary of findings

- The trust's Friends and Family Test performance (% recommended) was generally better than the England average between July 2015 and June 2016. In the latest period, July 2016 trust performance was 97.9 % compared to an England average of 95.4%. This was an improvement on the performance in the FFT in August 2014, when the score was 67% trust wide.

## 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.

## 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.

# Summary of findings

- 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.

# Summary of findings

- 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.
- Ensure that play specialist staff are employed to lead and develop play services in all areas where children are cared for.

In addition the trust should:

- 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 provide for the specialist palliative care team at Eastbourne District general Hospital weekly multidisciplinary meetings to discuss all aspects of patient's medical and palliative care needs.
- 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 (NCDAA) 2016.
- Develop and implement a programme of regular audits for end of life care.
- The trust should ensure audits of infection control practices in ED including hand hygiene are used to improve practice.
- Investigate and reduce the mixed sex breaches on surgical wards at EDGH. The reason for these should be documented in all cases.

# Summary of findings

- Continue to consider ways to improve staff recruitment and retention such that it meets the national recommended levels.
- Work with local stakeholders to address the delays to patient pathways and continue to progress towards meeting their referral to treatment time targets.
- The diagnostic imaging department should ensure they have a recent audit from their Radiation Protection Advisor.
- Play services should be developed and a play specialist employed.
- The trust should ensure hazardous waste management and disposal practices in the ED meet national control of substances hazardous to health guidance.
- 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 a patient receiving their first treatment within 62 days of an urgent GP referral is met.
- The diagnostic imaging department should ensure they are reporting incidents in line with legislation and demonstrate following their own policy.
- 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 and reporting times.
- The diagnostic imaging department should ensure staff attend mandatory training in line with the trusts target.
- The children's service should develop clear criteria for the transfer of patients by private car between sites.
- The children's service should ensure that children are not transferred to the Conquest Hospital late at night, through timely decision making and effective planning of the transfer.
- The children's service should ensure that outpatients appointments are not subject to cancellation and delays,.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Requires improvement

### Rating



### Why have we given this rating?

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

- Consultant cover did not meet the minimum requirements of the Royal College of Emergency Medicine and there was a 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 increased pressure on staff.
- Compliance with hand hygiene was variable and there was not a robust improvement plan in place to address this.
- Waste management did not meet national guidance and presented infection control risks.
- Pain management was inconsistent and there was room for improvement in the documentation of risk assessments and observations, including in fluid charts and comfort rounds.
- There was limited provision for paediatric services and no trauma surgery services at this site and incidents indicated staff had not always acted sufficiently quickly to ensure appropriate transfers took place.
- Delays to triage, assessment and treatment were continually poor and changing leadership and clinical governance systems had not addressed this significantly.

However we also found areas of good practice:

- Staff worked in a culture that empowered them to report incidents and errors and senior teams provided investigations and feedback. Where an incident resulted in patient harm or occurred due to a staff mistake, appropriate training and support was provided. There was consistent evidence the duty of candour was used to maintain transparency and communication with patients and relatives.



# Summary of findings

- 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 special bereavement and keepsake resources for the parents of infants who experienced sudden infant death syndrome.
- 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

# Summary of findings

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.

Since the visit dated September 2014, there have been significant improvements in the quality of care being provided by Eastbourne Hospital emergency services. There are still areas where the service needed to continue to make improvements (detailed above) but we saw mitigation of risk where there were shortfalls and robust plans with timescales for the improvements to be made. Staffing continued to be a challenge for the trust but consultants were working as an effective team and providing additional cover where there were gaps in the rota. Additional nurses had been recruited, including specialist paediatric nurses and improvements in training for healthcare assistants. The departmental leadership was clearer. The leadership of the ED 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. Band seven matrons led shifts. A service manager had responsibility for flow and patient journeys through the department.

## Surgery

Good



We found the surgery services at Eastbourne District General Hospital (EDGH) to be good because:

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- The hospital had good medicine management processes in place, which related to the security and storage of medicines on all the wards we visited. In general, medicines in theatres were well managed but we observed the block signing of controlled drugs which was contrary to best practice guidance.
- The trust was compliant with the intercollegiate document, safeguarding children and young people: role and competences for health care staff (March 2014). Staff we spoke to were able to demonstrate an understanding of their responsibilities to safeguarding vulnerable adults.
- The identification, reporting and investigation of incidents had improved significantly since our previous inspection. We saw minutes of meetings where incidents including never events were discussed and learning fed back to staff via ward meetings and newsletters, which were available in hard copy and circulated by email. There were readily observable changes made across the trust in relation to never events that had occurred, with learning widely disseminated. Learning from Morbidity and Mortality meetings needed further development. Records were brief and suggested limited discussion and challenge.
- The recently introduced electronic observation recording system had led to improvements in the management of deteriorating patients. Earlier recognition and identification resulted in more timely review by the critical care outreach team, who had oversight of all NEWS Scores for all patients in the hospital. Where the NEWS score was elevated to a higher level there was automatic review by the medical emergency team.
- The incidence of both pressure damage and falls had shown a sustained improvement over time. Ward and departmental safety thermometer results showed improvements across the service. Medicines management had been added to the safety thermometer as an additional performance measure.

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- 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.
- Infection prevention and control measures had improved since our previous inspection. The 'Bare below the elbow' policy was enforced more rigorously through the daily safety huddles. Hand hygiene audits showed sustained high levels of compliance with results maintained above 97% since February 2016.
- The trust rate of surgical site infections (SSIs) was better than the national average.
- Equipment checks were now given a higher priority. Daily checks of essential equipment were taking place with records available to confirm senior oversight of equipment checks occurring.
- Care pathways used in surgery referred to national guidance from the National Institute for Care and Excellence (NICE) guidance and other bodies such as the British Orthopaedic Association guidelines. We observed staff following national best practice guidance in theatres.
- Consent was obtained in accordance with the trust policy and guidance from the professional regulatory bodies. Staff had an understanding of what informed consent entailed. They had received training in the Mental Capacity Act 2005 and knew how this impacted on their work.
- Friends and Family Test results showed a higher than average response rate and the scores were higher than the England average. Over 98% of surgical patients would recommend the hospital.
- The hospital staff tried to ensure that the individual needs and preferences of patients were met. There was a system in place to identify patients who might be a little confused and need careful support in decision making. The coloured butterfly markers allowed

# Summary of findings

staff to differentiate these patients from those with more advanced dementia. The dental team provided exemplary planning of care for patients with learning difficulties who needed dental surgery. Every adaptation was offered to make the appointment as comfortable and relaxed as possible.

- A robust governance system was being introduced. At the time of our inspection visit it was partially rolled out with a clear timeline for continued introduction of key aspects of the framework. The triumvirate management structure for the division gave clear lines of reporting, clear accountabilities and responsibilities and was known to staff. All those we spoke with were clear who their immediate manager was; this was not the case on the last inspection visit in 2015.
- The majority of staff reported positive changes in their workplace culture and spoke of approachable and supportive middle managers. We saw real warmth in the relationships between ward leaders and nurses and from the HoN towards their wider team. One team of staff felt their manager was less approachable and they felt less supported but this appeared to be about an individual middle manager's approach.
- Black and minority ethnic (BME) reported that they felt supported and accepted as part of the hospital workforce. We saw respectful and confident interaction between BME staff and white British staff on the wards we visited. However
- The trust systems for the management of patient records were new and not yet fully embedded. Patient records had been moved off site and were retrieved when needed but staff reported some delays in this. There were times still when patient records were not available for pre-assessment clinics and consultations.
- There was a high vacancy rate of 12% for surgical nursing staff and the service was highly reliant on bank and agency staff for both nursing and medical staffing. Recruitment continued to provide challenges and whilst the

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trust had taken many steps to address this, the problem of recruiting sufficient permanent staff continued. The nursing staffing levels had improved since our previous inspection visit in September 2014. Theatres staffing met the recommendations of the AfPP and ward level planned nursing staffing versus actual staffing was usually met, albeit with temporary staff.

- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance since July 2015.
- There were 735 mixed sex breaches on surgical wards at EDGH during a 12-month period. The reason for these was not documented in most cases.

## Maternity and gynaecology

### Requires improvement



Overall, we rated maternity and gynaecology services as requires improvement because:

- There were delays for patients using gynaecology services and referrals to treatment times were consistently worse than the 18-week target.
- A lack of specialist training for nurses who cared for gynaecology patients presented a risk that may have impacted upon patient care.
- Most of the maternity policies and procedures were outside their review date. This meant staff might not have been informed around all the relevant and current evidence-based guidelines, standards or best practice.

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.
- Staff checked and maintained equipment to ensure that it worked safely.
- Staff received up-to-date mandatory training in all safety systems. This included responding to childbirth emergencies such as post-partum haemorrhage (excessive bleeding after childbirth) and cord prolapse. Cord prolapse is

# Summary of findings

when the cord comes out before the baby during labour, which can cause a reduced supply of blood and oxygen to the unborn baby.

- 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 patients who used services were generally positive and met expectations.
- Appraisal rates met trust targets.
- Staff treated patients with dignity, respect and kindness. Patients felt supported and said staff cared about them.
- Patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- The service made reasonable adjustments and removed barriers when people found it hard to use or access services, for example, through provision of interpreters.
- 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 its 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.

**Services for  
children and  
young  
people**

**Requires improvement**



We rated this service as requires improvement because:

- There was no play service provision at the hospital.

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- Incident reporting, whilst improved from 2014, was still inconsistent and did not reflect the number of incidents that should have been reported
- The hospital had no paediatric recovery nurse
- Paediatric nurse cover overnight in the emergency department was limited.
- A number of pathways and policies were still in development
- Waiting times for outpatients appointments for some patients were excessive
- The appointment system was not working well and patients were not being sent letters regarding upcoming appointments
- Transfers to the Conquest hospital were taking place very late from the SSPAU
- There were no explicit criteria to guide staff as to whether a child should be transferred by ambulance or fit to go by private car.

However:

- The Friston Unit was clean, uncluttered and had a good play area for children.
- We saw a good example of staff adhering to the duty of candour
- We were given positive accounts about the compassionate care children had received from parents and children themselves
- All staff were aware of the vision and strategy for the trust and how services for Children and Young People fits in.
- Initiatives had been introduced to help keep children out of hospital.
- There were plans in place to have a paediatric nurse in the emergency department and on the wards on a rotational basis.
- Links between acute and community services were good.
- There was clear line management and staff were aware of their responsibilities.
- Service development was being encouraged.

**End of life  
care**

**Requires improvement**



Overall we rated the end of life care service at Eastbourne District General Hospital Requires Improvement. This was because:



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- 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 (NCDAAH) 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 (2005) assessments and recording of ceilings of care (best practice to guide staff, who do not know the patient, to know the patients previously expressed wishes and/or limitations to their treatment) for patients with a completed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form.
- Patients did not have access to a specialist palliative support, for care in the last days of life in all cases, as the hospital did not have a service seven days a week.
- The specialist palliative care team at the hospital did not have a weekly multidisciplinary meeting to discuss all aspects of patient's medical and palliative care needs.
- The hospital did not have a rapid discharge process for end of life care patients to be discharged to their preferred place of death.
- The hospital did not monitor or record end of life care patient's referrals to the chaplaincy team.
- 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.

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## 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 that we saw were all completed in accordance with national guidance.
- 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 medical team at the local hospice.
- A current end of life care policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.

**We identified some improvements in the service but judged that it still needed further work and**

# Summary of findings

investment to ensure it could continue to meet the needs of the patients it served. There was better end of life care planning and recording of individual care needs and preferences.

We could see that discussions with patients and their relatives were now taking place around dying. All the DNACPR forms that we saw were correctly completed with clear reasoning and recording that the decision to withhold resuscitation had taken place. Previously, DNACPRs were poorly completed, with limited information as to why the decision had been made and whether there had been any family involvement.

The bed management arrangements had been revised since our previous visit and site managers were now clear that where a patient was receiving end of life care there was an expectation that they would be nursed in a side room. Movement of these patients was restricted and made only when all other possibilities had been considered.

## Outpatients and diagnostic imaging

### Requires improvement



We found the outpatient and diagnostic imaging services at Eastbourne District General Hospital to be 'requires improvement'. This was because:

- Staff numbers in the diagnostic imaging department were 33% below the number required to cover all examinations and the on call rota.
- The diagnostic imaging department did not clearly demonstrate or document the process of investigating incidents or follow its own incident reporting policy. The radiology manager did not have a clear understanding of reporting incidents under IR (ME) R.
- The diagnostic imaging department had not met the target for mandatory training, which included safeguarding training.
- The trust referral to treatment time (RTT) had fallen below the 92% standard from March 2016 onwards.
- The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.

# Summary of findings

- Morale was described as low by some staff 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.

However

- The outpatient department had systems and processes in place to keep patients free from harm. Incident reporting was now embedded in everyday practice and there was evidence of learning from incidents.
- Infection prevention and control practices were in line with national guidelines. The department was clean and there was a newly refurbished reception area. Staff adhered to the trust infection prevention and control policies. 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. Equipment checks were taking place and labels were used to clarify when equipment had been cleaned and was ready for re-use.
- 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. Records were available for clinics; the number of temporary records was monitored daily using the clinical administration dashboard. Less than 1% of appointments were held where records were not available, which was in line with the trust target.
- Records were accurate, legible, complete and were stored securely. The outpatient service was in the process of centralising the records store and planned to scan all paper records onto an electronic system.
- Safeguarding arrangements were understood and followed by staff. Training, to an appropriate level, was provided and senior advice was readily available.

# Summary of findings

- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement. The outpatient and diagnostic imaging departments participated in a variety of local and national audits to demonstrate compliance with best practise, professional standards and National Institute for Health and Care Excellence guideline (NICE) guidelines.
- The outpatient services had sufficient numbers of competent staff to provide their services. Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- There were differentiated outpatient pathways to meet the needs of different groups of patients. Particular consideration was given to meeting the needs of patients on cancer pathways.
- We observed good radiation compliance as per national policy and guidelines during our visit. 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 the ionising radiation (medical exposure) regulations (IR (ME) R, 2000).
- Consent was obtained and recorded in line with national guidance and the trust policy. Staff had a sound understanding of the Mental Capacity Act (2005) and how this impacted on their work.
- 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.
- Patient engagement had developed and hospital staff worked with the local Healthwatch, a patient experience group and local community to listen and work together to improve experiences.

# Summary of findings

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

We noticed considerable improvements in the way the outpatient services were now being managed when compared to the findings from our previous inspection visits.

We reported serious concerns about both the availability and condition of individual medical records after both the September 2014 and March 2015 inspections. In March 2014 we saw that one clinic of 24 patients had run with seven sets of notes unavailable. We were told this was usual. The trust did not hold data relating to missing notes at the time of that inspection. From the current inspection visit we saw data was now collated that the service was meeting the trust target of less than 1% notes missing. A new tracker system had been introduced and records storage had been moved offsite with a retrieval system put in place. The trust was in the process of introducing an electronic records system with all current records being scanned into the system before it went live.

The premises looked cleaner and some areas had been refurbished. 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. Staff were adhering to the trust policies on infection prevention and control.

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.

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%. At this inspection, 12 of the

## Summary of findings

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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.

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# Eastbourne District General 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

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## Background to Eastbourne District General Hospital

Eastbourne District General Hospital is located in the town of Eastbourne and geographically serves the population of Eastbourne, Polegate and Hailsham. Along with Conquest Hospital in Hastings and the community locations it forms East Sussex Healthcare Trust. Healthcare is provided to the whole population from this and other trust locations.

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 at Eastbourne District General Hospital 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 2016 for 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.

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

# Detailed findings

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.

\* rate per 100,000 population

## 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 on 4, 5, 6, October 2016 and the team who visited the

hospitals on 16 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 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 on 4, 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 Eastbourne District General 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
<b>Urgent and emergency services</b>	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
<b>Surgery</b>	Good	Good	Good	Requires improvement	Good	Good
<b>Maternity and gynaecology</b>	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
<b>Services for children and young people</b>	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
<b>End of life care</b>	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
<b>Outpatients and diagnostic imaging</b>	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
<b>Overall</b>	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

# 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 Eastbourne District General Hospital has a five-bedded emergency nurse practitioner unit, six majors cubicles, four adult resuscitation bays, one paediatric resuscitation bay, one neonatal resuscitation bay, a helipad and decontamination unit. There is also a clinical decision unit with 11 beds including a side room for isolation, a medical assessment unit with 31 beds and an ambulatory care unit.

The trust's adult emergency departments saw 131,509 patients between April 2015 and March 2016, of which 23% were admitted. The paediatric emergency department was responsible for seeing and treating 11,308 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 not available on site and patients are transferred to the trust's Conquest site.

During our inspection, we spoke with 25 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 three relatives, seven patients and spent time observing care being delivered, reviewed 25 sets of patient notes and looked at 67 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.

On the previous inspection in September 2014, we rated the emergency services at Eastbourne Hospital as 'requires Improvement'. Issues identified as concerns at that visit included ineffective staff engagement and poor staff satisfaction rates. There was a lack of visible 'on the floor' leaders which meant that staff felt unsupported and that there was no oversight of the department on each shift. Staff were unclear who to turn to for advice. We observed that there was poor recording of observations and a limited escalation response when patient's condition was deteriorating. Not all patients had a senior review in a timely manner and some suffered harm because of this. Medicines within the unit were not being well managed. A trust wide shortage of pharmacists reduced their availability to the emergency department. Poor staffing levels resulted in shortcuts that meant medicines were not always stored and administered in accordance with the national guidance. Staffing was a concern with insufficient consultant cover and low nurse staffing levels on many shifts.

# Urgent and emergency services

## Summary of findings

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

- Consultant cover did not meet the minimum requirements of the Royal College of Emergency Medicine and there was a 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 increased pressure on staff.
- Compliance with hand hygiene was variable and there was not a robust improvement plan in place to address this.
- Waste management did not meet national guidance and presented infection control risks.
- Pain management was inconsistent and there was room for improvement in the documentation of risk assessments and observations, including in fluid charts and comfort rounds.
- There was limited provision for paediatric services and no trauma surgery services at this site and incidents indicated staff had not always acted sufficiently quickly to ensure appropriate transfers took place.
- Delays to triage, assessment and treatment were continually poor and changing leadership and clinical governance systems had not addressed this significantly.

However we also found areas of good practice:

- Staff worked in a culture that empowered them to report incidents and errors and senior teams provided investigations and feedback. Where an incident resulted in patient harm or occurred due to a staff mistake, appropriate training and support was provided. There was consistent evidence the duty of candour was used 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 special bereavement and keepsake resources for the parents of infants who experienced sudden infant death syndrome.
- 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

# Urgent and emergency services

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.

Since the visit dated September 2014, there have been significant improvements in the quality of care being provided by Eastbourne Hospital emergency services. There are still areas where the service needed to continue to make improvements (detailed above) but we saw mitigation of risk where there were shortfalls and robust plans with timescales for the improvements to be made. Staffing continued to be a challenge for the trust but consultants were working as an effective team and providing additional cover where there were gaps in the rota. Additional nurses had been recruited, including specialist paediatric nurses and improvements in training for healthcare assistants.

The departmental leadership was clearer. The leadership of the ED 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. Band seven matrons led shifts. A service manager had responsibility for flow and patient journeys through the department.

## Are urgent and emergency services safe?

Inadequate



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

- The unit did not meet the Royal College of Emergency Medicine minimum requirement 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. In addition, medical cover on the medical assessment unit did not meet the minimum requirement of the Royal College of Physicians.
- Nurse to patient ratios frequently fell short of established safe minimum standards and this was reflected in incident reports submitted by staff.
- The department did not meet the trust's minimum hand hygiene audit compliance of 90% in any month between April 2016 and October 2016. During this period compliance was highly variable, with a score of just 25% in the emergency department in April 2016 and a score of 70% in the medical assessment unit in September 2016.
- Hazardous waste was not collected and disposed of in line with national guidance and there were risks to patients in the environment due to a lack of vigilance, including a discarded needle and syringe left within reach of a confused patient. Chemical products were not always stored securely.
- There was inconsistent and sometimes inaccurate use of the national early warning scores system and there was inconsistent use of a sepsis pathway tool, safety checklist and body maps to record injuries. This meant that risks to patients were not always appropriately managed.

However, we also found areas of good practice:

- Processes were in place to ensure all staff in the department were able to confidently submit incident reports and have them investigated by a senior member of the team, including with multidisciplinary input. Serious incidents were investigated thoroughly but



# Urgent and emergency services

there was limited evidence that outcomes were disseminated adequately to staff. There was evidence learning from incidents was made available for staff although there was variable recognition of this.

- 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.
- Fire safety and major incident processes were well established and a trauma nurse service coordinator was developing a major incident training programme.

## Incidents

- Between March 2016 and June 2016, 101 incidents were reported in the emergency department (ED) including the clinical decisions unit (CDU) and in resuscitation. The most common incidents, 19% of all reported, related to falls and staff took appropriate action in each case, including investigating how patients could be more safely supported to move. Eleven incidents related to short staffing in cases where staff felt the service was unsafe as a result. In each case the site team and head of nursing were made aware of the situation and reallocated staff where possible.
- All of the staff we spoke with demonstrated knowledge of the incident reporting system and told us they were confident in its use.
- Where incidents related to other teams working in the ED, senior staff worked with relevant colleagues to ensure they were investigated and acted upon. For example, where a patient was inappropriately discharged by a member of staff from the therapies team, ED managers and the therapies manager worked together to support the member of staff involved and identify how the error could be avoided in future.
- In accordance with the Serious Incident Framework 2015, ED reported four serious incidents (SIs) which met the reporting criteria set by NHS England between August 2015 and July 2016. Two SIs related to the inappropriate management of deteriorating patients,

one SI related to an inappropriate discharge that led to readmission and one SI related to a fall that resulted in a bone fracture. In each case there was evidence that senior clinicians and governance staff were involved immediately in investigations and that a multi-specialty approach was taken to identify further related risks. For example, the SI that related to an inappropriate discharge was found to have occurred because a member of staff did not read the patient's notes. A manager provided structured training and support for the member of staff and ensured their work area was modified to reduce the risk of a recurrence until the investigation was fully completed.

- The outcomes of incidents were shared with staff through a 'lessons learnt' folder available in the staff room as well as through e-mail and in handovers. However, despite these methods and the detailed investigations of SIs, there was limited awareness of learning from incidents amongst clinical staff we spoke with.
- Incident reporting information indicated staff spoke openly with patients and relatives when things went wrong in line with the trust's duty of candour policy. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- 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.
- In September 2016, the urgent care clinical unit had 62 unresolved mortality reviews in place. This meant 62 patient deaths, of which 36 were attributed to ED, had not been reviewed by an appropriate clinician. To address this, a clinical governance support office led a mortality review improvement plan 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.
- All of the staff we spoke with, including nurses, doctors, ENPs, the hospital intervention team and non-clinical staff demonstrated a good awareness of the principles

# Urgent and emergency services

of the duty of candour. 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. This included how it worked in practice, including being open with patients and relatives following unavoidable moving and handling incidents.

- A clinical governance facilitator supplied a weekly overview of incident reports to the ED and the head of nursing identified a key theme or area for staff to focus on reducing incidents in, such as medicines management.

## Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism.
- We saw evidence that safety thermometer data was being routinely used to improve the quality of care, such as the number of 'harm free days' in each area. The medical assessment unit (MAU) had experienced 182 days without a new pressure ulcer and there had been no instances of hospital-acquired *Clostridium Difficile* or MRSA infections for over 18 months.

## Cleanliness, infection control and hygiene

- Signs at the entrance to clinical areas instructed staff and visitors to use hand gel but there was none available in these areas.
- We observed staff using personal protective equipment appropriately including wearing gloves but we did not always see every member of staff wash their hands before or after patient contact or follow guidance consistently. For example, one doctor did not use hand gel before examining a patient and washed their hands afterwards but used their hand to turn off the tap. This meant their hands might not be fully clean and disinfected.
- 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 an average of 55% compliance in five months and did not contribute data in one month. This included a compliance result of 25% in April 2016 and 43% in May

2016. The unit did not achieve the trust's minimum target of 90% compliance in any month during this period. An infection control link nurse was in post who monitored hand hygiene audit results and said the variance in scores was usually due to visiting staff and poor compliance with uniform policy.

- The MAU hand hygiene audit for September 2016 indicated 70% compliance with trust policy and the environmental cleanliness audit result indicated 86% compliance.
- 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 89%. This related to all staff groups responsible for cleanliness and hygiene practices. The rate of compliance amongst nurses was similar, at 94%.
- The nurse in charge monitored cleaning activities and ensured cleaning staff completed basic initial checklists between 8am and 11am each morning. Cleaning staff were available 24-hours, seven days a week to conduct a deep-clean of any clinical areas used to care for patients with an infectious condition. However, cleaning standards were not consistent or thorough in all areas. For example curtain rails and other high-levels surfaces in the MAU and shelving in the ambulatory care unit were dusty.
- The children's waiting room contained soft toys that could not be wiped and staff said there was not a routine infection control or decontamination process for them. This meant there was a risk for cross-infection between children who handled the toys.

## Environment and equipment

- Refurbishment of some areas of the ED was under way, including a mental health assessment room and paediatric areas. 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.



# Urgent and emergency services

- 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 a day, 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.
- Faulty sample delivery equipment sometimes contributed to a delay in patient diagnostics and treatment. For example, the delivery chute system used to transport blood samples around the hospital sometimes malfunctioned and delivered patient blood samples to another clinical unit rather than the laboratory. There was not a robust procedure in place to ensure staff were alerted to this and ED staff relied on the receiving person to contact them about the error. Staff told us this situation had recently changed as they could previously ask the portering team to deliver blood samples but this service had stopped.
- Orange waste bags were used for all waste in the unit, regardless of whether it was clinical, hazardous or general waste. This meant it was not possible to differentiate how hazardous waste segregation took place. This was not in accordance with HTM 07-01, the Control of Substances Hazardous to Health (COSHH) and Health and Safety at work regulations.
- There was inconsistency in how staff managed hazards in line with COSHH regulations. For example, in the MAU four containers of chlorine tablets were on show in an unlocked sluice room. This posed a risk of poisoning and was against national best practice guidance. In addition, two sinks had plugs attached, which contravened the Department of Health's Health Building Note 00-09 relating to infection control in the built environment. However, all other areas of the ED were compliant with this guidance.
- The disposal of consumables did not always follow trust policy or safe guidance. For example, staff in MAU had discarded used saline syringes on a general rubbish bin on a phlebotomy trolley. We asked a nurse about this who said they usually decanted syringes into a hazardous waste bag after a sample was taken or saline administered. This meant contaminated waste was not disposed of at the point of use and there was a potential risk of cross-infection. In an ED cubicle we found a discarded used needle and syringe on a shelf within reach of a confused patient. This presented an immediate risk to their safety and we escalated it to a nurse, who removed the items. A 30 litre sharps bin had been used for paper towels, used gloves and urine bottles and was full to capacity, which indicated inappropriate waste streaming.
- Although procedures relating to the disposal of needles and syringes were inconsistent, staff adhered to the European Union Council Directive 2010/32/EU relating to the prevention of sharps injuries during the administration of treatment and diagnostics, including the use of a safer sharps system.
- Resuscitation trollies were in a good state of repair, clean and tidy. Staff documented daily safety and stock checks on each trolley and electrical equipment had been serviced at appropriate intervals.
- We checked 19 items of electrical equipment and found they had an up to date electrical safety test.
- There was limited use of 'I'm clean' stickers to indicate when equipment had been cleaned and decontaminated. For example, some items of equipment had stickers on them in the ED but none of the equipment in MAU had stickers.

## 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. Daily support was provided by a pharmacy technician who supplemented the central monitoring checks with stock taking and stock rotation.
- Between March 2016 and June 2016, nine incidents were submitted in relation to medication administration and communication errors. Although each incident was investigated, learning was not always evident to help prevent a recurrence. For example, one incident occurred where staff were unable to immediately treat a patient with a life-threatening condition because senior site staff were unaware of where to find a specific medication. The investigation found small doses of the drug were kept in critical care and noted the site manager should have a list of all drugs kept on site. This incident occurred in March 2016 and had not been concluded by October 2016.

# Urgent and emergency services

- A few medicines were clustered as “kits” for the treatment of sepsis and other situations such as rapid sequence intubation where the prompt access to a group of medicines can improve patient outcomes
- Bulky medicines like IV fluids and irrigations were stored securely in a separate room
- Patient Group Directions were used by registered nurses to provide pain relief during triage and to supply medicines to take away within the minor injuries unit. These PGDs were within their review dates and had been appropriately approved by the organisation. Individual staff were also appropriately approved to use the PGDs
- To improve patient experience suitable patients were offered access to IV antibiotics via the ambulatory emergency care clinic (AECC). We spoke to one patient who had been discharged on oral antibiotics, however these were not effective. The option of once daily IV antibiotics administered initially in the AECC, then by district nurses was offered as an alternative to a hospital admission. The patient explained how they preferred to be at home, but appreciated the need for the IV antibiotics. Staff explained how they had supported another patient with IV antibiotics whose lifestyle made the AECC service more convenient than the district nurse service.
- Staff in the ENP unit did not consistently record the temperature of the medicines fridge in the unit. For example, eight daily temperature checks were missed between August 2016 and October 2016. We asked an ENP about this who told us short staffing in the team would sometimes mean the member of staff on duty did not have time to complete checks.
- The CDU admissions protocol required staff to complete a drug chart and management plan before patients could be admitted. Both documents were complete in the 12 cases we looked at.
- Nursing risk assessments were completed inconsistently. In eight sets of notes we looked at, five had incomplete or missing risk assessments for falls, pressure ulcers or venous thromboembolism. Medication charts did not have patient weights recorded but staff told us they did not have access to scales. One patient had been admitted to the CDU following a fall but staff had not completed a falls risk assessment.
- Staff used an integrated patient care document to record observations, social care needs and updates to patients’ condition. The nursing section of this document was completed inconsistently. For example, in seven sets of patient records we looked at, two had documented nursing input in the integrated care document.
- In all of the patient records we looked at, medical entries were legible and included the doctor’s name and the date and time of the entry.

## Safeguarding

### 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.
- 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 was in line with the Safeguarding Children and Young People – Roles and Competencies for Staff Intercollegiate Document updated in September 2010 which recommend all staff who work directly with children complete the appropriate level of training.
- Of the staff required to complete child safeguarding level two, 95% were up to date and 69% were up to date with child safeguarding level three.
- 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

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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.

- A health visitor had recently delivered a training session to staff on recognising warning signs relating to child protection. This session was also used to empower staff to contact out of hours urgent support services when they were worried about the welfare of a child.
- Detailed and up to date information was readily available to staff about referring patients to out of hours crisis support teams, social workers and child protection duty officers.
- Multidisciplinary staff working in the department could refer directly to the paediatric liaison team, safeguarding team and social services if needed.
- An incident investigated, highlighted the need for a significant improvement in staff knowledge and understanding of safeguarding processes in relation to vulnerable young people. For example, staff failed to complete a mental capacity assessment or risk assessment documentation of an adolescent who presented in the department with an overdose. There was no evidence staff had discussed the possible consequences of the patient's refusal or treatment and child and adolescent mental health services had not been contacted. ED staff had not recognised the risk in this incident and a member of staff from corporate services had raised it. Staff were unaware if additional training had been provided in the safeguarding of vulnerable young people, particularly those under youth offending orders.

## Mandatory training

- Senior staff monitored completion rates for mandatory training of staff against the trust's 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 and were generally positive about their training experiences. Matrons and the practice development nurse helped to monitor staff progression.

## Assessing and responding to patient risk

- Staff were trained in life support to a level in line with their role and level of experience and responsibilities. Nurses and HCAs were able to take ALERT (acute life-threatening events recognition and treatment) training and 26% of staff had completed this in the three years prior to our inspection. Between August 2015 and August 2016, the department implemented a programme to increase the numbers of staff with advanced or specialist training. This included one member of staff who successfully completed advanced life support training, one member of staff who successfully completed European paediatric advanced life support (EPALS) training and two members of staff who successfully completed advanced trauma life support training. Staff also completed paediatric intermediate life support (PILS) training and trauma intermediate life support training.
- Staff used the national early warning scores (NEWS) system to monitor patient condition and to identify when someone was deteriorating. This was not always recorded regularly and staff did not consistently use a proforma for the management of sepsis. For example, in three out of five patient records we looked at, the NEWS score had been calculated incorrectly. The results of monthly NEWS audits in the 12 months prior to our inspection showed average completion rates were between 70% and 90%. However, staff demonstrated appropriate knowledge of how they would escalate a deteriorating patient to the critical care outreach team. The paediatric early warning (PEWS) score was used appropriately in all cases we looked at. 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.
- 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. For example, one patient had been admitted after being found on the floor at home but staff had not completed a body map to record their injuries.

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- Staff were required to complete an ED safety checklist for each patient who was seen in the majors section of the ED. The checklist detailed safety checks that should be carried out at key time intervals for sick patients. However, checklists had been completed in only two out of five records we looked at. We observed staff using this tool effectively when treating patients in the resuscitation room.
  - An alert system was in place to help staff identify specific risks to patients separate from their medical condition. For instance, a discreet symbol was placed on patient records if they were known to be under the care of child protection services or were known to be living with Parkinson's disease. This prompted staff to review their medical history in secure electronic files before proceeding and provided an extra level of safety for patients.
  - Two SI investigations found staff had failed to respond appropriately to acutely unwell or deteriorating patients. This included a 12-hour delay in escalating a deteriorating patient for medical review and failure to manage the airway of a patient. The incident report indicated resuscitation efforts had been hampered by short staffing, a lack of equipment and inappropriate administration of drugs. Outcomes of both incidents were yet to be formally determined at the time of our inspection and staff were not aware of any interim measures to improve risk management.
  - 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. These data were provided by the ambulance trust and the hospital did not collect or monitor handover data. It was therefore difficult to ascertain an accurate reflection of the waiting times as they were not being recorded for the majority of patients.
- ## Nursing staffing
- A nurse director and deputy nurse director provided senior clinical oversight in the ED and a head of nursing, deputy head of nursing and a service manager were responsible for the ED and CDU.
  - A team of 38 nurses, supported by a team of healthcare assistants (HCAs), led nursing care in the emergency department. There were five nurse vacancies and the senior management team were preparing a review of safe nursing levels using the Royal College of Nursing (RCN) baseline emergency staffing tool. A deputy head of nursing had also recently been appointed to provide greater oversight of the quality of care provided in relation to staffing levels.
  - Planned staffing levels were 10 nurses including an emergency nurse practitioner (ENP) and four HCAs from 8am to 8.30pm and six nurses and three HCAs between 8.30pm and 8am. The ambulatory care unit was open from 8am to 4pm and planned staffing was two nurses and one HCA and the CDU had a planned staffing level of two nurses and two HCAs. However, nurse staffing levels were often inconsistent. During our weekend unannounced inspection the ED was operating with one less registered nurse than considered necessary to run it safely, with a further reduction in the afternoon. This correlated with increasing waiting times in the ED, including up to 52 minutes for triage and up to 5 hours and 20 minutes to see a doctor.
  - A lack of paediatric nurses was highlighted as a significant risk on the urgent services risk register. The trust had mitigated this by increasing the number of nurses with PILS and EPALS training and improving training in the use of the paediatric streaming pathway. In addition, an on-call paediatrician attended each paediatric crash call to support the nursing team and three paediatric nurses had recently been recruited to improve the department's ability to treat children.
  - Five ENPs provided a dedicated clinic seven days a week from 8am to 12am. Although the team operated independently from the ED, ENPs told us the matron and medical team were always readily available and easy to access if they needed support. Where an ENP service was not available due to non-availability of staff, doctors covered the service in addition to their usual workload.
  - Two nurses had successfully completed an ENP course in the 12 months prior to our inspection, which enabled them to increase cover for the ENP service.
  - Nursing skill mix varied between day shifts and nights shifts. For example, doctors told us during the day nurses could complete venepuncture and cannulation but overnight the team was less skilled and they had to complete some basic procedures themselves. This was

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reflected in patient feedback for the hospital submitted through the Patient Opinion independent feedback service whereby a relative was distressed by the lack of nursing staff to insert a cannula and the resulting delay in waiting for a doctor.

## 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.
- 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.
- 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 not meet the minimum consultant cover required by RCEM. 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 just been recruited into substantive posts between this ED and the trust's Conquest site.
- Three SHOs and three middle grade doctors provided cover on a staggered shift basis on 24 hour cycles between 8am and 8am, including two SHOs and a middle grade doctor overnight between 12am and 4am. However, this could not always be achieved due to the non-availability of staff. For example, during one night of our inspection, the ED was staffed by a consultant and an SHO who also had to cover the ENP service due to short-staffing.
- Staff told us on a weekend a consultant was usually available until at least 3pm although during our weekend unannounced inspection there was no consultant available at 1pm.
- A consultant led a review clinic from 9am to 10am Monday to Friday in the ENP unit. This enabled them to support ENPs in the treatment of patients with infected wounds and similar conditions. Outside of these hours, junior doctors provided a support role to patients with injuries in this unit.
- Twice daily handovers took place, led by either a consultant or senior registrar. We observed a handover and saw a very high standard of concise communication from the consultant that included identification of key patient risks, including the use of the sepsis six pathway. Each doctor present contributed effectively regarding care and planned treatment and the specialist skills of one doctor were used to ensure appropriate allocation of staff to patients took place.
- There was no lead consultant in place but a senior consultant led medical care in the unit pending a new governance and unit structure in November 2016.
- A paediatric registrar was based in the ED overnight from 8.30pm.
- Consultant cover in the medical assessment unit (MAU) did not meet the minimum requirements of 12 hours a day, seven days a week set by the Royal College of Physicians. Although cover was provided by a respiratory consultant, there was no further back-up to this arrangement and as a result the risk of clinical decisions being made by junior staff was highlighted as an 'extreme' risk on the urgent care service's risk register. This had last been reviewed in August 2016 with no immediate resolution. Despite this, all patients admitted to the MAU had an initial consultant review.
- A registrar, two SHOs and a core medical trainee doctor provided medical care on the MAU in addition to the consultant. This cover was typically provided between 8am and 5pm Monday to Friday and out of hours the medical on-call team of two SHOs and a twilight doctor covered the unit. An on-call registrar and consultant were also available. Medical trainees and other doctors on MAU spoke highly of their opportunities for learning and the support they received from the unit's consultant.

## 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



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staff to take part in a fire drill or fire evacuation drill every 12 months. Two fire wardens were in post and records demonstrated they had completed weekly fire safety checks in the six months prior to our inspection.

- 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.
- Care was provided in accordance with National Institute for Health and Clinical 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 dedicated practice development nurse provided structured practical support to nurses and healthcare assistants in developing professional competencies. Staff also had access to training from a range of specialists.
- 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:

- Management of pain scores and pain relief was inconsistent, particularly in relation to paediatric pain scores.
- There was inconsistent use of tools to manage risks associated with dehydration, including a lack of fluid balance monitoring and observation.
- There was variable performance in the time it took for patients to undergo a computerised tomography (CT) scan.
- The department performed worse than similar units in the Royal College of Emergency Medicine audits for assessing cognitive impairment in older people and in the management of mental health needs.
- The department performed worse than the national average in four of 12 measures in the most recent Royal College of Emergency Medicine audit for severe sepsis and septic shock.

## Evidence-based care and treatment

- A local audit programme was shared with the Conquest urgent care clinical unit and included 28 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, regional Commissioning for Quality and Innovation

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priorities, 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 of compliance with the Royal College of Emergency Medicine (RCEM) Guidelines for the use of thromboprophylaxis in ambulatory trauma patients.

- An audit of sepsis and septic shock care in the ED was due to take place between August 2016 and January 2017.
- Emergency nurse practitioners (ENPs) worked in accordance with national best practice guidance issued by NICE, including for safe staffing practices in accident and emergency and in the treatment of head injuries. Guidance was readily available to ENPs in the department.
- Staff were encouraged to conduct audits in their own specialist areas to develop and improve practice. For example, an ENP had completed an audit into the effectiveness of the use of an injection to prevent blood clots in patients with plaster of Paris on their lower limbs. In addition, a staff nurse had completed an audit of the number of patients seen in the ambulatory care unit and the level of their need.

## 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 similar to other trusts.
- The trust scored 7.4 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.
- The CDU provided patients with overnight pain management delivered by a multidisciplinary team and was a dedicated area for continual pain observation.
- A clinician was due to conduct an audit of pain relief in the ED between September 2016 and December 2016.

- Staff consistently completed initial pain scores for all patients in the ED and in four out of five notes we looked at in the ENP unit. However, in ten paediatric records we looked at, pain scores were documented in only five cases.
- Information was provided in the waiting room to instruct patients how to request pain relief if they needed it and we heard clinical staff asking patients about pain regularly.

## Nutrition and hydration

- In the CQC A&E Survey, the trust scored 7.0 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 than other trusts.
- The malnutrition universal screening tool was available in integrated care documentation to enable staff to monitor risks associated with malnutrition. We did not see that staff routinely used this document during patient assessment.
- Staff did not routinely or consistently use fluid balance charts to monitor patients at risk of dehydration. For example, one patient was being treated with intravenous fluids but staff did not use a fluid balance chart. Another patient had been admitted with dehydration and staff had started a fluid balance chart but there was a gap of over seven hours in recording.
- Refreshments including drinks and sandwiches were available in the ED 24 hours a day, seven days a week and staff could order hot meals for patients who were in the department for an extended period. Patients in the day ambulatory care unit also had access to food and drinks throughout the day.
- Following feedback from patients about the quality of food on the medical assessment unit, staff introduced a process for steaming hot meals just prior to serving them.
- 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 that patients did not always have access to timely, expert input from a nutritionist or dietician.

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## 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 2015/16 year, 60 patient cases were considered in the TARN audit, which included one trauma death. This audit identified a trajectory of improvement in the mortality rate in the ED, from 13% of trauma patients in 2015 to 2% in 2016.
- In 2015/16, the number of patients who survived a trauma as a result of treatment was better than the expected rate of survival. For example, 80% of patients were expected to survive and an average of 93% actually survived.
- The ED performed variably in the time to CT scans for patients admitted with a trauma such as 32 minutes in July 2015, 57 minutes in March 2016 and 43 minutes in July 2016.
- Stroke services had been consolidated at the Eastbourne site. A recent report issued by the Stroke Association in early November 2016 showed that the hospital was providing good access to stroke services. The Stroke Association map was based on data from the Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) for 2015-16.1 Eastbourne hospital came within the top ten stroke service provider nationally on the five metrics that measured access to services. Overall it was placed as the best provider for access to treatment.
- In the 2013/14 RCEM audit for severe sepsis and septic shock, the trust was in the lower quartile compared to other trusts for four of the 12 audit measures. There were eight measures between the upper and lower quartiles and no measures in the upper quartile. This meant the department performed worse than the national average in comparison to other trusts. The trust performed in the lower quartile of results for the following measures:
  - A serum lactate measurement was obtained in the ED in 46% of cases
  - There was recorded evidence that blood cultures were taken in 62% of cases
  - Antibiotics were administered in 70% of cases
  - There was evidence that urine output measurements were instituted in the ED in 26% of cases
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the trust performed variably. A cognitive assessment took place in 54% of eligible patients although a structured assessment tool was used in 92% of these cases. The hospital did not meet the fundamental standard of having an early warning score documented for every patient.
- In the 2014/15 RCEM audit for mental health in the ED, the trust was in the lower quartile compared to other trusts for three of the six audit measures. Of the two fundamental standards included in the audit, the trust did not meet the fundamental standard of documented risk assessment. The trust met the fundamental standard of dedicated assessment room for mental health patients at this site. In addition, a risk assessment was taken and recorded in the patient's clinical record in only 10% of cases and staff had conducted and recorded a mental state examination taken and recorded in only 6% of cases. There were no cases where a patient had been assessed by a mental health professional within one hour.
- Between May 2015 and April 2016, the trust's unplanned re-attendance rate to ED 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%.

## Competent staff

- Overall in the urgent care clinical unit, 90% of staff had received an appraisal in the previous 12 months. Nurses and HCAs were positive about the appraisal process and said they felt it gave them the opportunity to identify where they would like more training or experience. Recently appointed nurses said they were happy with their induction programme and felt they had enough support and supervision to develop their professional competencies.
- A paediatric nurse and two dual-qualified nurses had completed specialised paediatric accident and emergency training modules.



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- All ENPs had completed specialised post-registration training to enable them to lead the ENP unit.
  - Staff had access to specialist training provided by other teams and clinicians. Recent training had included burns care with a burns advisor, a paediatric triage study day, an eye and head injury study day and observation training from a cardiology nurse.
  - A senior sister practice development nurse (PDN) was in post and offered staff bedside teaching and learning sessions to help develop their skills and competencies, including in suturing and plastering. Staff nurses also had the opportunity to shadow ENPs to develop their skills in treating minor injuries. The PDN also provided targeted support for new staff recruited from outside of the UK in establishing their existing skills against national practice. For example, staff had been recruited who held accreditation in another country for paramedic skills and radiography skills and the PDN worked with them to find out how their knowledge could be best used. Overall 84% of staff had completed a mentorship course and 26% of staff had attended accident and emergency specialist training modules. Twenty two percent of nurses had completed paediatric training modules.
  - Nurses and HCAs undertook additional training to work in link roles in areas in which they had a special interest. This included keeping up to date with new policies and procedures, assisting with audits and attending training sessions so they could brief their colleagues. 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 diabetes link nurse attended multidisciplinary meetings every two months to ensure they were up to date with new protocols and treatment information and cascaded this to colleagues through handovers and a communication file that was regularly updated.
- Multidisciplinary working**
- A team of seven nurse practitioners, occupational therapists and physiotherapists formed the hospital intervention team (HIT) and were dedicated to the ED with services provided Monday to Friday 8am to 6.20pm and between 9am and 5pm Saturday and Sunday. This team had two vacancies and had filled one with a locum member of staff to minimise disruption to the service. The HIT team supported patients in their admission to an inpatient ward and could refer patients directly to the rapid discharge team.
  - 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.
  - Staff had access to support from four speech and language therapists in the hospital.
  - The ED had a dedicated clerical team who staffed the reception desk and a reception manager was responsible for ensuring the department had sufficient medical cover. This was an experienced team but the numbers of staff and workload meant they did not always feel part of the whole department team. For example, overnight only one receptionist was on duty and the reception manager described difficulties in attracting doctors to work at the site.
  - The medical team and a dietician, physiotherapist and senior nurses conducted a daily multidisciplinary review of each patient on the medical assessment unit. This included input from the HIT team and rapid discharge team where needed.
  - 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 15 ED patients with palliative care needs, a clinician contacted an out of hours palliative care team on only one occasion. In the MAU, clinicians contacted specialists in only four out of 28 patients who needed palliative care. This meant that patients at the end of life might not always receive the most appropriate treatment, including pain and breathlessness management. The audit team were due to present the results and their recommendations to the clinical unit board in December 2016.

## Seven-day services

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- Consultants were available seven days a week although the cover provided did not meet the minimum 16 hours per day required by RCEM or the 12 hours per day on the medical assessment unit required by the Royal College of Physicians.
- 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. Other services were not available at weekends or out of hours, including dietetics and speech and language therapy. This met clinical services seven day standard 3, 2016. This requires all emergency inpatients 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.

## 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.
- 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.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In March 2015, a hospital records audit identified that in a sample of 15 ED patient records there was no documented evidence staff had completed a Mental Capacity Act (2005) (MCA) assessment. The same audit

indicated staff obtained formal consent for treatment in only 40% of patients. Staff in the MAU documented consent more readily and this was present in 85% of the 26 patients included in the audit.

- Staff recorded they had obtained consent from patients for examination, diagnostics and treatment in all of the records we looked at. During our inspection, clinical staff at all levels of responsibility demonstrated a good understanding of the principles of the MCA and the Deprivation of Liberty Safeguards.
- A mental health risk assessment tool was in place for vulnerable patients and included an escalation plan to ensure patients were safeguarded appropriately whilst waiting for a mental health assessment. This tool was also used for young people when staff needed input from child and adolescent mental health services and had been developed as a result of feedback from the relative of a patient in the department.
- These findings represented an improvement on the department's practice earlier in 2016 as demonstrated by incident reports that indicated a significant lack of understanding of mental capacity assessments or their responsibilities in line with legislation.

## Are urgent and emergency services caring?

Good



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

- 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.
- Patients and relatives told us they felt treated with kindness and compassion by staff and said they felt involved in their care.
- We observed most staff were friendly in their interactions with patients and ensured their privacy and dignity with the appropriate use of curtains and good communication. We did notice some members of staff address people in a gruff or unfriendly manner but this was an exception during our inspection.

# Urgent and emergency services

## 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 88% of patients said they would recommend this emergency department (ED) compared to an England average of 87%.
- Most of the interactions we observed between staff and patients were positive and staff demonstrated kindness and understanding although this was not always consistent. For example, one nurse spoke gruffly with a patient who was disorientated and confused and did not alter their style of communication when the patient could not answer their questions. A colleague noticed this and intervened. However, other interactions we observed were much better, such as one nurse who patiently encouraged an elderly patient to take small sips of a drink to stay hydrated.
- The trust published patient, relative and public feedback using their social media-based '#ourmarvellousteam' programme. The ED had recently received positive feedback. For example, one patient commented "The way the team respond to diverse needs whilst working under pressure from arrivals...is inspirational."
- One patient said, "The staff are all wonderful, I'd give them 11 out of 10." One relative said, "Staff have checked on my wellbeing as well as that of [patient], they just seem very naturally caring."
- Feedback from the Friends and Family Test in the medical assessment unit indicated a 91% recommendation rate for September 2016 and included comments such as, "You were all so cheerful" and "General care was excellent."

## 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 were positive about the care they had received. One patient said, "Staff have updated me often on what's happening and told me to ring my bell if I need anything." A relative said, "Everything has been fully explained, I feel really confident in the staff here." Another patient said, "I've had to come here a few times but every time staff are just as involved and they explain what they're doing and why."
- 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

- A practice development nurse provided support to staff in the department following a death. This included facilitating a formal debrief with other staff when needed.
- A multi-faith chaplain was available 24 hours a day, seven days a week.
- Staff provided immediate signposting to support services, including emergency counselling services, for the relatives of babies who died from sudden infant death syndrome.

# Urgent and emergency services

## 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:

- 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. This represented a deteriorating situation and the trust had identified as a significant risk, with short staffing a contributory factor although several new initiatives were in the implementation stage to help reduce delays.
- Delays to triage and assessment were substantiated following a peer review by the Academic Health Science Network.
- Although resuscitation facilities were available, there was limited provision for trauma care and no trauma surgery service.
- A mental health assessment room in the department was poorly equipped and presented a number of safety risks to patients and staff.

However, we also found areas of good practice:

- The service was planned and delivered with consideration to the needs of local people. This included on-site mental health liaison services offered 24 hours a day, seven days a week and a dedicated mental health urgent care lounge. Staff had prepared Polish translation cards in response to an increase in visitors during the summer months.
- Separate areas for children were available once they had been triaged and relatives had access to a comfortable, well-equipped pastoral room.

- Staff had completed audits to identify how they could further meet the needs of vulnerable groups, including those with suicidal intent. A dementia specialist was available on site and dementia link nurses helped colleagues in communication with patients.
- The median time to assessment for patients arriving by ambulance was better than the national average and between April 2015 and April 2016 there had been no ambulance handover delays longer than 30 minutes.
- 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.
- Patients had been involved in the resolution of complaints and improvements had been made to the service, including to noise levels overnight on the medical assessment unit.

### Service planning and delivery to meet the needs of local people

- Services for children were limited at this site and after 8pm, paediatric patients who needed to be admitted were transferred to the Conquest Hospital. This took place according to an established pathway and involved a telephone consultation between sites before the patient was transferred and admitted to Kipling ward.
- Mental health liaison nurses were available on site 24-hours, seven days a week and could see patients if they were medically fit and not under the influence of alcohol. A mental health urgent care lounge was available elsewhere in the hospital between 9am and 9pm, seven days a week. Patients could be seen there by agreement between emergency department (ED) staff and a mental health nurse. In addition, a child

# Urgent and emergency services

and adolescent mental health team offered an urgent care service but staff told us the wait for this was often lengthy and resulted in delays in young people being seen.

- In response to an increase in international visitors seen in the department during the summer months, staff had prepared translation cards in Polish that meant they could communicate in basic terms more rapidly than obtaining a formal interpreter.
- Organ donation nurses were available on call and senior staff in the unit had been trained to discuss this sensitively with relatives and to make urgent referrals.
- 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 then 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. We saw positive interactions between the crisis response team and ED staff that demonstrated attention to detail in planning to meet patient needs, including personal needs such as making sure their pets were cared for.
- Senior clinical staff raised concerns about the lack of provision at Eastbourne Hospital for trauma surgery. For example, one patient who presented in the ED with a need for urgent intestinal surgery was reviewed by a surgical registrar but could not be treated at the hospital and deteriorated too rapidly to be transferred to the Conquest site.

## Meeting people's individual needs

- The ED had a dedicated waiting room and treatment room for children, which could be isolated from adult areas to ensure children were protected from unpleasant sights and sounds. However, children shared the same waiting area as adults while waiting to be triaged. The paediatric waiting room was well equipped with toys and a TV that staff used for distraction if needed.

- Clinical staff had completed two audits of the care and treatment received by patients based on individual needs. This included patients who presented in ED with palliative care needs and those with a risk of self-harm or with suicidal intent. This followed the introduction of a mental health triage tool, which staff used to provide individualised care. An audit was also underway to establish how well the ED cared for patients who presented with alcohol withdrawal symptoms against National Institute for Care and Excellence guidance.
- Staff completed comfort rounds for patients to ensure they could reach their call bell and had food and drink where appropriate but these were not documented consistently. For example, in five patient records we looked at, only three had a recorded comfort round.
- 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 that 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.
- A dementia care specialist was available on site during the day and staff could refer to them to help assess patients and provide targeted support. Staff used a butterfly sticker on patient notes to discreetly identify when someone was living with dementia. This helped staff to communicate appropriately.
- A pastoral room was available in the unit for relatives and provided a quiet, private space for staff to hold difficult conversations.
- The hospital intervention team (HIT) provided physiotherapy, occupational therapy and other multidisciplinary support to patients. This team demonstrated understanding of the communication needs of patients with dementia or a learning disability and were able to modify their communication techniques to reduce anxiety and help patients to understand their treatment.
- The hospital's League of Friends team had knitted comfort bands for patients, which helped them stop



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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. 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 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 for 95% of patients between July 2015 and June 2016. 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 director of quality improvement. 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 unit also planned to trial a consultant-led rapid assessment and treat model beginning February 2017 to enable them to assess and treat majors patients more quickly.
- 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 was similar to the England average. Between July 2015 and March 2016 performance against this standard 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 A&E for admitted patients was consistently higher than the England average. Performance against this showed an overall trend of decline between June 2015 and March 2016.
- Between May 2015 and April 2016 the monthly median time to initial assessment for patients arriving at this trust's urgent and emergency care services by emergency ambulance was consistently lower than the England average. In May 2015 the median time to initial assessment was two minutes and in April 2016 it was one minute.

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- 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 in comparison to national averages.
- 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 56 % of ambulance journeys had turnaround times over 30 minutes; in June 2016 the figure was 64%.
- 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.
- A hospital ambulance liaison officer was sometimes deployed to the ED by the local ambulance provider during times of high demand, typically when patients had been waiting in ambulances for more than 30 minutes. 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.
- Staff used an admission protocol to ensure patients were only admitted overnight to the clinical decisions unit (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.
- 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.
- 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.
- During our inspection an ambulance team leader was on site to support patient flow through the ED and to reduce the time paramedics needed to spend in the unit.
- 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.
- Staff utilised the CDU and MAU depending on the clinical status of each patient and each unit had a clear admissions policy that enabled staff to stream patients to the most appropriate area for the care they needed. For example, medically fit patients were admitted to the CDU for stays of between 24 hours and 48 hours and medically unwell patients were admitted to the MAU.
- Staff could refer patients to two out of hours GP services between 6.30pm and 6am if they were not urgent enough to be seen in the ED.
- 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 RCEM, Royal College of Nursing, Faculty of Emergency Nursing and Emergency Nurse Consultant Association state triage should occur within 15 minutes of a patients’ arrival. This was also the

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standard adopted by the trust's internal professional standards policy. Triage times varied significantly depending on the status of the department. We looked at the care of ten children in the department and seven of them had waited more than 15 minutes for initial triage.

- Following a successful pilot, an HCA was assigned to assist the triage nurse. This helped improve the efficiency of the triage system and meant the HCA could take blood samples and conduct diagnostic tests ready for when the patient was seen by a doctor. HCAs were also trained to use pathways to refer patients to the mental health liaison team, paediatrics, ambulatory care and the ear, nose and throat specialty.

## Learning from complaints and concerns

- Between August 2015 and July 2016, urgent and emergency services received 69 formal complaints. This represented 11% of all complaints received for all departments in the trust, including the Conquest Hospital. In October 2016, 18 of the complaints remained unresolved and under investigation. Of the total complaints, 32 related to aspects of clinical treatment and 11 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.
- All of the staff we spoke with demonstrated a good understanding of the complaints procedure and what they could do immediately to help patients or relatives.
- A patient who had made a complaint was invited to attend a nurse training day to talk to staff about their experience and what had contributed to their decision to make a complaint. Staff spoke positively about this and said it helped them to consider how they could ensure their communication was always of an appropriate standard. This formed part of a wider improvement in how the service responded to complaints. For example, every individual who made a

complaint was invited to a meeting with the clinical services manager or another member of the senior team and matrons were empowered to resolve complaints.

- As a result of learning from complaints, staff now completed two hourly essential care rounds that enabled them to make sure patients were as comfortable as possible.
- The MAU included a 'you said, we did' noticeboard to demonstrate how staff used feedback to improve the service. For example, patients had commented that night times could be noisy and as a result staff now provided ear plugs.

## 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 Conquest 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:



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- 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 they 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. Staff spoke positively about the changes in leadership and also said the trust senior team was more visible, including the chief executive officer.
- Nurses told us they had noticed positive changes in the leadership of the department. One nurse said, "There's been a big improvement, the managers are really supportive. During busy periods when we feel really stretched, everyone comes out to help."

## 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 Conquest 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 a day, seven days a week trauma service.
- A working group had been established to redesign the casualty cards used to initially document patients in the department. As part of this work two nurses were studying the documentation used by other EDs to identify areas of good practice that could be adapted for this trust.

## Governance, risk management and quality measurement

- The ED was part of the urgent care clinical unit, which included the clinical decision unit (CDU), the medical assessment unit (MAU) and the ambulatory care unit. Two clinical unit leads, a general manager and a head of nursing led the governance and risk management structure. This included the use of a risk register to

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assess and monitor risks to the service, its users and staff. One risk was in place at the time of our inspection that related to Conquest Hospital and a further 11 risks were shared with the Eastbourne site. The risk at the Eastbourne site related to eight nursing vacancies on the MAU, which increased reliance on temporary staffing. The trust had responded with ongoing national and international nurse recruitment campaigns although this had been insufficient to reduce the risk to the service. The head of nursing typically led the quality agenda, including a focus on the quality of clinical care such as improving pain scoring. A clinical services manager monitored access and flow including how problems were escalated and acted upon. A governance facilitator supported monthly governance and business meetings to ensure risks were identified and shared appropriately. However, there was limited evidence of substantive improvement in delays to care and treatment or to staffing levels.

- Seven of the risks the Eastbourne ED shared with the Conquest 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 one 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 they demonstrated in-depth understanding of the risks and challenges in the unit as well as a proactive approach to resolving them. For example, it was recognised that consultants did not have time to attend meetings aimed at reducing the number of patients who were not seen and treated or admitted

within four hours, which was placing additional pressure on senior nurses. As a strategy to improve clinical input at such meetings, it was agreed middle grade doctors would attend on a trial basis.

- A review by the Academic Health Science Network identified poor processes and lack of oversight of how staff used policies as 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. 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

- A senior team offered a weekly drop-in session that enabled staff to visit and discuss concerns or to have a chat if they were having a stressful week. Staff we spoke with said this was a positive initiative but felt it was sometimes difficult to get enough time to do this.
- Staff told us they felt the executive team were visible and supportive. A nurse said, "I know who the chief executive is and the chief nurse, they often come and see how we're doing." Staff also told us they felt there had been significant improvements in the working culture and environment in recent months. One nurse said, "I felt pretty low about working here a few months ago but things have improved a lot. More staff have been retained and it feels like we're all engaging with the work more." While most staff said they felt there had been a number of positive changes in the department, not all non-clinical staff felt this way. For example, one member of clerical staff said, "I don't think much has changed for us. It still feels like clerical staff are the forgotten relatives in the department."
- The hospital intervention team spoke highly of their relationships with other clinical staff in the department. One person said, "There is no 'them and us' here, we all work really well together. This is a very integrated team and everyone can learn from each other."

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- We observed positive working relationships between clinical staff of all levels, including obvious respect between doctors, nurses and healthcare assistants. This working culture was not always apparent amongst all non-clinical staff. For example, although reception staff were part of a coherent team, we observed high levels of pressure resulted in poor working relationships amongst housekeepers. For example, one member of staff who was struggling with their workload asked a more experienced colleague for guidance. Their colleague refused to help and did not offer a supportive solution.

## Public engagement

- 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.
- The newly-appointed deputy head of nursing had a remit to increase public engagement in the ED and had begun planning how this could be achieved.
- Information was provided in the waiting area to help patients and relatives understand waiting times. For example, an electronic screen explained that even though the waiting area might appear quiet, staff could also be dealing with ambulance arrivals that were not visible from there. The information also informed patients priority was given to children and the elderly.

## 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 Conquest Hospital 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 trust's other ED.

- The deputy head of nursing had introduced regular Friday meetings to give each band of staff the opportunity to meet on a regular basis.
- Managers and senior staff had involved everyone in the department in restructure and reorganisation plans through the trust's listening in action' and 'better together' programmes. This included in the plan to trial a rapid assessment and treat model and the development of paediatric services.
- A monthly staff award recognised a nominated individual for their contribution to the service. Most recently an ENP had been recognised for their commitment to patient experience and care with 622 patients they saw during one month.
- The deputy head of nursing had introduced a new strategy to gain staff feedback and identify their training and support needs. This included using a series of colour-coded postcards staff could use to write down their experiences and feelings on each shift and leave for senior staff to read.

## 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 service planned to develop its advanced nurse practitioner services and two members of staff had completed advanced physical assessment training as part of this.
- The designated Emergency Nurse Practitioner (ENPs) area continued to expand its clinical provision and ENPs assessed an average of 36% of the patients attending the department. This included supplementing the team with a trained HCA and increasing the range of minor injuries they could treat.
- The urgent care and out of hospital's clinical unit developed a frailty practitioner service that covered

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community services, the ED and wards. The model of care supported the comprehensive geriatric assessment to ensure care planning reduced length of stay and admission and attendance avoidance.

- An entrepreneur programme was being established that focused on the reduction of ambulance handover delays.
- A clinical navigator role was in development that would support patients after initial triage who did not need admission to the hospital.
- 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.
- Senior staff offered more junior colleagues opportunities to progress in the department through opportunities such as funding to attend a Royal College of Nursing leadership conference.
- 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 departments at East Sussex Healthcare NHS Trust provide care for a population of 525, 000 people making it one of the largest healthcare organisations in the country. 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).

The trust has 833 beds, 250 of these beds are surgical beds.

This report is focused upon the EDGH however; both hospitals follow the same guidelines and policies.

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

The trust has main operating theatres covering general surgery, trauma and orthopaedics, gynaecology, ear, nose and throat, urology, ophthalmology and anaesthetics across the two sites; 10 theatres are located at EDGH.

Between April 2015 and March 2016 the trust had 27, 449 surgical episodes, of these 12,765 were at EDGH. Emergency episodes accounted for 16%, 64% were day case, and the remaining 20% were elective at EDGH.

We visited all clinical areas including theatres, day surgery, ward areas, the pre assessment unit and the surgical assessment unit during our inspection.

During our inspection, we spoke to 52 members of staff including doctors, nurses, allied health professionals,

administrative staff and the executive team. We spoke with six patients and three patient's relatives and reviewed patient feedback. We reviewed 13 sets of patient records and a variety of data including meeting minutes, policies and performance data.

The report published following our visit in September 2014 rated surgical services at Eastbourne Hospital as inadequate. Wide ranging serious concerns were identified across the surgical wards and operating theatres. Specific areas that needed to be addressed included an insufficiently robust incident management process with significant under reporting and little medical involvement or oversight of clinical incidents. A lack of mortality and morbidity reviews meant that opportunities to learn were limited. Individual patient records were often unavailable and many were maintained in a very poor condition with loose pieces of paper held onto the main file with an elastic band. Staffing was an issue with exhausted staff providing task orientated care and sometimes displaying a lack of empathy towards patients. Temporary staff did not always receive an induction and did not have access to the trust IT recording systems; there was no oversight of whether longer term temporary staff had completed mandatory training.

At the time of that inspection there was poor 'buy in' from consultants with ongoing conflict about cross site working and provision of out of ours cover. In some specialities consultants were not providing adequate support for junior doctors with a resultant lack of patient review by a senior clinician.



# Surgery

## Summary of findings

We found the surgery services at Eastbourne District General Hospital (EDGH) to be good because:

- The hospital had good medicine management processes in place, which related to the security and storage of medicines on all the wards we visited. In general, medicines in theatres were well managed but we observed the block signing of controlled drugs which was contrary to best practice guidance.
- The trust was compliant with the intercollegiate document, safeguarding children and young people: role and competences for health care staff (March 2014). Staff we spoke to were able to demonstrate an understanding of their responsibilities to safeguarding vulnerable adults.
- The identification, reporting and investigation of incidents had improved significantly since our previous inspection. We saw minutes of meetings where incidents including never events were discussed and learning fed back to staff via ward meetings and newsletters, which were available in hard copy and circulated by email. There were readily observable changes made across the trust in relation to never events that had occurred, with learning widely disseminated. Learning from Morbidity and Mortality meetings needed further development. Records were brief and suggested limited discussion and challenge.
- The recently introduced electronic observation recording system had led to improvements in the management of deteriorating patients. Earlier recognition and identification resulted in more timely review by the critical care outreach team, who had oversight of all NEWS Scores for all patients in the hospital. Where the NEWS score was elevated to a higher level there was automatic review by the medical emergency team.
- The incidence of both pressure damage and falls had shown a sustained improvement over time. Ward and departmental safety thermometer results showed improvements across the service. Medicines management had been added to the safety thermometer as an additional performance measure.
- 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.
- Infection prevention and control measures had improved since our previous inspection. The 'Bare below the elbow' policy was enforced more rigorously through the daily safety huddles. Hand hygiene audits showed sustained high levels of compliance with results maintained above 97% since February 2016.
- The trust rate of surgical site infections (SSIs) was better than the national average.
- Equipment checks were now given a higher priority. Daily checks of essential equipment were taking place with records available to confirm senior oversight of equipment checks occurring.
- Care pathways used in surgery referred to national guidance from the National Institute for Care and Excellence (NICE) guidance and other bodies such as the British Orthopaedic Association guidelines. We observed staff following national best practice guidance in theatres.
- Consent was obtained in accordance with the trust policy and guidance from the professional regulatory bodies. Staff had an understanding of what informed consent entailed. They had received training in the Mental Capacity Act 2005 and knew how this impacted on their work.
- Friends and Family Test results showed a higher than average response rate and the scores were higher than the England average. Over 98% of surgical patients would recommend the hospital.
- The hospital staff tried to ensure that the individual needs and preferences of patients were met. There was a system in place to identify patients who might be a little confused and need careful support in decision making. The coloured butterfly markers allowed staff to differentiate these patients from those with more advanced dementia. The dental

# Surgery

team provided exemplary planning of care for patients with learning difficulties who needed dental surgery. Every adaptation was offered to make the appointment as comfortable and relaxed as possible.

- A robust governance system was being introduced. At the time of our inspection visit it was partially rolled out with a clear timeline for continued introduction of key aspects of the framework. The triumvirate management structure for the division gave clear lines of reporting, clear accountabilities and responsibilities and was known to staff. All those we spoke with were clear who their immediate manager was; this was not the case on the last inspection visit in 2015.
- The majority of staff reported positive changes in their workplace culture and spoke of approachable and supportive middle managers. We saw real warmth in the relationships between ward leaders and nurses and from the HoN towards their wider team. One team of staff felt their manager was less approachable and they felt less supported but this appeared to be about an individual middle manager's approach.
- Black and minority ethnic (BME) reported that they felt supported and accepted as part of the hospital workforce. We saw respectful and confident interaction between BME staff and white British staff on the wards we visited.

However

- The trust systems for the management of patient records were new and not yet fully embedded. Patient records had been moved off site and were retrieved when needed but staff reported some delays in this. There were times still when patient records were not available for pre-assessment clinics and consultations.
- There was a high vacancy rate of 12% for surgical nursing staff and the service was highly reliant on bank and agency staff for both nursing and medical staffing. Recruitment continued to provide challenges and whilst the trust had taken many steps to address this, the problem of recruiting sufficient permanent staff continued. The nursing staffing

levels had improved since our previous inspection visit in September 2014. Theatres staffing met the recommendations of the AfPP and ward level planned nursing staffing versus actual staffing was usually met, albeit with temporary staff.

- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance since July 2015.
- There were 735 mixed sex breaches on surgical wards at EDGH during a 12-month period. The reason for these was not documented in most cases.

# Surgery

## Are surgery services safe?

Good



We rated safety as 'Good' for the surgery service at EDGH. This was because:

- Incident reporting was promoted and investigations arising from reported incidents provided an opportunity for learning. Incidents, including never events, were discussed and learning fed back to staff via ward meetings and newsletters, which were available in hard copy and circulated by email. There were readily observable changes made across the trust in relation to never events that had occurred, with learning widely disseminated.
- All clinical areas we visited were visibly clean. Cleaning audits were being completed and results were displayed for patients and members of the public to see. Staff were adhering to the trust policy of being bare below the elbows; the message about this was reinforced through the daily safety huddle. Staff were given a strong message that they should challenge poor infection prevention and control practice. The environment in all areas inspected was fit for purpose. Areas were tidy and free from clutter.
- The trust rate of surgical site infections (SSIs) was lower than the national average
- We observed good practice in relation to the management of sharps.
- The trust had introduced an electronic observation system that was showing improvement in patient outcomes through better escalation of deteriorations in patients' conditions. The number of cardiac arrests and admissions to level three critical care had reduced. The outreach staff and senior clinicians felt that this was as a direct consequence of early intervention.
- The hospital had good medicine management processes in place, which related to the security and storage of medicines. Improved access to pharmacy advice on the wards and for review of individual patient medication was noted.
- Staff had access to the appropriate level of safeguarding training. Staff we spoke to were able to demonstrate an understanding of their responsibilities to safeguarding vulnerable adults.
- The safety thermometer was used to benchmark ward and departmental performance against other units and over time. The incidence of both pressure damage and falls had shown a sustained improvement over time and was markedly reduced from our previous inspection visit in September 2014.
- 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.
- There was a high vacancy rate of 12% for surgical nursing staff and the service was highly reliant on bank and agency staff for both nursing and medical staffing.
- The trust had recently changed its system for managing patient records and these were now stored off site. Staff told us that there was still sometimes a delay in accessing notes but that notes now went missing less often. The lack of patient records appeared on the surgical care risk register since November 2015. However, this risk had not been reviewed since December 2015.
- Staff told us that notes were often in poor condition. During our inspection, we found that there were sometimes loose papers within the set of notes but most were in good order.
- Minutes of the trust morbidity and mortality meetings were brief and we did not see sufficient evidence of learning.
- We found controlled drug (CD) record keeping related to patient's own drugs on wards and administration of CDs in theatres did not comply with the Misuse of Drugs Regulations 2001.
- Ward and theatre staff had limited knowledge of procedures in the event of a major incident.

### Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety



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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 three incidents, which were classified as Never Events for surgery. These were appropriately reported using the Strategic Executive Information System (STEIS). There were two incidents related to medicines and one surgical/invasive procedure meeting serious incident (SI) criteria.
- We saw learning from the never events circulated to staff via newsletters which were available in hard copy and circulated by email. For example, the wrong route incident where oral ketamine was administered intravenously in October 2015. Learning included reminding staff to use a purple oral syringe to administer oral medication and posters placed as reminders. As per the March 2016 trust audit of safe handling of medicines 100% of surgical clinical areas had purple oral syringes available.
- We saw purple oral syringes and posters in clinical areas we visited. Staff we spoke to were aware of the changes made because of this never event.
- In accordance with the Serious Incident Framework 2015, the surgery directorate reported 20 SIs, which met the reporting criteria set by NHS England between August 2015 and July 2016 of these; the most common type of incident reported was slips, trips and falls with 30% of total incidents. Between July 2015 and June 2016 2,270 surgical care incidents were reported at the trust.
- Heads of Nursing maintained oversight of specific locations of incidents through ward level performance dashboards. These were used to identify any areas of particular concern, which were then addressed through 'challenge meetings'.
- We saw evidence that root cause analysis (RCA) investigations were completed following never events and SIs. However, a review of eight incidents that occurred across the trust showed a lack of consistency in the quality of investigation and the completion of RCAs.
- There was robust scrutiny of incidents, from the trust SI group, through the quality and safety committee to board level.
- The trust has an up to date incident reporting and management policy in place.
- The trust used an electronic incident reporting system. Staff were aware of it and knew how to access it. However, a number of staff we spoke to had not reported an incident using the system.
- We saw evidence in ward meeting minutes of incidents being discussed. For example, an incident related to missing controlled drugs (CDs) was discussed at a November 2016 ward meeting with a reminder to staff that the nurse in charge should have possession of the CD keys.
- Staff we spoke with were aware of the 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 knew what DoC meant and could describe their responsibilities relating to it. However, we reviewed incident forms and patient notes relating to these and could not find evidence that staff had applied DoC correctly in all cases. This meant that we did not have assurance that patients were consistently made aware of incidents that involved them in line with DoC.
- We saw a copy of the surgical divisional performance report to the board, which stated that morbidity, and mortality (M&M) reviews were being undertaken although there was still some improvement needed. We saw minutes of the M&M meetings, documentation of the discussion and felt that learning was potentially limited by the brevity of the discussion. A lack of M&M meetings for some specialities was highlighted in the trust's last inspection report.

## Safety thermometer

- The safety thermometer is a national tool used for measuring, monitoring and analysing common causes

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of harm to hospital inpatients. These included falls, new pressure ulcers, catheter and urinary tract infections (UTIs) and venous thromboembolism (VTE, blood clots in veins).

- Ward matrons told us they also completed the medication safety thermometer each month, which is an additional non-mandatory tool.
- Noticeably, across all areas of the trust, the prevalence of pressure damage to patient's skin had been falling consistently since April 2016. At July 2016, the pressure ulcer rate was 0.4 per 100 patients surveyed which was a major improvement when compared to the August 2014 rate which was 5 per 100 patients.
- The number of falls had remained fairly static over the reporting period of this inspection (April 2015- March 2016) but had improved by a similar amount to the pressure sore prevalence over the period 2014-2016.
- Trust level data from the safety thermometer showed that there were 38 pressure ulcers, six falls with harm and 12 catheter UTIs between July 2015 and July 2016. The prevalence of pressure ulcers peaked in April 2016 and had since reduced. Of these, 28 pressure ulcers, eight falls and 12 catheter UTIs were in surgical patients.
- The trust Integrated Performance Report showed trust compliance for VTE risk assessment was above 95% from July 2015 to June 2016. We saw completed VTE risk assessments documented in patient records and appropriate prescribing of anticoagulation (medication to prevent blood clots) on prescription charts.
- Wards we visited had boards, which indicated the date of the last fall and pressure ulcer for patients and members of the public to see.

## Cleanliness, infection control and hygiene

- All clinical areas we visited were visibly clean. We saw evidence of cleaning audits being completed and results were displayed for patients and members of the public to see. We saw minutes of a ward meeting, noting that due to an unclean commode found during the recent cleaning audit the ward would implement an afternoon check in addition to one completed by the night staff. However, the use of 'I am clean stickers' was not consistent in all areas of the service we visited.

- The most recent patient led assessment of the care environment (PLACE) score, completed in 2015 scored 97% for cleanliness at EDGH, which was broadly in line with the national average of 98%. We were not provided with scores for all areas but noted that surgical wards Seaford 4 and Hailsham 4 both scored 100%
- There was adequate supply of personal protective equipment available for staff, and we saw it used appropriately in clinical areas.
- There were hand washbasins in clinical areas, which met the requirements of the Department of Health's Health Building Note 00-09. We also saw copies of the World Health Organisation 'Five moments of hand hygiene' poster displayed in clinical areas. This meant that relevant guidance was readily available for staff.
- We observed staff in theatres use the surgical scrub technique as per the Association for Perioperative Practice (AfPP) guidelines.
- Management and availability of sharps bins demonstrated compliance with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This required 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 been fully completed which ensured traceability of each container.
- During the inspection, staff we observed were compliant with the bare below the elbow (BBE) policy. We noted that BBE compliance was part of the trust safety huddle agenda; it stated that the nurse in charge was required to ensure daily that all staff were BBE as per the trust uniform policy. During a safety huddle, we observed staff being reminded to challenge colleagues who were not BBE in clinical areas.
- The hand hygiene audit for July 2016 showed an average compliance of 99% across surgical care. The score had been above 97% for each month since February 2016.
- Between July 2015 and June 2016, there were two cases of methicillin resistant staphylococcus (MRSA). In the year to date (at November 2016) there had been 31

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cases of clostridium difficile (C. Diff) infections at the trust compared to 28 cases in the same period for the previous year. This data was not broken down by core service.

- The trust had an on-going heightened infection prevention and control strategy to address the increased levels.
- Surgical 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.

## Environment and equipment

- Overall, the environment in all areas inspected was fit for purpose. Areas were tidy and free from clutter.
- We saw that there were appropriate fire doors in theatres that would automatically close if the fire alarm was activated. Staff needed a swipe card to access theatres ensuring security and confidentiality.
- The most recent PLACE score, completed in 2015 scored 91% for condition, appearance and maintenance at EDGH, which was better than the national average of 90%. The surgical wards Seaford 4 and Hailsham 4 both scored 91%, a breakdown of the scores for other surgical areas was not provided by the trust.
- We saw evidence of monthly generator tests and air testing completed in theatres.
- The safety huddle template stated that the nurse in charge was to physically undertake a double check to ensure the resuscitation trolley has been checked and all appropriate actions taken. We inspected five emergency trolleys and found them sealed, with completed weekly checklists, evidence of expiry dates checked and medication restocked once used or expired. Staff used a standardised form to complete the checks in all areas ensuring consistency in the checks. However, in day surgery we noted that daily checks were not completed on Wednesdays. Staff told us that this was because there was no general anaesthetic list on Wednesdays.
- All equipment we inspected had a label with an asset number and date of next service due.

- We saw evidence of quarterly environment and equipment audits, which included documentation of actions taken when areas of non-compliance were noted.
- Theatre staff reported that there was sufficient equipment for operating lists. No incidents relating to a lack of equipment had been reported.

## Medicines

- 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 a quarterly audit against these recommendations as part of this safe handling of medicines audit. The March 2016 audit found 85% and 79% compliance with the recommendations in theatres and surgery respectively, which was worse than the trust target of 90%. However, during our inspection we did not identify any areas of concern. For example, we found all drug cupboards locked, drug trolleys locked and secured to the wall when not in use and fridge temperatures in range. We saw minutes of ward meetings on two surgical wards at EDGH reminding nurses that drug cupboards need to be kept locked.
- The trusts March 2016 pharmacy led audit of standards within the management of controlled drugs (CD) procedures found 100% compliance on all surgical wards and theatres at EDGH. During the inspection, we carried out ad hoc balance checks on CDs and did not identify any discrepancies and we found CD cupboards were locked.
- We found CD registers for stock on the ward were well maintained with clear documentation of receipts and administration, double signatures and evidence of pharmacy balance checks. We saw evidence that daily balance checks were completed. However, records of patients own CDs were poor with multiple patients and medication recorded on each page and numerous obliterations making balance checks and audits challenging and not meeting the requirements of record keeping as per the Misuse of Drugs Regulations 2001.

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- In theatres, we noted that practice was to block sign multiple entries for CDs. 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.
- The trust August 2016 drug chart audit found that although medication reconciliation (MR) was completed for all patients only 40% of patients had the MR completed within time frame as per trust policy. The audit found no omissions due to the medicine not being available. During our inspection we noted that MR had been completed on all drug charts we reviewed on surgical wards but we did not assess the timeliness of the MR.
- We saw oxygen cylinders were secured to the wall and each cylinder had a daily checklist completed. The daily checklist was a standardised form ensuring consistency in checks across all areas.
- We reviewed seven prescription charts and found them legible and mostly completed appropriately with evidence of pharmacy endorsements.

## Records

- The trust had recently changed its system for managing patient records and these were now stored off site. Staff told us that there was sometimes a delay in accessing notes but that less notes went missing now. Staff on Firle pre assessment unit told us that there could be approximately 300 sets of patient records in the unit at one time. Staff requested notes in advance to ensure they were available.
- However, staff told us records were regularly not available on the day of the appointment. Ward staff told us that notes were not always available on the day of patients' admission for emergency admissions. Lack of patient records can compromise continuity of care and result in clinical decisions being made in the absence of all the necessary information, which can compromise patient safety.
- From July 2015 to June 2016 69 incidents related to missing or incorrectly managed notes were reported on the trust's electronic reporting system within surgery and theatres, 30 of these occurred at EDGH. Examples of 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 had been on the surgical care risk register since November 2015. It stated that consultants had agreed that patients will not be seen in clinic or surgery will not be undertaken without the records being available. However, this risk had not been reviewed since December 2015 and nursing staff told us that patients were sometimes pre assessed without the full patient record and nurses would write, "pre assessed without notes".
- Lockable storage was available for patient records on the wards and pre assessment units and during our inspection, we found these were stored securely.
- During our inspection, we found that although documentation was mostly signed, legible and complete there was sometimes loose papers within the set of notes. Failure to file paperwork risked confidential patient information falling. This risked unauthorised access to confidential data and accidental loss of essential medical information.
- Ward staff told us a monthly audit of nursing documentation was completed. Four sets of patient records were audited each month.
- Staff told us that an electronic document management system was being launched in October 2016 and hoped that this would resolve some of the issues related to patient records.
- We reviewed 13 sets of patient records and found they contained relevant risk assessments for example falls, which demonstrate that patients were having their care needs risk-assessed.

## Safeguarding

- The trust had up to date policies for safeguarding adults at risk and child safeguarding. The policies state that in addition to other reporting requirements safeguarding incidents must be reported on the trust electronic reporting system. From July 2015 to June 2016, 11 incidents categorised as safeguarding had been reported within the surgical and theatres, one of these occurred at EDGH.

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- Staff we spoke to were able to demonstrate an understanding of their responsibilities related to safeguarding.
- We saw a copy of the trust safeguarding algorithm on the walls in clinic rooms within the pre assessment unit and we saw copies of the September 2016 safeguarding adult's newsletter for staff reference, on a ward.
- As at March 2016, trust data for surgical services showed 100% compliance for level 1 safeguarding children training. Nursing staff had a completion rate of 91% for child safeguarding training and 87% for adult safeguarding training.
- Medical staff has completion rates of 75% for child safeguarding and 68% for adult safeguarding.
- The trust requirement was that all staff were trained to level 1 safeguarding children, clinical staff were trained to level 2 and staff working directly with children were trained to level 3. All clinical staff were trained to level 2 safeguarding adults. This meant that the trust was compliant with the intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014.
- PREVENT is part of the government counter-terrorism strategy. It is designed to tackle the problem of terrorism at its roots, preventing people from supporting terrorism or becoming terrorists themselves. The safeguarding lead role includes being the Trust's PREVENT Lead. NHS England have provided training to the adult and children safeguarding leads to deliver workshops to raise awareness of PREVENT to all staff.

## Mandatory training

- For surgical services at EDGH 91% of nursing staff had completed all mandatory training. For medical staff the figure was 75%
- Overall, in areas we visited we found that compliance with mandatory training was good across the surgery and theatres. The person in charge of areas we visited had an up to date training matrix and could identify staff learning needs and future dates for mandatory training.
- Mandatory training was delivered as a combination of online learning, face-to-face sessions and workbooks. Examples of training courses included basic life support, fire safety, deprivation of liberties and conflict resolution.
- Staff told us they were allocated time to complete the training and did not have any issues with accessing the training.

## Assessing and responding to patient risk

- The trust used the National Early Warning System (NEWS). NEWS is 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 additional support.
- We observed safety huddles where patients with rising NEWS scores were discussed and a plan put in place for their care. This meant that staff were able to identify deteriorating patients and escalate as per the trust policy.
- In June 2016, an average 89% of observations were taken on time on wards in the surgical division. This was below the trust target of 92%. The surgical division had not met the target for any month from February 2016 to June 2016. However, from August 2015 – September 2016, the percentage of observations taken on time has improved from 77% to 91% across the trust
- Data was taken from the trusts electronic vital signs recording system. The data recorded all NEWS scores generated, and measured the time it had taken staff to perform timely observations on each patient. Monthly NEWS audit results were sent to ward matrons detailing the previous four weeks performance. The wards requiring support to improve compliance were invited to 'challenge' sessions where issues are discussed and potential solutions sought.
- Where the observations taken resulted in a NEWS score of five or more a review by the critical care outreach (CCO) team was triggered. This also resulted in completion of a sepsis screen. There was no track and trigger automated escalation incorporated into the electronic observation system. Whilst it was the responsibility of the ward staff to make contact and



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follow the escalation plan for the individual patient, there was also a failsafe provided by the CCO team having direct oversight of all NEWS scores for all admitted patients in the hospitals.

- A NEWS score of nine resulted in a review by either the medical or surgical emergency team or consideration of a move to a critical care environment.
- Since the introduction and monitoring of the electronic observation system, the number of cardiac arrests and admissions to level three critical care had reduced. It was felt by the outreach staff and senior clinicians that this was as a direct consequence of early intervention.
- The use of the electronic observation system allowed discussions around the management of deteriorating patients to take place at an earlier stage than previously. The active involvement of the CCO team supported conversations with patients and their families about ceilings of care and futility of active treatment. The recognition of dying patients had improved and this allowed for care in a more appropriate environment than a critical care unit.
- The CCO team had provided training across the trust in recognising and managing deteriorating patients including sepsis pathways and peri-arrest.
- Agency staff were offered a session on the use of the electronic observation system and managing deteriorating patients.
- The WHO Surgical Safety Checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are the team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre) and debrief. We observed good practice in the use of the checklist and this was supported by positive results in a trust WHO surgical safety checklist audit.
- We observed theatre staff carrying out the WHO checklist for one procedure and staff completed all the required checks. We saw evidence of completed WHO checklists filed in patient records.

## Nursing staffing

- Staffing levels on the surgical wards were 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). Staffing establishment on the surgical wards had recently been reviewed by the assistant director of nursing, following data collection over a two week period. Analysis of data resulted in a majority of the wards having an increase in their nursing establishment. Ward matrons told us that recruitment was currently in progress and was being managed with bank and agency staff in the interim.

- Surgical wards we visited were staffed to their agreed establishment during the inspection. Planned versus actual staffing levels were displayed on the wards for patients and members of the public to see. We saw records demonstrating that on the week of our inspection theatre staffing levels met Association for Perioperative Practice (AfPP) guidelines.
- We reviewed nursing staffing data from March 2016 to June 2016. At EDGH, 100% of registered nurse planned day shift hours and healthcare assistants (HCAs) planned night shift hours had been covered each month. However, in March and April 2016 only 92% of registered nurse planned night shift hours had been covered, 97% in May and 100% in June. For healthcare assistants (HCAs) 99% of planned day shift hours had been covered in March and April, 100% in May and June.
- In August 2016 at EDGH there were 22 full time equivalent (FTE) vacancies for surgical nursing staff, this was equivalent to 12% of the nursing staff establishment.
- From April 2016 to September 2016, 93 incidents regarding staff shortages were reported to the National Reporting and Learning System.
- From September 2015 to August 2016, bank or agency nursing staff were used to fill an average of 18% shifts each month at EDGH. This showed the surgical wards were highly reliant on bank and agency staff to deliver the service. High usage of bank and agency staff can affect the continuity of patient care and impact patient safety as the same level of training and induction has not been completed as that of permanent staff.
- The trust had an in depth induction pack for bank and agency registered nurses and HCAs. It included various

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competency assessments including drug administration, NEWS score and pressure ulcer prevention. We saw this in use for agency staff in theatres.

- Staff on Hailsham 3 ward told us that they were regularly asked to cover medical wards due to staff shortages. Staff moves occurred at short notice on the day, rather than planned. It was not clear if staffing data was adjusted to reflect the impact of these unplanned changes.
- When we asked staff about the challenges of working at the trust and areas they would like to see improvement, nurse staffing was a recurrent answer amongst nursing and medical staff.

## Surgical staffing

- The proportions of consultants and junior doctors reported to be working at the trust were about the same as their respective England averages.
- In August 2016 at EDGH there were 1% FTE vacancies for medical staff in surgery, this was equivalent to 2% of the medical staffing establishment.
- From September 2015 to August 2016, bank or agency staff were used to fill and average of 12% of medical staffing shifts. This showed that the trust was heavily reliant on locums to deliver services.
- The availability of locum medical cover for general surgery was on the surgical risk register. The register detailed one incident in April 2016 where a registrar from EDGH was transferred to CH to cover night duty, leaving EDGH without surgical cover. Medical staffing for ENT and middle grade doctor vacancies for general surgery were also on the risk register. Although, the trust had taken steps since identifying the risks, the residual risk and likelihood of the risks remained the same as the initial risk which was high.
- A consultant anaesthetist was on-call 24 hours a day and on site at EDGH from 8am to 11pm. General surgery consultant on-call cover was available 24 hours a day, the junior doctors we spoke to said they were well supported by their consultants.

## Major incident awareness and training

- The trust had a major incident plan in place for both the EDGH and Conquest sites. The plan at EDGH included

consideration to suspend electives and delay day patients entering theatres during a major incident standby and emergency ward rounds to discharge patients including those waiting for elective surgery if a major incident was declared.

- A trust Emergency Preparedness Resilience Response Policy (EPRRP) was in development and the scheduled to be launched in October 2016.
- We saw records, which showed that surgical senior managers on-call, had completed training on EPRRP, except the surgical head of nursing who was due to undertake the training. However, ward and theatre staff had limited knowledge of procedures in the event of a major incident.
- We saw a major incident folder containing flow charts and contact numbers for managers available in an office
- within theatres.

## Are surgery services effective?

Good



We rated effective as good for the surgery service at EDGH. This was because:

- Care pathways used in surgery referred to national guidance from the National Institute for Care and Excellence (NICE) guidance and other bodies such as the British Orthopaedic Association guidelines.
- The department had a local audit programme and theatre staff had a regular audit meeting where learning was shared.
- There was an acute pain team available, we saw evidence of pain scores used in patient records and pain relief given pre-operatively was documented on the intermediate care pathways.
- We saw evidence that nutritional needs of surgical patients were assessed appropriately and met. Patients had access to dieticians.
- The hospital had a lower than expected risk of readmission for elective and non-elective admissions.
- Surgical and theatres staff had good appraisal rates. Staff felt the appraisals were valuable.

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- Staff felt competent to carry out their roles and had access to training.
- We identified a multidisciplinary team (MDT) approach to care at the hospital.

However,

We saw non-compliance with NICE CG65 Hypothermia: prevention and management in adults having surgery.

## Evidence-based care and treatment

- We observed staff in theatres engage in evidence-based practice such as Association for Perioperative Practice (AfPP) guidelines for surgical scrub technique and Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines related to capnography.
- Care pathways used in surgery referred to national guidance from the National Institute for Care and Excellence (NICE) guidance and other bodies such as the British Orthopaedic Association guidelines.
- The department had a local audit programme. Examples of audits included the national prostate cancer audit, the national joint registry knee and hip replacement audit and a monthly audit of the WHO surgical checklist.
- The hospital participated in some national audits such as the national bowel cancer audit but was not eligible for some because speciality surgery was not carried out on the site.
- 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. The 2014 figure was 69%.

The Risk-adjusted 90-day post-operative mortality rate was 5.3% which was within the expected range. The 2014 figure was 7.6%.

The Risk-adjusted 2-year post-operative mortality rate was 20.7% which falls within the expected range. The 2014 figure was 25.7%.

The Risk-adjusted 90-day unplanned readmission rate was 15.3% which falls within the expected range. The 2014 figure was 9.9%.

The Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 51% which is higher than expected. The 2014 figure was 50%.

- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was defined as "Poor Quality Data" as the proportion of records which had the referral source missing was greater than 15%. This meant the trust couldn't be compared to other trusts for this measure. The 2015 proportion was 3.7%. The 90-day post-operative mortality rate and 2015 rate were N/A.
- Theatre staff told us they had regular audit meetings where learning from audits was shared with staff.
- We saw non-compliance with NICE CG65 Hypothermia: prevention and management in adults having surgery. Temperatures were only taken in recovery and not during the procedure as per the guidelines. This was discussed with trust management following the inspection and we have received assurance that temperature checks are now taking place during surgery.

## Pain relief

- The service using a pain-scoring tool to effectively monitor and treat patients' pain. We saw evidence of these pain scores recorded in patient records and pain relief given pre-operatively was documented on the intermediate care pathways and MAR charts
- We saw a completed post-operative observation chart for two patients who had received opiates (strong painkillers such as morphine). This provides assurance that staff were appropriately monitoring patients who had received opiates.
- Ward staff told us that an acute pain team was available and would come to see the patients on the same or following day if a referral was completed. Staff on Hailsham 3, an elective orthopaedic ward told us the pain team visited daily and would see urgent patients on request. We saw evidence of advice given by the pain team to offer the patient pain relief for physiotherapy and dressing changes documented on nursing handovers on Seaford 4 ward as a reminder.



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- Patients we spoke to told us that they were offered pain relief and felt that their pain had been managed appropriately.
- There were a number of audits related to pain management underway or scheduled. These included a re-audit to determine the acute pain management in post-operative care at the EDGH site, pain relief for patients with dementia and learning disabilities and post-operative pain in laparoscopic nephrectomies.
- Between March 2015 and February 2016, patients at EDGH had a lower than expected risk of readmission for elective and non-elective admissions.
- Urology, had the largest relative risk of readmission for elective surgery and maxillo-facial surgery had the largest risk of readmission for non-elective surgery.
- The trust had made steady improvement in their performance in the national hip fracture audit 2015 against their 2014 results. It performed below the England average for three areas, was in the middle 50% of trusts for two areas and above the England average for one area.

## Nutrition and hydration

- A trust audit carried out in March 2016 showed that 84% of the 25 surgical patients audited had their nutritional goals met and 8% did not have them met. The outcome was unknown for 8%, two patients due to incomplete documentation.
- Other audits related to nutrition and hydration included an audit of the compliance to acute nutrition support care pathway and quality of Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition. It also includes management guidelines which can be used to develop a care plan.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2015 scored 93% for food at EDGH, which was better than the national average of 88%. We were not provided with scores for all areas but noted that surgical ward Seaford 4 scored 92% and Hailsham 4 scored 96%
- Ward staff told us that they had access to dieticians if patients needed to be referred and dieticians visited the wards regularly.
- We saw clear documentation of dietician input in patient records and documentation of completed MUST scores.
- We saw dietary requirements for patients noted on nursing handovers and on boards above the patients' bed, for example nil by mouth, mashed diet and eating and drinking.
- Feedback related to the quality of food was generally good although two patients we spoke to were not happy with the quality of the food at the hospital.
- In the 2015 bowel cancer audit, the trust performed worse than the England average for one area, was within the expected range for four areas and performed better than the England average for one area.
- In the 2015 oesophago-gastric cancer national audit (OGCNCA), the trust was within the worst 25% of all trusts for age and sex adjusted proportion of patients diagnosed after an emergency admission. However, the proportion of patients treated with curative intent in the Strategic Clinical Network was 43.5%, significantly better than the England average.
- The trust results from the Patient Recorded Outcomes Measures (PROMS) from April 2015 to March 2016 showed percentage of patients improved were better than the England average in three measures, worse in five measures and the same in two measures. For the percentage of patients that had worsened, two were better than the England average and the rest of the measures were either in line or slightly worse than the England average

## Competent staff

- At the trust between April 2015 and March 2016 88 of the 99 doctors, working in surgery had completed an appraisal. Six doctors were new starters not due to have an appraisal and two doctors had an authorised deferred appraisal. However, three doctors missed having an appraisal in the year. In theatres, 51 of the 53 doctors had an appraisal and the two that did not have an appraisal were new starters who were not due an

## Patient outcomes

# Surgery

appraisal. Overall, this showed good compliance with appraisals (91%) for medical staff within the directorate. Doctors we spoke to told us they had an appraisal and they found it useful.

- We found that compliance with appraisals for nursing staff was good across surgery and theatres with 93% of staffing having received an appraisal within the preceding year. 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. We saw two appraisal records, which were fully completed.
- Nursing staff told us that appraisals were useful and they felt they had the appropriate training available to do their jobs, although some said that it was difficult to find the time to complete training besides for mandatory training.
- Examples of additional training included a competency for airway treatment for health care assistants as this formed part of their role in the care of ear, nose and throat (ENT) patients. Theatre staff told us about modules available at university which they could undertake once they had completed their preceptorship, physical intervention training by an external provider and human factors training led by a consultant. Medical staff told us that there was a study leave and budget allocation for training for consultants and doctors not on the foundation-training program.
- Junior doctors we spoke to told us they were well supported by their consultants.
- The trust had an oversight of Nursing and Midwifery Council (NMC) revalidation, the director of nursing checked registrations of all agency staff during a night walk. Medical and nursing staff told us that discussions about revalidation formed part of the appraisal process.
- We saw evidence that the trust raised concerns related to staff to appropriate bodies such as the NMC and General Medical Council (GMC).

## Multidisciplinary working

- We identified a multidisciplinary team (MDT) approach to care at EDGH. On the wards, we saw evidence of nursing staff liaison with the medical staff, pain team, physiotherapists, pharmacy staff, porters, housekeeping and the outreach team through documentation on

nursing handovers, observations of care and staff interactions. Nursing staff in theatres and the pre assessment unit told us that anaesthetists were very helpful.

- We spoke to patients who recalled receiving care from members of the MDT including physiotherapists, dieticians and nursing staff.
- We found evidence of a MDT approach to care in patient records, this included input from physiotherapists, dieticians and adult social care.
- A ward matron gave us an example of MDT working to facilitate the assisted discharge scheme. This scheme is designed to enable faster and safer discharge of patients from hospital. Physiotherapists and occupational therapists see patients suitable for this scheme during their pre assessment appointment where their needs are assessed, for example, any equipment needed on discharge was ordered. Nurses saw the patient during pre-assessment and carried out a follow up visit with the patient in their home following discharge.
- We saw a best practice example of MDT working as part of the dental list for patients with special needs and learning disabilities. A multidisciplinary planning meeting was conducted in advance of the attendance. The anaesthetist, operating department practitioners, dental team, representatives from the patient care home and members of the ambulance team, attended this.

## Seven-day services

- The pharmacy department was open at EDGH from 9am to 5:30pm Monday to Friday and 9am to 12pm Saturdays and Bank Holidays. Outside of these hours, an on-call pharmacist was available via switchboard for urgent supply of medication and medicine information. A project group has been established to develop plans for a seven day pharmacy service.
- Ward staff told us that physiotherapists were available from Monday to Friday with a 24 hours a day seven days a week on-call service. On the elective orthopaedic wards physiotherapists provided a ward based service from Monday to Friday. On weekends, the physiotherapy service was provided on an ad-hoc basis based on the needs of the service.

# Surgery

- A consultant anaesthetist was on-call 24 hours a day and on site at EDGH from 8am to 11pm.
- General surgery consultant on-call cover was available 24 hours a day, the consultant worked at CH during the day. A middle grade or registrar level general surgery doctor is resident at EDGH 24 hours a day.
- The trust had two working groups to address the cross organisational multidisciplinary issues; the hospital at night group and the seven day service working group. The associate medical directors chaired these and the oversight of these groups is incorporated in the terms of reference of the clinical improvement committee and reported to the clinical leaders' forum and to the board.
- Additionally cross-organisational work was underway with the commissioners under East Sussex Better Together, this would alter where and who managed non-elective patients 24 hours a day, seven days a week.

## Access to information

- Staff demonstrated that they had electronic access to trust policies and training packages.
- We saw information on display for staff related to recent clinical updates, audit and survey results and trust and department notices.
- Staff told us that imaging, histology, and pathology results were accessible electronically.

## Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS)

- There was an up to date policy in place related to the implementation of the DOLS.
- There were mandatory training modules related to MCA and DOLS and staff we spoke to had a clear understanding of these.
- We saw three consent forms; all of these were completed fully and patients we spoke with demonstrated that consent was being obtained.
- We saw a good understanding of consent, MCA and DOLS in staff involved in the dental service for patients with special needs or learning disabilities. An acute liaison disability nurse ensures all policies and procedures related to these are followed.

- Junior doctors we spoke with were able to articulate the principles of the MCA 2005.
- The nurses that we spoke with confirmed that they had completed training in the MCA and DOLS.
- We spoke with four patients on two wards who all said they felt safe and were well cared for. They described staff as kind and supportive.

## Are surgery services caring?

Good



We rated caring as good for the surgery service at EDGH. This was because:

- Patients we spoke to told us that they were happy with the care provided and that staff that came to their bedside explained what care they were going to provide and always gave their names.
- In latest period, July 2016 the NHS Friends and Family Test (FFT) results indicated that 98% or more patients attending the trust would recommend it. This was better than the England average of 95%. The FFT response rate for surgery at EDGH was 39%, which was better than the England average of 30% between July 2015 and June 2016.
- We saw thank you cards with plaudits for staff displayed on wards. Feedback from patients demonstrated that the trust was meeting people's emotional care needs.
- We saw cards and leaflets on the wards with information for patients on how to leave feedback. The trust's website had the facility for patients to leave feedback.
- We saw an example of best practice in care provided to dental patients with special needs or learning disabilities. 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 sedation in the patient's home and anaesthesia in the car park or in the hospital depending on the need.

## Compassionate care

# Surgery

- 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%. The data was not broken down by site or core service; therefore, results were for all patients attending the trust. The FFT response rate for surgery at EDGH was 39%, which was better than the England average of 30% between July 2015 and June 2016.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2015 scored 83% for privacy, dignity and wellbeing at EDGH, which was worse than the national average of 86%. We were not provided with scores for all areas but noted that surgical ward Seaford 4 scored 86% and Hailsham 4 scored 89%. However, during our inspection we observed curtains were drawn when personal care was delivered to patients to maintain their privacy and dignity.
- Patients we spoke to told us that they were happy with the care provided, one patient told us he was “very happy with all the care received from start to finish”. We observed staff interacting with patients in a friendly and kind way.
- We saw thank you cards with plaudits for staff displayed on wards. Seaford 4 also displayed positive comments from the NHS Choices website related to the ward.
- Ward areas had ‘you said we did’ boards; displaying actions taken following patient feedback.

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

- We spoke to patients who told us that staff that came to their bedside explained what care they were going to provide and always gave their names.
- On the wards, we saw a named nurse and HCA displayed for each bay for patients and members of the public to see.
- We saw cards and leaflets on the wards with information for patients on how to leave feedback. The trust’s website had the facility for patients to leave feedback.

- We saw a variety of health-education literature and leaflets available on wards. Some of this information was general in nature while some was specific to certain conditions.
- We saw an outstanding example of care provided to dental patients with special needs or learning disabilities. 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 sedation in the patient’s home and anaesthesia in the car park or in the hospital depending on the need.

## Emotional support

- Patients told us that staff were understanding and they felt listened to. A thank you card on the day surgery unit said, “I was so scared and worried but I could not have hoped for such wonderful care”.
- The trust had a chaplaincy service that was available at any time. Patient could contact the service via nursing staff or telephone. It offered religious, pastoral and emotional support. There was a Christian chapel and multi-faith quiet room on each site.

## Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement for the surgery service at EDGH. This was because:

- The trust’s referral to treatment time (RTT) for admitted pathways for surgical services has been worse than the England overall performance since July 2015.
- There were 735 mixed sex breaches on surgical wards at EDGH during a 12-month period. The reason for these was not documented in most cases.
- Patient flow continued to provide challenges with medical patients occupying elective surgical beds and reducing the ability of the service to admit and treat patients on surgical pathways. There was an underutilisation of theatres at EDGH as operations were cancelled due to a lack of available beds, sometimes at short notice.

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- Urology had the highest elective and non-elective average length of stay. This was also noted at the last CQC inspection.

However,

- Services provided reflected the needs of the local population.
- The average length of stay for surgical elective and non-elective patients at the hospital was lower than the England average.
- The trust had provisions in place to meet the needs of patients with learning difficulties, bariatric patients, blind patients, deaf patients and patients needing translation services. The specific care management of people with learning disabilities facing dental surgery was exemplary.
- Complaints were dealt with appropriately as per trust policy.

## Service planning and delivery to meet the needs of local people

- Services provided reflected the needs of the local population. The most recent census data showed there was a higher percentage of people aged 60 and over living in the local area compared to the England average. For example, 8% of people living in Eastbourne were age 75 to 84, which was higher than the England average of 6%. The hospital offered a range of surgeries to treat age-related conditions. This included eye surgery to treat age-related macular degeneration (loss of central vision) and cataracts, and orthopaedic surgery such as joint replacements.
- Between April 2015 and March 2016, the average length of stay for surgical elective patients at EDGH was 2.2 days, compared to 3.3 days for the England average.
- For surgical non-elective patients, the average length of stay was 3.8 days, compared to 5.1 for the England average.
- Urology had the highest elective and non-elective average length of stay compared to other specialities at the trust. This was also noted at the last CQC inspection.

## Access and flow

- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance since July 2015. The latest figures for June 2016 showed 60% of this group of patients were treated within 18 weeks.
- Oral surgery was the only specialty with an RTT higher than the England average. Trauma and Orthopaedics at 41% and ENT at 49% were particularly low compared to their England averages of 70% and 73% respectively.
- At EDGH, theatre utilisation ranged from 68% to 103% and averaged 87% between May and June 2016. Theatre four utilisation was 68% and Day Surgery Theatre 2 utilisation was 69% in June 2016. This demonstrated an underutilisation of theatres.
- There were 735 mixed sex breaches on surgical wards at EDGH during a 12-month period. The reasons for the breaches included acute emergency admission requiring assessment and patient safety requirement-airway management. However, the reason was not documented in most cases.
- Staff told us that there had been a mixed sex breach the week prior to the inspection, permission was sought from the director on call before the patients were admitted and letters of apology were issued to patients who stayed two days or more in mixed sex bays.
- From April 2016 to September 2016, EDGH had 1,576 medical outliers on surgical wards; this was an average of nine per day. Nursing staff told us that outliers caused obstruction in patient flow for surgical beds. During our inspection there were medical outliers on two surgical wards we visited. On Seaford 4 ward, two bays were permanently allocated to medical patients and a locum consultant specialising in the care of older people was based on the ward to manage their clinical needs.
- For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 668 surgeries. Of the 668 cancellations, 2.7% were not treated within 28 days.
- Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust was generally better than the England average.
- There were no urgent operations cancelled for the second time at the trust from April 2016 to June 2016. During this time, all last minute cancellations were rebooked within 28 days. We observed ward handovers



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and a bed meeting where bed allocation was discussed. We noted that patients without beds allocated on wards were on the theatre operating list. Theatre staff told us that occasionally operating was stopped due to blockages in patient flow caused by delayed discharges.

- The trust had a nurse led discharge programme for day case patients. This was an effective and efficient approach to patient discharge. If needed doctors were still able to complete the discharge letter and facilitate discharge.
- The trust told us they mitigate against nursing patients overnight in theatre recovery or day surgery at EDGH by moving patients to the appropriate ward setting before 10:00pm. There was an appropriate escalation process for staff to use if there were concerns about delays in flow.
- A ward matron told us about an assisted discharge scheme for elective orthopaedic patients. This scheme was designed to enable faster and safer discharge of patients from hospital. Physiotherapists and occupational therapists saw patients suitable for this scheme during their pre assessment appointment where their needs were assessed, for example, any equipment they needed on discharge was ordered, and measurements for toilet facilities were taken. Nurses saw the patient during pre-assessment and followed up the patient in their home following discharge.

## Meeting people's individual needs

- 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 sedation in the patient's home and anaesthesia in the car park or in the hospital depending on the need.
- We saw boards on wards displaying information related to the 'This is me' campaign. 'This is me' is a tool, endorsed by the Alzheimer's society, that people living with dementia can use to tell staff about their needs,

preferences, likes, dislikes and interests. It enables staff to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs.

- Staff had an understanding of the caring for patients living with dementia. They told us about the butterfly pathway used at the trust. 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. We saw a sensory room located in the day surgery unit; this provided an ideal environment for patients with dementia and learning difficulties having day surgery.
- In theatres, we saw guidance on managing patients with special needs was available for staff.
- Equipment was available for treating bariatric patients. For example, hoists and appropriate mattresses for patient transfer.
- The pre assessment unit provided telephone appointments, in exception, when patients were unable to travel to the hospital.
- The trust had a service level agreement in place for provision of translation services for patients where English was not their first language. This included sign language, lip speakers and translation to braille. The service was available face to face, via telephone or written and audio services.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2015 scored 57% for dementia at EDGH, which was worse than the national average of 75%. We were not provided with scores for all areas but noted that surgical ward Seaford 4 scored 55% and Hailsham 4 scored 48%.

## Learning from complaints and concerns

- The trust policy related to the recording, investigation and management of complaints, comments, concerns and compliments was due for review in November 2015.
- From April 2014 to March 2015 the trust received 653 complaints. Complaints data was not broken down by core service, however trauma and orthopaedics and general surgery were two of the four most complained about services at the trust.

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- In March 2016, Healthwatch East Sussex carried out a volunteer led, independent review of the trust's complaints process. Sixty-six individual complaints cases were reviewed. The review highlighted areas of good practice and recommendations for improvement. Our review of five complaints reports found evidence that the trust had implemented the Healthwatch review recommendations.
- The five complaints reviewed had evidence of the trust complaints policy being followed. The trust attempted to contact complainants at the outset to clarify the points of the complaint. Face to face meetings were offered and these are taped so the complainant has a record of what was discussed. The response letters were good; a clear improvement in quality was seen from those reviewed in our previous inspection visits. The letters were personal and clear, with apologies where necessary.
- The chief executive officer had personal responsibility for the complaints procedure, for the review and sign-off 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.
- The trust website provided clear information on how to make a formal complaint. Printed information was also available throughout the hospital including contact details for the patient advice and liaison service (PALS).
- We saw minutes of ward meeting where complaints had been discussed and learning shared. Staff told us that learning was shared across the trust following a bi monthly complaints audit meeting.
- Ward matrons demonstrated a good understanding of the trusts complaints process. They gave us examples of complaints they had investigated recently which included complaints about staff attitude and a patient complaining about a nurse trying to administer a medication for a second time because it had not been signed for on the previous medication round.
- The trust executive now had a greater willingness to accept responsibility and were less defensive about

complaints. The director of nursing, in particular was proactive in seeking early local resolution by meeting with complainants and listening to what they wanted as an outcome.

- Where complaints had been made about specific individual members of staff this was followed up by their line manager, for medical staff this was included as part of their appraisal.

## Are surgery services well-led?

Good



We rated well-led as good for the surgery service at EDGH. This was because:

- Staff on the wards and anaesthetists told us they felt that teams were coming together following the reorganisation of services a few years ago. Consultants were now more willing to work across both sites and were working more closely with surgeons from the other hospital.
- Surgery and theatres had clear priorities set out for 2016-2017. This included top three priorities for each area and other areas for improvement against quality, access and performance targets.
- The trust was in a period of transition around the governance structure. We saw that on-going work was taking place to ensure that the Board was properly assured by the information that it received through the Board Assurance Framework. A triumvirate structure of management of the Surgical Division had been introduced which gave clear areas of accountability and responsibility.
- We saw evidence of regular divisional meetings where incidents, complaints and risks were discussed.
- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in theatres and on the wards.
- Staff we spoke to did not feel there was a culture of bullying and harassment, most staff described an open and honest culture. Staff at focus groups told us they thought EDGH was a good place to work and that they would recommend it as a place to work to other people.



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- The trust actively engaged to seek the views of patients and their relatives. They had developed ways of engaging with the local community through the East Sussex Healthwatch and had built a positive sustainable relationship which welcomed the volunteers into the hospital.
- The trust had a strategy of it aims and objectives to be met by 2020. The message about 'Outstanding by 2020' was delivered and promoted across the hospital in a variety of formats. However, not all staff we spoke with were aware of it.

However

- At a local level, we found an inconsistent approach to meetings and passing information on to staff. Team meetings occurred regularly, sporadically or not at all dependent on the local manager. This meant that information was not cascaded consistently to all staff.
- We saw risks on the surgical care risk register, which had not been reviewed in six months. This included failure to provide timely diabetic retinopathy screening within recommended timescale, which was highlighted, to us as one of the top three risks for the division by the surgical management team.
- Although morbidity and mortality meetings were taking place, there was a lack of assurance regarding learning from these.

## Vision and strategy for this service

- Surgery and theatres had clear priorities set out for 2016-2017. This included top three priorities for each area and other areas for improvement against quality, access and performance targets.
- The trust had a strategy of it aims and objectives to be met by 2020 called 'Outstanding by 2020'. All staff had been given a pocket sized leaflet about this but some staff claimed to not know about this.
- The trust 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 detailed the systems in place to manage them. The strategy includes the meeting schedule for risk and governance meetings for the surgery, anaesthetics and diagnostics division.

- Robust reporting and escalation processes were being put in place as part of the new strategy with clear lines of accountability and responsibility.

## Leadership of service

- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in theatres and on the wards. At EDGH nursing staff reported to the ward matron who reported to the deputy head of nursing.
- In all areas except one, staff told us they saw their line managers regularly and they would feel comfortable raising concerns to them. In the one exception staff reported concerns about a particular manager.
- At the focus groups we heard from staff of all grades and disciplines that they felt the leadership had improved and was now more open to challenge, was more supportive and more willing to listen to ideas.
- Band 7 and 8a managers talked about their teams with pride in focus groups. There was a unanimous that the best thing about their job was their teams and how all staff supported them as managers.
- Staff were positive about the leadership at senior management level. They told us the leadership team was visible and approachable. The chief executive officer had visited a majority of the clinical areas and they felt he listened to them.
- The DoN was felt by all staff we spoke with to be visible, approachable and genuinely caring of her staff and patients. Staff told us they held her in high esteem and respected her.
- The medical director was very recently appointed and had not been in post sufficient time for staff to develop a particular view.

## Governance, risk management and quality measurement

- The surgical services were led by a triumvirate of managers who had responsibility for clinical and non-clinical management of the directorate.
- The Head of Nursing (HoN) had specific responsibility for oversight, monitoring and support to the ward and theatre team leaders. The HoN received data from the safety thermometers and used this as a performance

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indicator to allow a comparative review the quality of care being delivered on different wards and to compare the performance of any ward or department over time. Where concerns were identified, the HoN chaired a challenge meeting with ward staff to look at the possible causes and to consider solutions to bring about improvements.

- Directorate performance was reviewed and discussed at HoNs meetings which provided a challenging but supportive forum for discussion of wards and departments where performance fell short.
- Bed management meetings were held at least twice daily and more often in periods of exceptional activity. HoNs and site managers looked at the needs of the service, including pending admissions and discharges to try and identify sufficient bed availability. Elective admissions were cancelled as a last resort and only after all other possible solutions had been considered.
- We saw the surgical care risk register. Most risks on the register had been reviewed recently. However, three of the 31 risks had not been recorded as reviewed in six months. These were patients not always placed on the agreed surgical pathways, lack of medical notes and failure to provide timely diabetic retinopathy screening within recommended timescale. When we spoke to the surgical management team they told us that the diabetic retinopathy screening service was one of their top three risks.
- We saw a copy of the surgical divisional performance report to the board, which stated that morbidity, and mortality (M&M) reviews were being undertaken although there is still some improvement needed. We saw minutes of the M&M meetings, documentation of the discussion and learning was brief. A lack of M&M meetings was highlighted in the trust's last inspection report.
- We saw minutes of theatres, anaesthetics and critical care two monthly risk meetings and orthopaedics monthly risk meetings. We saw individual incidents and trends, complaints and the relevant risks on the risk register were discussed.
- We saw minutes of the bi-monthly quality and governance meetings. Trends in incidents and

complaints, the divisional risk register, serious incidents, safeguarding, compliance to guidance and policies, patient feedback and human resources data were discussed here.

- At a local level, we found an inconsistent approach to meetings and passing information to staff. Although most areas undertook safety huddles, team meetings occurred regularly, sporadically or not at all. This meant that there was a risk that information was not cascaded consistently to all staff.
- The trust had identified and responded to an increased incidence of C.Diff by implementing a heightened infection prevention and control strategy to minimise cross infection.

## Culture within the service

- Overall, we identified a dedicated group of staff that were committed to providing quality patient care. However, some staff reported feeling frustrated, overworked and said they often worked through their breaks.
- Staff we spoke to did not feel there was a culture of bullying and harassment, most staff described an open and honest culture.
- Large numbers of staff attended focus groups via video conferencing from EDGH. Most reported feeling positive about the direction the trust was moving in. They felt they had been through a period of very significant change and now they all needed time for consolidation and to allow the new executive team to deliver. People told us about initiatives they felt proud of and about the work they had done to improve the service.
- The trust has appointed a Freedom to Speak Up Guardian. The role of the guardian is to raise the profile of raising concerns in the organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern was handled.
- Staff on the wards and anaesthetists told us they felt that teams were coming together following the reorganisation of services a few years ago. This had resulted in a reconfiguration of surgery between CH and EDGH, where most acute services were moved to CH.

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- We spoke with staff from Black and minority ethnic cultures working at EDGH. They told us they felt that they were supported and well integrated into the ward teams where they were working. Culture and ethnicity was discussed in an open and accepting way on the wards we visited.

## Public engagement

- The trust actively engaged to seek the views of patients and their relatives. We saw patient satisfaction questionnaires available throughout the hospital. The hospital also sought feedback through the NHS Choices website, their own website and the NHS friends and family test. This was a marked improvement on our findings during the last CQC inspection.
- The trust had worked closely with the local Healthwatch on numerous projects intended to support the trust in collecting longitudinal patient perspectives. This included teams of Healthwatch volunteers providing around the clock observations and reviewing complaints management processes. The DoN had worked with the Healthwatch manager on a review of the hospital at night and spent time observing the hospital 'being put to bed' at night and 'woken up' in the morning.
- Where a complaint had been made, the complainant was sometimes invited to speak with staff and the board to share their story. This was to allow staff to hear the impact and to consider what the patient felt might have made things better.
- EDGH has a four star rating on the NHS Choices website based on patient reviews. The hospital responded directly to a majority of the reviews left on the website.
- Patient feedback and actions taken were displayed on the wards for patients and members of the public to see.
- The trusts website provided a range of information about the surgical services provided. Members of the public could use the information to make decisions regarding the care and treatment they received.
- We saw a variety of appropriate general and condition specific health-education leaflets and signposting information such as stop smoking and flu advice available for patients.







## Staff engagement

- 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.
- We saw information displayed around the hospital related to a staff family care team, childcare and maternity support and benefits and discounts for staff.
- EDGH had a staff sports and social club with leisure facilities such as a tennis court, pool and gym.
- We saw 'Engagement and involvement matters' posters.
- The trust had introduced Schwartz Rounds. Schwartz Rounds 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.
- Regular staff awards nights were held to reward and incentivise staff that performed over the expected level.
- Cultural and social inductions were provided for cohorts of new staff from overseas. Recently recruited staff from the Philippines were met at the airport, provided with interim accommodation and introduced to organisations within the local community such as the Catholic Church.

## Innovation, improvement and sustainability

- 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 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 made within the trust to address perceptions of bullying and harassment.

# Maternity and gynaecology

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

## Information about the service

Eastbourne District General Hospital (EDGH) has a midwifery-led unit with seven beds. Two of the rooms are designated delivery rooms, and one of these has a birthing pool. The remaining five rooms are mainly used for postnatal care of new mothers and their babies, and two of these have ensuite facilities.

The unit reported 257 births in the period April 2015 – March 2016. There were 3,061 hospital births across the trust during the same period. This meant births at EDGH represented 8% of the trust's birth activity. Only women with low-risk pregnancies are booked to deliver their babies at the midwifery-led unit at EDGH. Women needing consultant-led care give birth to their babies in the obstetric unit at The Conquest Hospital.

Eastbourne Midwifery Unit (EMU) also provides weekly newborn hearing screening clinics, postnatal checks for women and babies who had been discharged home following birth and occasional antenatal (pregnancy) booking appointments.

The hospital has a four-bed antenatal day assessment unit. Women attend the day assessment unit if they need additional monitoring or scans during pregnancy. There is also an early pregnancy assessment clinic (EPAC) with three scan rooms. Women attend EPAC for routine 12 and 20-week pregnancy scans. EPAC also offers viability scans for any concerns in early pregnancy up to 14 weeks.

EDGH only provides elective gynaecology surgery. The service treated 792 gynaecology inpatients in April 2015 – March 2016. There is no dedicated gynaecology ward, and patients recover from gynaecology surgery on mixed-speciality surgical wards.

The hospital does not provide termination of pregnancy (ToP) services. All ToPs within the trust take place at Conquest Hospital.

During our inspection, we spoke to 14 members of staff including midwives, supervisors of midwives, maternity support workers, consultants, matrons, nurses and the head of midwifery. We spoke to one woman who used maternity services at EDGH and her partner. We reviewed four sets of medical records and a variety of hospital data including meeting minutes, policies and performance data.

# Maternity and gynaecology

## Summary of findings

Overall, we rated maternity and gynaecology services as requires improvement because:

- There were delays for patients using gynaecology services and referrals to treatment times were consistently worse than the 18-week national indicator.
- A lack of specialist training for nurses who cared for gynaecology patients presented a risk that may have impacted upon patient care.
- Most of the maternity policies and procedures were outside their review date. This meant staff might not have been informed around all the relevant and current evidence-based guidelines, standards or best practice.

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.
- Staff checked and maintained equipment to ensure that it worked safely.
- Staff received up-to-date mandatory training in all safety systems. This included responding to childbirth emergencies such as post-partum haemorrhage (excessive bleeding after childbirth) and cord prolapse. Cord prolapse is when the cord comes out before the baby during labour, which can cause a reduced supply of blood and oxygen to the unborn baby.
- 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 patients who used services were generally positive and met expectations.
- Appraisal rates met trust targets.

- Staff treated patients with dignity, respect and kindness. Patients felt supported and said staff cared about them.
- Patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- The service made reasonable adjustments and removed barriers when people found it hard to use or access services, for example, through provision of interpreters.
- 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 its 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.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Good



We rated safe as good. This was because:

- 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 minimise the risk of recurrence.
- Staff received up-to-date mandatory training in safety systems, including responding to childbirth emergencies such as post-partum haemorrhage and cord prolapse.
- Staff checked and maintained equipment to ensure that it worked safely.
- 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.
- Midwifery staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately.

### Incidents

- From August 2015 - 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.
- Maternity and gynaecology services across the trust reported ten serious incidents (SIs) which met the reporting criteria set by NHS England between October 2015 - September 2016. Trust data showed that one of these related to Eastbourne District General Hospital (EDGH). This incident involved an error during gynaecology surgery resulting in harm that required corrective surgery.
- There was a further trust-wide SI relating to maternity and gynaecology services in 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 (conditions existing at or before birth) 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.

- Maternity and gynaecology services at EDGH reported 102 clinical incidents between 1 July 2015 – 30 June 2016. Of these, 73 related to maternity and 29 to gynaecology. The service graded incidents on a scale of one to four, with one being the lowest level of harm and four being the highest. The service graded the majority of incidents (89) as grade one. There were no grade four incidents at EDGH within the reporting period.
- All staff we spoke to could describe the process for reporting incidents. Staff reported incidents using an online reporting system. The appropriate matron or clinical lead investigated incidents, with oversight from the head of midwifery. Staff told us they received email and verbal feedback with learning points following an incident investigation. Midwives also told us they would inform a supervisor of midwives immediately in the event of an SI.
- There was a trust-wide daily maternity risk meeting held at Conquest Hospital. We saw that staff at EDGH participated in these meetings via video link. Staff discussed learning from incidents at these meetings. A supervisor of midwives produced a newsletter every two to three weeks with learning points identified at risk meetings. Staff showed us copies of newsletters pinned onto the wall in the staff room. Midwives also told us they received this information via email. This process ensured there was a robust system of sharing learning from incidents amongst staff to help prevent recurrences.
- 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



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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.

- The trust held monthly perinatal morbidity and mortality meetings, and we saw evidence of meeting minutes. However, due to the low risk nature of the midwifery-led maternity service provided at EDGH, no cases from EDGH presented at these meetings.
- The trust also held cross-site gynaecology morbidity and mortality meetings every two months. We reviewed meeting minutes and saw that medical staff shared learning from incidents to help prevent recurrences.

## Safety thermometer

- The trust did not complete the national maternity safety thermometer at the time of our visit. The head of midwifery told us the trust planned to start using the national maternity safety thermometer from 30 November 2016.
- However, the trust did measure some of the thermometer metrics at the time of our inspection, in particular, perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby, and Apgar scoring. Apgar scoring is a method to quickly summarise the health of newborn children. The Apgar scale was determined by evaluating the newborn baby on appearance, pulse, grimace, activity, respiration and is generally done at one and five minutes after birth. Scores of seven and above are generally normal, four to six are fairly low and three and below are generally regarded as critically low.
- The trust's maternity dashboard showed EMU had a 1.2% rate of post-partum haemorrhage between 501-1000 ml blood losses between April 2016 – June 2016. This was better than the trust target of 12% or below. The rate of post-partum haemorrhage greater than 1000ml blood loss was 2.4% in the same period. This was worse than the trust target of 1.5% or less. There were no massive post-partum haemorrhages (defined as greater than 2500ml blood loss) in the same period.
- The trust's maternity dashboard showed two women had a third or fourth degree perineal tear at EMU in April

2016 - June 2016. During the same period, 98 women gave birth at EMU. This meant the rate of third or fourth degree tears was 2.0%. This was better than the trust target of 5.0% or less.

## Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean. We saw “I am clean stickers” on equipment to provide staff with assurances that equipment was cleaned and ready to use.
- All staff we met were ‘bare below the elbows’ to allow effective handwashing. We saw ‘bare below the elbows’ posters around the hospital to remind staff to follow this policy.
- Patient rooms on EMU had dedicated hand hygiene sinks for staff to wash their hands before and after direct patient care. The design of the basins was in-line with the Department of Health's Health Building Note 00-09.
- We saw alcohol hand gel dispensers available at the entrances to wards, Eastbourne Midwifery unit (EMU), and the day assessment unit. We saw staff use alcohol hand gel appropriately to clean their hands. We saw gloves available in patient rooms on EMU to protect staff and patients against infection.
- We saw hand hygiene audit results for EMU from February 2016 – July 2016. Each month, the infection prevention and control link facilitator observed hand hygiene practices before and after patient contact. Hand hygiene audits also included observations of whether staff were bare below the elbows in line with trust policy. Audits typically consisted of ten observations in each area per month. The results showed 100% compliance for five out of six months during this period. In the remaining month (May 2016), the unit scored 90%. This was worse than the target score of 100%. Auditors took action to address non-compliance, which included giving feedback for improvement to the members of staff involved.
- The trust also performed monthly cleaning audits. We saw the overall results for June and July 2016. These showed scores of 94.4% and 95.9%, respectively, for EMU. This was worse than the target score of 98% for this area. The maternity day unit scored 83.1% and 81.0%, respectively. This was worse than the target score of 95% for this area. Different areas of the hospital had different target scores based on risk of infection related to the type of activity that took place there.

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- We saw correct segregation of clinical and non-clinical waste. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that staff had labelled sharps bins and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks.

## Environment and equipment

- We checked the resuscitaire on EMU. A resuscitaire is a warming therapy platform for babies, which contains all the components needed for resuscitation. We saw evidence that staff checked the resuscitaire daily during the month of our visit to ensure it was safe and fit for purpose.
- We also checked the resuscitation trolley on EMU and saw evidence of daily checking. We saw that all items were within the recommended use by dates.
- EMU had a fixed birthing pool and a corner bath for women who wanted to labour in water. We saw the policy and procedures for birthing pool evacuation in an emergency. These referred to a hoist; however, no hoist was available. When asked, staff told us they would use a net for pool evacuation, and we saw an evacuation net available for this purpose. However, the policy did not refer to the use of evacuation nets. This may have presented a risk if staff were unsure of how to act if they needed to help a woman exit the pool quickly in an emergency.

## Medicines

- We checked the fridge temperatures on EMU and saw that these were within the safe range required by the trust policy. We saw evidence staff monitored and recorded the fridge temperatures daily during the month of our visit. This was important to ensure the unit stored refrigerated drugs within the correct temperature ranges to maintain their function and safety. All temperatures recorded on the chart were inside the safe range.
- We checked controlled drugs records and saw evidence staff on EMU performed daily controlled drugs checks. Controlled drugs were medicines liable for misuse that required special management. These included pethidine, a pain-relieving drug sometimes used during childbirth. We saw that the unit stored controlled drugs securely in a locked cabinet in line with national standards for medicines management.

- We saw oxygen cylinder records, which provided evidence staff on EMU performed daily oxygen cylinder checks. This ensured there was sufficient therapeutic oxygen available on the unit should a woman or baby require it.

## Records

- We reviewed four sets of records for women who had used maternity services at EDGH. We saw staff had signed and dated all entries in line with best practice guidance. All four sets of records contained a completed antenatal risk assessment, a record of assessment of the newborn baby and documentation of skin-to-skin contact and baby's first feed. However, only two out of the four records had evidence of venous thromboembolism (VTE) assessment, and we saw some loose pages staff had not filed securely. Failure to effectively file paperwork risked unauthorised access to confidential data and accidental loss of essential medical information.
- The unit gave all women a child health record, also known as the "red book", after their baby was born. Health professionals used the red books to record information on baby's health, including feeding assessments, NIPE checks and newborn hearing screening.

## Safeguarding

- Trust data showed 100% of clinical staff on EMU completed safeguarding level two training from April 2015 – March 2016. The data also showed 100% of nursing and midwifery registered staff also completed safeguarding level three training in line with national intercollegiate guidance. This level of training was appropriate to enable staff to correctly identify and respond to safeguarding concerns.
- We spoke to community midwives, who were able to identify the safeguarding lead for maternity services. They could describe the process for escalating safeguarding concerns. Staff completed an additional support form (ASF) online and sent this to the safeguarding lead for midwifery with copies to the woman's GP and the local child health visiting team. Midwives then placed an alert on the woman's computerised record so that all colleagues involved in

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her care were aware of the safeguarding concern. We saw guidance was available to all staff electronically within the trust wide “Child Safeguarding Policy and Procedure”.

- The trust followed local multi-agency safeguarding procedures for vulnerable adults and children. We saw links to these procedures in their safeguarding policies. We saw that the multi-agency procedures contained guidance for female genital mutilation (FGM), including specific guidance on reporting FGM concerns involving pregnant women. Trust board meeting minutes from 30 September 2015 confirmed that the trust followed multi-agency procedures.

## Mandatory training

- Trust data showed that overall mandatory training rates for all staff groups on EMU were 86.7% in April 2015 – March 2016. This was slightly worse than the trust target of 90%.
- Mandatory training included the following topics: Basic life support, blood transfusion, conflict resolution, deprivation of liberty, equality and diversity, fire safety, health and safety, infection control, information governance, the Mental Capacity Act, moving and handling, and safeguarding.
- Staff completion rates of different modules were variable in 2015-16. Blood transfusion, deprivation of liberty, the Mental Capacity Act, and infection control had the best completion rates for nursing and midwifery registered staff of 100%. Conflict resolution had the worst completion rates. Only 20% of nursing and midwifery registered staff and 25% of additional clinical services staff on EMU completed this module in 2015-16.

## Assessing and responding to patient risk

- EMU only accepted low-risk women to birth at the unit. This was because there was no consultant obstetrician on site. All women planning to birth at EMU attended a risk assessment with a midwife at 36 weeks of pregnancy to determine their suitability to birth at the unit. We saw a copy of the risk assessment paperwork. This included a comprehensive assessment of risk factors, including previous obstetric history, BMI and VTE. We saw that there were strict acceptance criteria for women wanting to give birth at EMU. This was to ensure the safety of women who birthed at EMU and their babies. The unit did not accept women with higher risk pregnancies. Any woman assessed as high risk gave

birth at Conquest Hospital, where consultant-led care was available. Midwives told us they could ask consultant obstetricians for advice around a woman's risk assessment if they needed to.

- Midwives provided one-to-one care for women during labour and monitored foetal heart rate intermittently during labour using a Doppler device. This was in-line with current National Institute for Clinical Excellence (NICE) guidelines for low-risk pregnancies. If the foetal heart rate went outside the expected range on one occasion, this immediately prompted a transfer to the obstetric unit at Conquest Hospital for continuous cardiotocography (CTG) monitoring.
- Midwifery staff could describe situations that prompted a transfer to Conquest Hospital during labour. As well as foetal heart rate anomalies, situations included failure for labour to progress and meconium in the waters. Meconium is baby's first stool and its presence in the waters can sometimes be an indicator of foetal distress during labour. We saw transfer forms staff completed for all women who transferred to Conquest Hospital during labour. Forms contained the reasons for transfer; however, senior midwives told us there were no recent audits to show the proportion of transfers that were in line with the unit's transfer policy.
- In situations that required a transfer to obstetric care, midwives called 999 to arrange an emergency ambulance transfer. Midwives told us they always escorted and cared for the labouring woman during the ambulance journey. Ambulance transfer times from EDGH to Conquest were 20-25 minutes. Midwives told us there were occasionally delays waiting for ambulances and a consultant was auditing ambulance response times to feedback to the local ambulance service. However, there had never been any serious incidents or adverse outcomes because of ambulance delays.
- A midwife staffed a dedicated telephone triage line at EMU on Monday – Friday, 8.30am – 7pm. Outside of these hours, the telephone system diverted calls to the labour ward at Conquest Hospital. Midwives at Conquest Hospital could access the electronic calendar for EMU to check availability at the unit and take the woman through a series of triage questions. Staff at Conquest Hospital subsequently telephoned staff at EMU to inform them when a woman in labour was on her way to the unit so they could prepare for her arrival.
- At weekends and nighttime, there was no dedicated triage midwife staffing the telephone at Conquest. This

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meant patients did not always get to speak to a midwife straight away and sometimes had to wait for a member of staff to answer their call. The trust recently trialled a 24-hour triage system for two weeks, where a community midwife from the homebirth team staffed the triage telephone line at each site. All staff we spoke to felt that this system worked very well and provided a safer service for women. Managers told us they were putting a business case to the trust for funding for a dedicated triage midwife at night so that the 24-hour triage system could resume.

- The service used modified early obstetric warning score (MEOWS) charts to monitor women who had given birth for signs of illness or deterioration. Staff calculated MEOWS scores by taking observations such as temperature and blood pressure and measuring changes or deviations from normal. A score of three or more triggered escalation. We saw completed MEOWS charts in the records we reviewed. In the records we reviewed, there was no escalation in line with the recorded scores and the associated guidance.
- For gynaecology patients recovering from surgery, nursing staff used the National Early Warning System (NEWS) track and trigger flow charts. 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 arrange additional support.

## Midwifery and nurse staffing

- EMU had 9.99 whole time equivalent (WTE) midwifery and nursing staff in June 2016. The expected number of staff was 10.43 WTE. This meant there was a vacancy rate of 0.42 WTE, or 4.03%. This was better than the trust-wide nursing and midwifery vacancy rate for this service, which was 9.40%.
- 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 midwifery-led 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 EDGH to ensure the capacity to achieve one-to-one care during labour.
- We saw data for the actual midwife to birth ratios from March 2015 – April 2016 across the trust. Please note that the trust was unable to split this data by site. In every month during this period, the midwife: birth ratio was the same as, or better than, the planned ratio of 1:28 in line with national intercollegiate guidance. This showed that the lowest (best) midwife: birth ratio during this period was 1:24. The highest (worst) midwife: birth ratio was 1:28 in March 2016, which was in line with the national guidance.
- Senior midwives told us EMU never used bank or agency staff. Trust data confirmed that the unit did not use any bank or agency staff in April 2015 – March 2016.
- We saw staffing records for EMU for the month before our inspection. The planned staffing level for each shift was two midwives and one maternity support worker (MSW). Records showed that on 30 out of 60 shifts, the unit had the planned number of staff. This meant that on the remaining 30 shifts (50%), the unit had fewer staff than the planned number.
- Staffing levels on EMU sometimes fell below the planned levels because the obstetric unit at Conquest Hospital asked the midwives from EMU to go and support them when they were particularly busy. However, staff told us midwives only left EMU to support their colleagues at Conquest Hospital if there were no women in labour at EMU. The movement of midwives from EMU to Conquest Hospital did not result in EMU closing, and data supplied by the trust supported this statement.
- Staff told us that if there were no women in labour on a particular shift, which often happened, then dropping below the planned staffing level did not affect women's care. If a woman called the unit in labour and there were fewer than two midwives and one MSW on a day shift, then the matron provided clinical care to make up the shortfall. If this happened at night, staff called in the on-call community midwife to provide additional support.
- Midwives at EMU had a handover at the start and end of their shifts. This ensured midwives starting their shift had all the relevant information they needed to provide continuity of care. We were unable to observe a handover, as there were no women birthing in the unit at the time of our visit.
- There was no dedicated gynaecology ward at EDGH. Therefore, women recovered from elective gynaecology surgery at EDGH on general surgical wards such as

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Hailsham Four. The trust monitored staffing levels on the surgical wards in line with the safer staffing tool. This was a decision support toolkit for establishing nursing staff levels endorsed by the National Institute for Health and Care Excellence (NICE). Staffing establishment on the surgical wards had recently been reviewed by the assistant director of nursing, following data collection over a two week period. Analysis of data resulted in a majority of the wards having an increase in their nursing establishment. Ward matrons told us recruitment was currently in progress and was being managed with bank and agency staff in the interim.

- We saw that surgical wards where gynaecology patients recovered from surgery had the planned numbers of nursing staff and healthcare assistants (HCAs) during our inspection. The wards displayed planned versus actual staffing levels on the wards for patients and members of the public to see.

## Medical staffing

- Gynaecology services at EDGH had dedicated registrar and consultant cover during daytime hours. However, the hospital had no dedicated gynaecology on-call cover at night. This meant that if a gynaecology patient deteriorated during the night, then a gynaecologist would not be able to review them or provide specialist care. Instead, the on-call surgical registrar covering the hospital at night would review the patient. If a gynaecology patient subsequently needed specialist care from a gynaecology consultant, staff transferred the patient by ambulance to Conquest Hospital.
- Staff on Hailsham Four and Michelham wards told us about occasions when gynaecology patients had bled excessively during the night post-surgery and needed ambulance transfer to Conquest Hospital. Transfers were rare, and less than five gynaecology patients had an emergency transfer in the past two years. All patients transferred to Conquest had made a good recovery.

## Major incident awareness and training

- All senior managers on call attended mandatory training in tactical leadership in a crisis. Records showed that service managers for women's services had attended training within the last 12 months. We saw the trust's emergency preparedness resilience response policy, which was awaiting ratification at the time of our visit.
- We saw the trust's major incident policy. The trust 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 in receiving casualties in response to a major incident.

## Are maternity and gynaecology services effective?

Requires improvement



We rated effective as requires improvement. This was because:

- Most of the maternity policies and procedures were outside their review date. This meant staff might not have worked to all the relevant and current evidence-based guidelines, standards or best practice.
- 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
- A lack of specialist training for nurses who cared for gynaecology patients presented a risk that may have impacted upon patient care.

However:

- Outcomes for people who used services were generally positive and met expectations.
- Appraisal rates met trust targets.
- We saw positive examples of multi-disciplinary working.

## Evidence-based care and treatment

- We reviewed 22 maternity policies and found that 15 of these were beyond their review date. These included management of flu in pregnancy (due for review since 2012) and management of post-partum haemorrhage (due for review since December 2015). This meant staff might not have worked to the relevant and current evidence-based guidance, standards, best practice and legislation. For example, we saw that the maternity records management procedure, which had been due



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for review since December 2015, referenced the 2004 Nursing and Midwifery Council (NMC) Midwives Rules and Standards. However, the NMC issued an updated policy in 2012, which replaced the 2004 version.

- Of the maternity policies that were within their review date, several did not refer to the current National Institute for Health and Care Excellence (NICE) or Royal College of Gynaecologists (RCOG) guidelines. For example, the procedure for care of women in labour referenced the 2007 NICE guidelines. NICE replaced the 2007 guidance with CG190: “Intrapartum care for healthy women and babies” in December 2014. The trust’s guidelines for venous thromboembolism (VTE) in pregnancy referred to the RCOG 2010 guidelines. However, the RCOG updated its green-top guideline No. 37b- “Thromboembolic disease in pregnancy and the puerperium: acute management” in April 2015.
- We also saw that some policies and procedures did not refer to appropriate national guidance. For example, the “care of routine healthy pregnant women” did not refer to NICE guidelines. However, we saw areas of evidence-based antenatal practice. For example, the trust offered foetal anomaly screening in accordance with current UK national screening committee programmes. This was in line with NICE quality standard QS22: Antenatal care.

## Pain relief

- EMU offered women the choices of Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour. If women requested an epidural, midwives arranged an ambulance transfer to the obstetric unit at Conquest Hospital.
- Trust data showed that 75% of women at EMU gave birth in water from April 2015 – March 2016. The unit had one fixed birthing pool in the “Lily Pad Room”, which women could use for pain relief during labour and birth. There was also a large corner bath in one of the bathrooms, which midwives told us women could use for pain relief during labour if another woman was using the Lily Pad Room.
- A woman who had recently given birth told us staff responded to her pain during labour and helped her cope, for example, by helping her into the pool.

## Nutrition and hydration

- EMU had breastfeeding specialist midwives to help support new mothers with breastfeeding. We met a woman who was staying in the unit with her baby for breastfeeding support. She told us she received lots of help from staff. The unit also had bottles and sterilising equipment for women who chose to bottle-feed their babies.
- A specialist breastfeeding midwife ran a monthly tongue-tie clinic at EMU to correct tongue-ties in babies, which can sometimes cause breastfeeding problems.
- We reviewed patient menus. We saw that there was a range of choices, including options for people with special dietary needs such as diabetes and gluten intolerance.
- EMU had a day room, where women and their partners could prepare hot and cold drinks and light meals such as toast or cereal at any time of the day or night. This allowed women labouring during the night to access snacks and drinks if they wanted them.

## Patient outcomes

- EMU reported 257 births in the period April 2015 – March 2016. During the same period, 318 women came to EMU in labour. Of these, 61 women transferred to Conquest Hospital during labour. The most common reasons for transfer were for pain relief and delays in the first stage of labour. Other reasons included meconium in the waters, foetal heart rate anomalies and delays in the second stage of labour.
- Data from April 2015- March 2016 showed that 35.5% of women having their first baby who started their labour at EMU transferred to Conquest Hospital. The transfer rate for women having their second or subsequent baby was 9.3%. These rates were about the same as the trust targets of 36% and below for first-time mothers and 9% and below for women who had given birth before. The trust based their targets on national data from the Birthplace Cohort Study by the National Perinatal Epidemiology Unit.
- Of the women who transferred from EMU to Conquest Hospital during labour in April 2015 – March 2016, 85.1% had a vaginal birth. This was better than the trust’s overall vaginal delivery rate of 76.0% during the same period, and the England average of 73.4%. This meant



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women who started their labour at EMU were more likely to have a vaginal birth, even if they transferred to Conquest Hospital, than women who started their labour at Conquest.

- There were no admissions of babies born at EMU to special care baby units (SCBU) or neonatal intensive care units (NICU) between April 2015 and March 2016. There were no early neonatal deaths for babies born at EMU in the same period.
- The trust's maternity dashboard showed two babies had shoulder dystocia at EMU in April 2016 - July 2016. Shoulder dystocia is where a baby's body becomes stuck in the birth canal following delivery of the head. During the same period, 98 women gave birth at EMU. This meant the rate of shoulder dystocia during this period was 2.0%. This was worse than the trust target of 0.5% or below. However, summaries of incident investigations showed midwives managed both situations appropriately and there were no adverse outcomes for either baby.
- Average breastfeeding initiation rates at EMU were 75.7% for the period April 2016 – July 2016. This was worse than the trust target of 85%.
- 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's 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 foetal movements, and local record-keeping audits in gynaecology.
- We saw on the trust's incident log that they failed to participate in the pregnancy in diabetes 2015-16 national audit. The reason for this was 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 care commissioning groups. However, we saw from the trust's audit schedule that they were participating in the 2016-17 NCAPOP diabetes in pregnancy audit at the time of our inspection.

## Competent staff

- Gynaecology patients received care on mixed-speciality surgical wards following elective surgery. This was because there was no dedicated gynaecology ward at EDGH. Staff confirmed that gynaecology patients did not always receive care from dedicated gynaecology nurses. For example, on Seaford Four Ward, three out of 26 nurses had a gynaecology background. The gynaecology nurses advised and supported nurses from other speciality backgrounds on the ward in the care of gynaecology patients.
- A consultant gave us an example of how the lack of specialist gynaecology nurses had a negative impact on patient care. They told us how non-specialist nurses caring for a gynaecology patient failed to recognise symptoms of urinary retention following surgery. This led to significant pain and distress for the patient. We also saw a record of an incident on Hailsham Four Ward where staff discharged a gynaecology patient without calculation or documentation of post voiding residual urine with a bladder scan. The incident investigation found this happened because staff on the ward were not familiar with trust policies for the care of gynaecology patients post-surgery. The service took action to ensure all staff who cared for gynaecology patients familiarised themselves with the relevant policies following learning from this incident.
- The overall appraisal rate for midwifery and nursing staff at Eastbourne Maternity Unit was 85% in April 2015 – March 2016. This was the same as the trust target of 85%.
- 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. This was about the same as the NMC target of 100%. One of the purposes of the annual review was to determine that individual midwives met the NMC

# Maternity and gynaecology

requirements for revalidation, including evidence of continuing professional development. All midwives had a named SoM and rotas ensured midwives had 24-hour access to a supervisor.

- Midwives attended annual “prompt” study days. These involved scenario-based training covering emergency obstetric situations such as post-partum haemorrhage (excessive bleeding after childbirth), shoulder dystocia and cord prolapse. Cord prolapse is when the cord comes out before the baby during labour, which can cause a reduced supply of blood and oxygen to the unborn baby. 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.
- Staff at EMU worked closely with community midwives. Community midwives often came into EMU as part of their on-call commitments when the unit needed additional staff. Community midwives felt the recent triage pilot, where they spent a nightshift covering triage on a rotational basis, worked well. All midwives we spoke to said they would like this arrangement to continue.
- Midwives at EMU gave us an example of multidisciplinary working with the hospital’s emergency department (ED). They described a situation that happened the year before our visit where a woman attended the ED with a concealed twin pregnancy. Midwives attended quickly to help deliver the first baby, and then realised the woman was carrying twins. Midwives told us the staff in ED were very grateful for their support and specialist input.

## Seven-day services

- The maternity day assessment unit was open Monday – Friday, 8.30am – 7pm. Community midwives could refer women for cardiotocography (CTG) monitoring or additional scans if there were any immediate concerns

during pregnancy. Outside of these hours, women could telephone the triage line with any urgent concerns and travel to the antenatal ward at Conquest Hospital for review.

- Community midwives or GPs referred women less than 14 weeks pregnant with concerns such as bleeding to the early pregnancy assessment clinic (EPAC). EPAC was open 8am – 1pm, Monday – Friday. Outside of these hours, the gynaecology ward at Conquest Hospital accepted referrals for this group of women. Women could get an urgent referral out of hours via the hospital’s ED. EPAC also offered routine appointments for antenatal scans at 12 and 20 weeks of pregnancy for local women.
- Midwives ran postnatal clinics seven days a week at EMU.
- EMU was open 24 hours a day, seven days a week for women who wanted to birth there.

## 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 EMU. This enabled ongoing care within the community.
- The hospital kept centralised records for gynaecology patients. A consultant and a manager told us patient notes were sometimes not available for gynaecology clinics. A consultant gave us an example of how this had affected a patient’s ongoing care.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed four sets of records and saw staff obtained and recorded verbal consent where appropriate, such as before a vaginal examination.

# Maternity and gynaecology

- Staff received training in the Mental Capacity Act (2005) as part of their annual mandatory training. Records showed that 100% of nursing and midwifery registered staff on EMU completed this course in 2015-16.

## Are maternity and gynaecology services caring?

Good



We rated caring as good. This was because:

- Staff treated patients with dignity, respect and kindness. Patients felt supported and said staff cared about them.
- Patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- Staff respected patients' privacy and confidentiality.
- Patients were supported to maintain and develop their relationships with those close to them.

## Compassionate care

- We asked staff at EMU what they thought were the best things about the unit. All answers related to the compassionate care they gave to women. Answers included the job satisfaction from caring for women and providing breastfeeding support, the continuity of care, the "compassionate, kind environment" and the "amazing experience women get".
- We saw a midwife ask her colleagues as soon as she came on shift about a woman she cared for in labour the previous day. The midwife was very happy that the woman's birth had a good outcome, and immediately went to see the woman and offer her congratulations.
- We spoke to a woman who had recently given birth and her partner. She felt she received good care from the staff at EMU. She told us every member of staff she met introduced themselves before caring for her. She told us staff respected her privacy and dignity at all times.
- A review of ESHT maternity services published by a local Healthwatch group in May 2016 reported "very complimentary feedback" from women who laboured at EMU. Some of the most common phrases women used to describe their experiences of care included "excellent", "first class", "wonderful memory" and "staff reassuring".

- NHS friends and family data from August 2016 showed 100% of women who responded would recommend the trust for antenatal care. This was better than the national average of 95.2% in the same period.
- NHS friends and family data from August 2016 showed 93.7% of women recommended the trust as a place to give birth. This was slightly worse than the national average of 96.0% for the same period
- The trust's friends and family recommendation rate for community postnatal care was 100% in August 2016. This was better than the national average of 97.4% for the same period. However, the recommendation rate for hospital postnatal care was 91.5%. This was slightly worse than the national average of 93.3%.

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

- A woman who had recently given birth told us staff fully explained things throughout her pregnancy and labour. She felt staff listened to her concerns and gave her enough information to make informed decisions about her care, such as place of birth.
- Trained screening midwives counselled pregnant women undergoing the combined screening test to check for genetic anomalies. This process ensured women were fully informed about the test and the possible implications before going ahead.

## Emotional support

- Antenatal screening midwives and consultants provided de-brief appointments for women whose antenatal screening results identified anomalies. As well as providing the opportunity for emotional support, these meetings allowed women to discuss their results, the implications, and to plan the next steps. A screening midwife told us women felt this service was very worthwhile.
- Women's partners were allowed to stay overnight with them after they had given birth. This enabled women to receive support from their partners as they recovered from birth and adjusted to the demands of a new baby.
- 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.

# Maternity and gynaecology

## Are maternity and gynaecology services responsive?

Requires improvement



We rated responsive as requires improvement. This was because:

- There were delays for patients using gynaecology services and referrals to treatment times were consistently worse than the 18-week national indicator.

However:

- Services were planned and delivered in a way that met the needs of women with low-risk pregnancies in the local population.
- The service made reasonable adjustments and looked to remove barriers when people found it hard to use or access services, for example, through provision of interpreters.
- Women with low-risk pregnancies who gave birth at EMU could access the right care at the right time.
- 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

- EMU provided facilities for women with low-risk pregnancies to give birth to their babies. All local women could also attend the early pregnancy assessment clinic for antenatal scans. Community midwives occasionally offered antenatal booking appointments at the hospital, although these usually took place at community premises. The day assessment unit provided cardiotocography (CTG) monitoring and urgent scans where there were medical concerns during pregnancy. Women also attended the day assessment unit for blood pressure monitoring and anti-D injections (for rhesus positive women) where clinically indicated.
- There was also a daily postnatal clinic at EMU. This enabled women and their babies to attend for a planned appointment if they wanted to. Some women preferred this to waiting at home for a community

midwife to visit at an unconfirmed time. Local women who gave birth at Conquest Hospital could transfer to EMU if they were medically fit for discharge but needed additional breastfeeding support.

- The range of maternity services offered at EDGH meant that local women could still go there for their antenatal and postnatal appointments, even if they delivered their baby at The Conquest Hospital.

### Access and flow

- Gynaecology referral to treatment times (RTTs) were consistently worse than the trust target of 92% within 18 weeks in March 2016 – August 2016. EDGH failed to meet the 92% target every month during this period. The worst month was March 2016, when only 38.6% of patients received treatment within 18 weeks of referral. The best month was July 2016, where the 18-week RTT was 59.7%. The hospital's 18-week RTTs were also worse than the England average of 80.7% during this period.
- Minutes from the women's, children's and sexual health governance and accountability meeting on 22 July 2016 stated waiting times for gynaecology treatment at EDGH were 22 weeks. This was worse than the 18-week target. However, we saw the service was taking action to address this by increasing the number of consultants.
- The trust's maternity dashboard showed 91.3% of women receiving antenatal care at EDGH saw a midwife for their booking appointment by 12 weeks and six days of pregnancy in April 2016 – June 2016. This was better than the trust target of 90% agreed with the local strategic health authority.
- Trust data from July 2015 – July 2016 showed the trust only diverted five women who called the unit in labour during this period. Diversions happened because EMU needed to close due to insufficient staffing. The unit diverted all five women to Conquest Hospital. One diversion took place in December 2015, one in January 2016 and three in February 2016. This meant closures only rarely affected women's birthplace choices.
- Data showed EMU did not close in the last four months of the reporting period, between April 2016 and July 2016. Staff told us there had been no closures since the new Chief Executive joined the trust in April 2016.

### Meeting people's individual needs

# Maternity and gynaecology

- The service had access to translators for many different languages. Interpreters attended appointments with women who did not speak fluent English. Midwifery staff were able to describe the process for booking interpreters for women who needed them.
- The trust had recently appointed a community midwife as a part-time perinatal mental health lead. The trust had also advertised for a teenage pregnancy lead and was going through the selection process at the time of our visit.
- EMU provided burners so that women could use aromatherapy oils during labour if they wanted to. The trust requested that women obtain the oils along with guidance from a qualified aromatherapist.
- Gynaecology services saw very few patients living with dementia. However, the mixed speciality surgical wards where gynaecology patients recovered from surgery, such as Seaford Four, used a butterfly scheme. The scheme involved placing a picture of a blue butterfly above the bed of patients confirmed as living with dementia. Patients who showed some confusion, but where a diagnosis of dementia was not confirmed, had a blue outline of a butterfly. This enabled staff to easily identify patients living with dementia and provide appropriate support.
- 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.

## Learning from complaints and concerns

- Maternity and gynaecology services at EDGH received 29 formal complaints from August 2015 – July 2016. Of these, six related to maternity and the remaining 23 related to gynaecology. The most common reasons for complaints related to clinical treatment. The second most common category was communication.
- We saw the trust’s policy for responding to complaints and concerns. The trust aimed to respond to complaints within 30 working days. For more complex complaints (including complaints where external agencies were involved), the trust aimed to respond within 45 working days. We saw that the trust responded to 12 out of the 29 complaints within the 45-day target. While this meant the trust exceeded the 45-day target in 17 cases, we saw

that only one of these cases was in the later part of the reporting period, from April 2016- July 2016. This meant the trust’s timeliness in responding to complaints improved from April 2016 onwards.

- 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 saw information on how to make a complaint available to people who used services via the trust’s website. We asked a woman receiving postnatal care in EMU whether she knew the procedures for raising complaints and concerns. She was aware of the processes and the availability of the trust’s patient advice and liaison services (PALS) for anyone who wanted to make a complaint.
- We saw a “You said, we did” board on display at EMU. This showed ways in which the unit had responded to feedback from women to improve services. Examples of improvements included displaying staff names and pictures, which we saw on the corridor wall, and improved wall art.

## Are maternity and gynaecology services well-led?

Good



We rated well-led as good. This was because:

- 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.
- 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.



# Maternity and gynaecology

- Through the daily maternity risk meetings, there was candour, honesty and transparency to enable the entire service to learn lessons and make improvements.

However:

- While data collection had improved since our previous visit, the trust were unable to split their midwife to birth ratio by site.
- The ratio of supervisors of midwives (SoMs) 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

- Eastbourne Midwifery Unit (EMU's) vision was to build upon its provision of local maternity care for local women. Staff felt the unit was sometimes under used, and managers and staff were keen to build upon the unit's success and increase the number of births at EMU.
- Managers we spoke to knew the trust's values. A matron was able to describe how the midwifery-led unit brought these values to life, for example, by showing respect and compassion towards women in labour. We saw posters with the trust's values displayed in corridors so that all staff were aware of them.

## Governance, risk management and quality measurement

- At EMU, midwives and maternity support workers (MSWs) reported to the matron. The matron reported to the clinical services manager for the Eastbourne site, who reported to the trust's 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.
- Maternity services also held a trust-wide daily maternity risk meeting held at Conquest Hospital. We saw that staff at EDGH participated in these meetings via video link. 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.

- We saw the maternity, gynaecology and sexual health risk register. One item on the risk register related to maternity services at EDGH. This was the issue of community midwives being called into either EMU or 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 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.
- One area of risk we identified that was not on the register was the lack of dedicated gynaecology medical cover at night. This meant the trust might not have fully considered all the risks related to gynaecology services at EDGH.
- 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.



# Maternity and gynaecology

- While data collection had improved since our previous visit, the trust were unable to split their midwife to birth ratio by site.

## Leadership of service

- All staff we spoke to felt supported by their line manager. Staff also felt the newly appointed head of midwifery was visible and approachable.
- Staff at EMU told us the new chief executive had visited the unit and met them. They felt the new executive team were much more visible as they did not know who the previous chief executive was.
- Managers told us how the chief executive had pledged support for EMU and told them it “must remain open”. A senior midwife described the new chief executive as “a breath of fresh air”. On our previous inspection in 2015, closure of EMU due to staff going to support their colleagues on the labour ward at Conquest was a frequent issue. Data showed the unit had never closed since the new chief executive joined the trust in April 2016.
- All midwives had a named supervisor of midwives (SoM). While rotas ensured 24-hour availability of SoMs, 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.

## Culture within the service

- Staff at EMU described working at the unit as “lovely”, with a “good team spirit”. Midwives based at the hospital described good working relationships with community midwives. Staff felt morale had always been good at EMU, whereas this may not always have been the case in other areas of the trust. Staff gave us examples of positive improvements since our last visit, such as better information sharing and feedback from incidents.
- Trust data showed there was 7.3% staff turnover for maternity and gynaecology staff at EDGH in April 2015 – March 2016. This was better than most other areas of the trust, and better than the trust wide turnover for maternity and gynaecology services of 11.0%.

- We saw posters in the staff office at EMU giving details of counselling services available for staff to help improve and maintain their wellbeing.
- 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.

## Public engagement

- The trust had an active maternity services liaison committee (MSLC). We attended an MSLC meeting during our visit and saw appropriate engagement between staff and other committee members such as service user representatives. We also saw evidence of engagement between maternity services and a local Healthwatch group. This was a significant improvement in engagement with local stakeholder groups since our previous inspection in 2015.
- The trust had a closed social media group, “focus on making it happen”, for local women to share experiences, insights and ideas about how to make maternity services better. EMU also had its own social media page to engage with local women using maternity services. A midwife monitored the page and answered questions from women. This helped extend the reach of the service to women who used social media as a regular means of communication.
- We saw a short film on the hospital’s website that gave information and a virtual tour of the midwifery-led unit. This provided comprehensive information to prepare women who wanted to birth there.

## Staff engagement

- The trust’s project lead midwife carried out an extensive maternity services review. The review involved engaging with staff and women using services to seek their views to help make service improvements. Staff told us they felt listened to because of the review. All staff we spoke to commended the work of the project lead midwife and felt the review had helped improve services and made staff feel more positive.
- Maternity services had an EMU development group. The group met every three to four weeks to steer the development of the service.







# Maternity and gynaecology

- The trust's maternity services had a closed social media group for staff called "make it happen". The purpose of the group was to engage and involve staff. The group had 152 staff members at the time of our visit.
- A matron gave us an example of how staff had been involved in service improvement by allowing them to choose new colour schemes for the rooms on EMU.

## **Innovation, improvement and sustainability**

- 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 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 07:00-19:00 hours adjacent to the inpatient unit. There is another SSPAU located at the EDGH site that operates seven days per week from 07:00 to 21:30 hours with admissions stopping at 19.00hrs Mon-Fri and 10.00 to 18.00 hours at weekends with admissions to the unit stopping at 16.00hrs. 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. We 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 15 nursing staff, three medical staff and nine other members of staff at EDGH.

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:

- There was no play service provision at the hospital.
- Incident reporting, whilst improved from 2014, was still inconsistent and did not reflect the number of incidents that should have been reported
- The hospital had no paediatric recovery nurse
- Paediatric nurse cover overnight in the emergency department was limited.
- A number of pathways and policies were still in development
- Waiting times for outpatients appointments for some patients were excessive
- The appointment system was not working well and patients were not being sent letters regarding upcoming appointments
- Transfers to the Conquest hospital were taking place very late from the SSPAU
- There were no explicit criteria to guide staff as to whether a child should be transferred by ambulance or fit to go by private car.

However:

- The Friston Unit was clean, uncluttered and had a good play area for children.
- We saw a good example of staff adhering to the duty of candour
- We were given positive accounts about the compassionate care children had received from parents and children themselves
- All staff were aware of the vision and strategy for the trust and how services for Children and Young People fits in.
- Initiatives had been introduced to help keep children out of hospital.
- There were plans in place to have a paediatric nurse in the emergency department and on the wards on a rotational basis.

- Links between acute and community services were good.
- There was clear line management and staff were aware of their responsibilities.
- Service development was being encouraged.

# Services for children and young people

## Are services for children and young people safe?

Requires improvement



We rated safe as requires improvement because:

- Incident reporting, whilst much improved from September 2014, was still inconsistent, in particular, the absence of records for some outpatients clinics were not being reported in full.
- Record keeping was inconsistent with some omissions including pain scores and paediatric early warning scores.
- The availability of medical records for outpatients appointments had caused difficulties, with some clinics needing to be postponed as the records had not arrived or had arrived late.
- Whilst there was a policy in place to support clinical judgement in deciding on how children were transferred to the Conquest hospital, there was limited monitoring of the effectiveness and safe implementation of the policy.

However:

- There were good processes in place to safeguard children attending the hospital and good involvement in the wider pan-Sussex child safeguarding work.
- Medicines were being managed well.
- Safety thermometer data showed care was harm free.
- A Paediatric Early Warning Scoring system was in use and enabled staff to identify children at risk of unexpected deterioration.
- There were clear protocols for the transfer of children with designated accountability for decision making and explicit criteria to inform the decision.
- The duty of candour was well established across a wide range of job roles and adherence to the protocols was well evidenced.

- The unit was visibly clean and uncluttered. Cleaning audits were now being undertaken and staff were observed to be compliant with trust infection prevention and control processes.
- Equipment was checked routinely.
- Staff recruitment continued to provide challenges but there were generally adequate numbers of children's nurses on duty.
- There was good paediatric medical cover for a unit of this size.

### Incidents

- There were a total of 58 incidents reported at Eastbourne District General Hospital (EDGH) 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. Of these, 43 were categorised as level one, 13 were categorised as level two and two were categorised at level three. We were provided with a summary of the incident and the action taken as a result. All incidents were handled appropriately.
- There was a perception amongst the staff that we spoke with that some incidents were not being reported, although we were assured that any clinical incidents were being reported appropriately. Staff reported that there had been real improvements in the learning taken from the reporting of such incidents although it was still inconsistent and needed to develop further.
- Between August 2015 and July 2016 the trust did not report any 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.
- Data from the Patient Safety Thermometer, reported trust wide rather than 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.
- Local paediatric morbidity and mortality case discussions / meetings occurred weekly and were

# Services for children and young people

facilitated by a consultant. Minutes showed good presentation of case 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.
- In addition to the local meetings, staff from across services for children and young people had bi-monthly mortality and morbidity meetings. These meetings were held across the Trust and not just at the EDGH.
- 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 two examples 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

- Hand hygiene audits were completed by the Infection Prevention and Control Link facilitator each month. The data for February 2016 to July 2016 showed 100% compliance in February April and June. Compliance in March and July was 90%. There was no data provided for May 2016.
- We observed staff frequently cleaning their hands with hand gel on the wards. We observed nursing staff regularly cleaning their hands, using gloves when necessary and washing hands again once they had finished with the gloves.
- PPE was available in appropriate places and used when necessary.
- Cleaning audits were conducted monthly across Friston Outpatients Department (OPD) and Friston Ward. The target for compliance on each unit was 95%. The most recent data available at the start of the inspection showed that in June 2016 Friston OPD scored 92.37% and in July 2016 scored 92.25%. Friston ward scored 94.29% in June 2016 and 89.75% in July 2016.

- There was clear signage outside isolation rooms which told those entering that PPE must be worn. Appropriate PPE was available outside these rooms.
- 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 site
- The Friston unit was clean with stickers on equipment displaying if an item was clean and when it was last cleaned. There was a separate, clean weighing room.
- There was a milk room where sterilising equipment for baby bottles was kept along with clean bottles and teats.
- There had been no hospital acquired urinary tract infections in children across the trust between July 2015 and June 2016.

## Environment and equipment

- The hospital carried out a Health and Safety inspection every 13 weeks. The inspection looked at a range of areas which included but were not limited to access routes, fire equipment, furnishings and security. In total, 22 different areas were inspected. The most recent inspection on 14 July 2016 showed there were two areas that needed attention. One related to the lack of a fire alarm in the outpatients department. This was raised with the fire officer immediately and arrangements were made for this to be rectified straight away. The statutory fire notices were also out of date. This was rectified immediately through the fire officer.
- A resuscitation trolley was available in recovery in the theatres with paediatric equipment of various sizes.
- The resuscitation trolley had the tag checked daily and a full check was completed weekly. Records held on the trolley confirmed that the checks had been completed appropriately.
- The resuscitation trolley at the EDGH was the same as the resuscitation trolley at the Conquest Hospital. This meant that staff that worked across the two sites were familiar with it.



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- There was one room for a trolley set aside for children in A&E with a separate waiting area. There was also a separate room for assessment for children and young people in A&E.
- In the outpatients department there were separate waiting areas for older and younger children with toys available
- Access to the Friston Unit was gained through a buzzer and intercom system. When the buzzer was pressed, a visitor would have to identify themselves to a member of staff on reception.
- There were facilities for parents to make a hot drink, although there was nothing to stop the drinks being taken into play areas and this posed a risk of scalding to young children who were running around.

## Medicines

- The hospital had a policy in place for allowing parents to give children their own medication that they brought into hospital with them. The trust policy said that parents can give the medication, depending on what the drug was. Nursing staff would complete the drug chart to record that it had been given by a parent. Drugs provided by the hospital would not be dispensed by the parents, although parents often administered them.
- Drugs cabinets on the SSPAU were accessed with a swipe card. This meant that there was no single key holder who would need to be found in the event of a member of staff needing access.
- Medicine records seen were completed appropriately.

## Records

- Patient records had been moved to a storage facility away from the hospital and at the time of the inspection, this had only been in operation for approximately three months.
- We were told by both nursing and medical staff about the difficulties in getting records where they need to be in time for clinics. This had resulted, on the odd occasion, in clinics being cancelled. These incidents had been reported on the datix system. However, it would only be reported as one incident rather than a separate

incident for each set of notes that were missing or late. This had the effect that the data reported on the datix did not fully reflect the impact that this had had on individual patients.

- 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 a patient's records that had surgery on the day of the inspection. Although the completion of the day surgery care pathway for the patients was, in the main thorough, there were sections that weren't completed in full. We saw that fasting instructions for parents were not recorded in some cases. PEWS scores had been omitted and consent on the day of the procedure had not been completed. This meant that there was an incomplete record of what had happened.
- We saw, in the records that we reviewed that risk assessments had been recorded as well as the risks associated with any surgical procedures.
- The records at assessment were, in the main well-kept although we did see a few examples of pain scoring not being completed or PEWS being recorded.
- Records were stored securely on the unit and were not left where anyone could read them without authorisation to do so.

## Safeguarding

- The Friston Unit had a named specialist child safeguarding nurse who assessed all attendances of children aged 16 and under at accident and emergency (A&E) to assess if there were any risks associated with the attendance and whether it would trigger any alerts.
- The trust had 2 Named Doctors who covered both acute and community. The Designated Nurse and Doctor activity remained within the CCG's.
- There was a full time named nurse for the acute services.
- The specialist safeguarding nurse provided a drop in for ward staff if they had any concerns.

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- The paediatric liaison nurses scrutinised all children's and young person's admissions and any children who were deemed to be at risk were referred to the Single Point of Advice within Children's Social Care.
- The specialist safeguarding nurse were notified if a patient had failed to attend two or more appointments to assess if the failure to attend was a cause for concern. Formal policy for the actions that needed to be taken in those circumstances was being drafted at the time of the inspection.
- If children of school age attend the hospital and there were any issues, this would be escalated to the local authority and subsequently to the school.
- Level three child safeguarding training was provided by the specialist safeguarding nurse to all clinical paediatric staff in A&E, on the ward and in outpatients.
- Staff seeing older children for dental work were trained to level three
- A multi-disciplinary safeguarding meeting was held weekly across the ward and in A&E
- Female genital mutilation (FGM) is covered in level three safeguarding training.
- All staff in the department, except for the ward clerk were trained in safeguarding children at level three.
- Safeguarding children training compliance at level two was 83%, this was below the trust target of 90%. Safeguarding children training compliance at level three was 83%, this was below the trust target of 90%. However there had been a significant increase in the number of staff completing child safeguarding training across the trust. The improvement moved from 43% of staff working directly with children having level three training in 2014 to 86% in 2016.
- 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.

- Records of incidents demonstrated that staff acted appropriately where there were safeguarding concerns.

## **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 children level one and safeguarding vulnerable adults. The trust target for mandatory training was 90%.
- 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 is a central database that recorded the staff's compliance with mandatory training.
- On Friston unit the nursing and midwifery staff achieved the 90% target in all areas except for conflict resolution (33%) equality and diversity (83%) health and safety (83%) mental capacity act (83%)

## **Assessing and responding to patient risk**

- We saw evidence of paediatric early warning scores (PEWS) being completed. However, the use was mixed with some scores being recorded and some not. Some records had also had them taken at one point in time, but not at others. We were told by nursing staff that PEWS scores were not routinely recorded in the day case surgery pathway document. This was despite there being a place to record it. Instead the PEWS scores were recorded separately in the patient notes.
- Staff escalated concerns identified through a raised PEWS score or other clinical concerns to the medical staff. The PEWS scoring system and policy gave clear guidance as to when and who to escalate concerns to.
- 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.
- An electronic observation recording system was in use across the hospital and was due to be rolled out in

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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.
- Children were not necessarily cared for by staff with specific training in the care of children whilst in the recovery area.
- The medical staff on the Friston Unit had introduced departmental risks meetings where clinical risks would be reviewed. If any issues identified were serious, these could be escalated to senior staff to look at ways to mitigate the risk. These were not risks about individual patients but risks that could impact on the ability to deliver appropriate care and treatment to children and young people.
- Arrangements were in place to ensure that any children that needed to be admitted to a ward would be transferred from the EDGH to Conquest. We saw that there was frequent communication between the two sites. The implementation of a video conferencing facility between the Kipling ward at the Conquest Hospital and the EDGH had proved useful in allowing staff at both sites to communicate effectively.
- The transfer of children and young people was either by ambulance or in their parent's car, dependent on their presenting condition and how unwell they were. The decision on how a patient would be transferred was taken in accordance with the Operational Policy for Acute Children's and Neonatal Services. This document was published in August 2014 and revised in October 2016. The policy gave a clear rationale for how children should be transferred based on the clinical decision of the consultant on call.
- The decision as to whether the patient required a nurse escort was made by the appropriate clinical staff in conjunction with ambulance trust staff. A decision as to whether a blue light transfer was required was made by the Senior Nurse or Paediatric Consultant in conjunction with ambulance control.
- All transfers from ESHT to another hospital were discussed with the Consultant on Call prior to the transfer taking place.
- Whilst there was a policy to support clinicians in deciding on the appropriate method of transfer of children to the Conquest Hospital, there was limited monitoring of the effectiveness and safe implementation of the policy. There was no collation and analysis of data or audit of outcomes related to transfer between sites.
- Children requiring critical care were transferred using the South Thames retrieval team specialist ambulances and staff.
- 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.

## Nursing staffing

- The short stay paediatric assessment unit was scheduled to have one registered children's nurse between 7am and 3pm with a further two registered children's nurses working between 9am and 9pm. Nursing staff were supported by one health care assistant between 7am and 7:30pm.
- At the time of the inspection there was no paediatric nursing cover in the hospital overnight. It was anticipated that there would be an internal rotation between the Short Stay Paediatric Assessment Unit (SSPAU) and Accident and Emergency (A&E) for one paediatric nurse.
- We were told that there was a paediatric nurse employed in recovery but they could not always be on shift when children were in surgery.
- The post anaesthesia care unit practitioner and recovery nurse were not trained paediatric nurses.
- The paediatric outpatients department at EDGH was staffed by one paediatric band 6 sister and an HCA.
- At the time of the inspection there were three nurses with paediatric training in A&E, two were band seven and one was band six. There was also an HCA employed

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in A&E who had paediatric competencies, could take observations and report on those observations. We did not see any evidence that the registered children's nurses were rostered to allow for a children's nurse in the ED at all times.

- There was an annual sickness rate across children's services at the EDGH of 4.8%.
- 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
- The use of agency and bank staff in the Friston Ward outpatients, in the period April 2015 to March 2016 fluctuated from zero staff in some months to 14.23% of staff in Mar 2016. The use of agency and bank staff on Friston Ward for the same period also fluctuated from zero to 14.4% although this dropped back to 7.7% in March 2016.
- The nurse staffing numbers for June 2016 show that the Friston unit had 3.3 whole time equivalent vacancies. This amounts to 18% of the staff complement.
- 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. Agency staff were often not paediatric nurses. If this was the case, these nurses would be asked to care for the lower acuity patients.

## Medical staffing

- On the ward there was a consultant paediatrician available from 9am to 7pm and then on call overnight.
- They were supported by a paediatric registrar who worked from 9am to 6pm. Paediatric registrar cover overnight was provided from the ED.
- Senior House Officer cover was provided between 9am and 6pm
- Medical staffing numbers were reported trust wide and were split into junior and senior medical staff.
- 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 was available between 9am and 5pm, Monday to Friday.

- 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.
- In the period April 2015 to Mar 2016, the rate of use of locums fluctuated from zero to a high of 35.08% in June 2015 before dropping back to 6.62% in March 2016.

## 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 plan had been updated in August 2016. 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.

## Are services for children and young people effective?

Good



There was a limited amount of data relating to the children's services at this hospital as the provision was small and emergency and inpatient care were not offered. The majority of children were seen at and admitted to the Conquest Hospital.

We rated effective as good because:

- The hospital was delivering care that was generally in line with the national guidance, 'Standards for Children's Surgery (2013)' and 'Getting it Right – National Service Framework for Children (2003)'.
- The trust had appointed a consultant to review all National Institute for Health and Care Excellence (NICE). All paediatric guidelines from NICE were adopted.

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- Local audits in a number of key areas were taking place across the trust.
- Pain was well managed with a variety of tools available that were age appropriate to establish the level of pain a child was in.
- The trust had introduced a new fluid balance chart to give more comprehensive information to staff caring for the patients.
- The appointment of a practice educator had ensured that mandatory training compliance was properly managed as well as a number of other initiatives to improve the competence levels of all staff caring for children and young people.
- The implementation of video conferencing facilities had helped facilitate effective communication across the trust.

However:

- Consent was not always recorded as having been rechecked on the day of surgery on the surgical pathway form.

## 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.
- The trust had appointed a consultant who had dedicated time in their job role to review all NICE guidelines and implement them. We were told by senior medical staff that all paediatric guidelines from NICE were adopted.

- 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.
- Audits given a priority rating of one included, paediatric asthma, paediatric pneumonia, and Diabetes (Paediatric) (NPDA) 2016-2017.
- Other audits were carried out at each priority level.

## 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 to describe how they felt.
- 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.
- The practice educator had implemented pain study sessions for nursing staff.
- We observed a nurse discuss pain relief with a child using a paediatric pain assessment tool.
- We observed a consultant write up post-operative pain relief for a child scheduled to have an operation. Pain relief was also given by nursing staff, following discussion with the consultant prior to the procedure. The nursing staff discussed the pain relief with the child using a paediatric pain assessment tool. Parents of children were also 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

- During the inspection we were shown the new daily fluid / feed balance chart. This had times broken down into individual hours, whether the intake was oral or intravenous. There was space for the asset number of



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the pump used for intravenous fluids. Previous fluid / feed balance charts did not have the hours broken down. Reviews of these charts demonstrated that they were being used correctly.

- Food and drink were provided, according to the patient's dietary requirements
- Formula milk and feeding equipment were available on the Friston Unit for those children that required it.
- In the CQC children's survey 2014 the trust scored 5.31 for the question 'Did your child like the hospital food provided?' This was similar to other trusts.

## Patient outcomes

- The Royal College of Emergency Medicine (RCEM), Vital Signs In Children Clinical Audit 2015/16 for Eastbourne District General Hospital showed that the hospital had performed better than the national median in four of the six standards. However, it failed to meet the RCEM standard of 100% in five of the six standards.
- The hospital did meet the RCEM standard of 100% for children discharged having been reviewed by a senior doctor. This was significantly higher than the national median. This meant that seriously unwell children were not discharged home.
- 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 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.
- Across the trust, 98.2% of all paediatric patients with diabetes had Type 1 diabetes.
- In five out of six measures recorded as part of the national paediatric diabetes audit the trust scored better than the England average. 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%.
- HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)".
- 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.
- Readmission rates were reported across the trust rather than hospital site specific. Between February 2015 and January 2016 there were fewer than six readmissions per specialty, as such no comparisons with the England averages could be made for either the under 1 age group or the 1-17 age group for elective readmissions within two days of discharge following elective surgery.
- Between February 2015 and January 2016 the percentage of less than one year old age group (3.8%) readmitted following an emergency admission was broadly in line with the England average (3.4%). The percentage of patients in the one to 17 age group readmitted following an emergency admission (4.4%) was worse than the England average (2.8%).
- 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.

## Competent staff

- Staff told us that the practice educator supports them through revalidation by operating a buddy system. This allowed the buddy to assist their colleague by helping



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collate information to support their application for revalidation. They had also developed a portfolio of competencies and development for staff to complete to assist in preparing for revalidation. When this was completed, it was signed off by the ward matron

- All band six nurses had been to a two day training course that looked at leadership and self-education skills. These were key elements of their role and the training would assist with revalidation.
- The appraisal rate for nursing staff on the Friston unit at EDGH for the period April 2015 to March 2016 was 93%. However, this had increased to 100% in the period April to July 2016
- Figures for medical staff appraisal rates were reported trust wide and not hospital site specific. The appraisal completion rate for medical staff was 100%
- Band three healthcare assistants (HCAs) were provided with a book of skills that they needed to complete from when they started in their role. The practice educator provided supervision to the HCAs as they completed the book and gained the necessary skills.
- The practice educator arranged an infusion equipment device training away day in commonly used infusion pumps.
- The practice educator attended 'super mentor' training following which any learning was cascaded down to other staff who acted as mentors.
- A programme entitled 'Sepsis Six' was being rolled out across the department. The majority of nursing staff had attended a session. A programme of training staff in tracheostomy care had also started.
- Junior doctors had also been provided with additional training in the identification and management of acutely deteriorating patients and sepsis, via the deanery.
- We were told by medical staff across the Friston ward how they had implemented a new 'challenging cases' weekly meeting. This helped ensure that any learning was shared across the unit

## Multidisciplinary working

- Handover from nursing staff to theatre staff was short but appropriate and followed the day surgery care pathway. This made the transition to the anaesthetic room smooth and the patient was not kept waiting.
- We observed staff from different areas of the SSPAU speak with each other in order to gather accurate information regarding a particular child. Each member of staff was sensitive to the needs of the parent while at the same time ensuring that the needs of the child were met.
- 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 who dealt with young people that were transitioning communicated with the Learning Disability lead for adult services as required to discuss the transition.
- If a patient required transfer to the Conquest hospital, transport would be arranged through the local ambulance service. There was a two or four hour target depending on the needs of the patient. If it was an urgent transfer, the EDGH would call 999 for an emergency ambulance.

## Seven-day services

- The Short Stay Paediatric Assessment Unit (SSPAU) opened Monday to Friday from 7:00am until 7:30pm. The SSPAU was open from 10am until 6:30pm on Saturdays and Sundays.
- 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. Staff we spoke with were aware of how to contact the on call consultant.
- Patients requiring out of hours imaging, pharmacy or any therapists would be treated as inpatients. EDGH did not have paediatric inpatients as they were transferred to the Conquest Hospital.

## Access to information

- Trust policies were available on the trust intranet and could be easily accessed by all staff.

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- 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.

## 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 or 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. However, the surgical pathway records seen did not always have the rechecking of consent recorded.
- The annual audit of consent (data period June 2015 – February 2016 ) showed that 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.

- All consent forms had the date the consent was obtained recorded; this was an improvement from 92% in the 2014 audit.
- The audit showed that for the women and children's directorate there had been 100% compliance with the applicable key indicators.

## Are services for children and young people caring?

Good



We rated caring as good because:

- Feedback from people who use the service was positive about the way staff treat people.
- Parents and children were involved and encouraged to be partners in their care and in making decisions. Parents were encouraged to be actively involved in their child's care.
- Staff spent time talking to parents, carers and the children
- We saw good interactions between a wide range of staff and patients/families
- Parents and children described how they felt cared for and how they were treated with dignity and respect.

## Compassionate care

- Parents and carers were encouraged to accompany their child to theatre. We observed a patient that was anxious when being taken to the anaesthetic room. The nurse and porter both spoke to the child in order to comfort them. Both were friendly and appropriate with their communication
- We witnessed good interaction between an anaesthetist and a child. This involved the anaesthetist speaking to a child about their favourite children's TV character and giving a reward sticker. The explanation of what would happen with the anaesthetic was done in a way that was appropriate for the age of the child. A game of 'Where's Wally' was also used while the anaesthetic mask was applied.
- We observed a nurse comforting a patient that had been taken to theatres for their procedure. The parent of

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the child had become distressed so a nurse escorted the parent to the ward while talking and explaining the expectations around the length of time the procedure would take and the recovery period.

- As soon as the child was awake, the parents were called to recovery to sit with them until they were ready to return to the ward.
- A patient returning from theatres with their parent was taken to the ward by the same porter that had taken them there. The nurse accompanying pulled the curtains, got a drink and ensured the child and family were comfortable. The child was then given a bravery certificate with their favourite TV character on it as well as a small toy bear.
- We heard the views of 11 parents of children attending the EDGH. The vast majority described positive experiences. They described staff that were responsive to any of their concerns and were able to answer any questions they may have had.
- One child we spoke with who was a regular attender at the Friston Ward explained that their experience was positive. Staff had been friendly and very helpful. The child's parent also explained how they were treated with privacy and dignity.
- 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

- We were told by one parent that as well as the staff being caring to them and their child, they were seen quickly by the nursing staff. They were also pleased that they saw the same consultant on each visit which gave consistency to their child
- Another parent told us how they attend regularly and are usually seen quickly, the staff are skilled and efficient. Bloods were taken in a quiet, private area and their child's privacy and dignity were respected.
- We were told by another parent that the staff had always been kind and willing to help with answering any question they had.

- 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

- Young children who were attending the hospital, who may have been apprehensive about going to theatre for a surgical procedure were asked if they wanted to travel to theatre in a large toy car rather than on a hospital trolley.
- Families were encouraged to participate in the care of their child and to be present during any procedures (excluding in the operating theatre) where they could provide emotional support and reassurance.
- Nursing staff provided emotional support to parents who might be distressed about their child's condition. They provided reassurance and were happy to answer any questions
- The continence team that are based on the Friston unit provided psychological support to the families and patients in their care. They worked with the families to empower parents wherever they can.

## Are services for children and young people responsive?

Requires improvement



We rated responsive as requires improvement because:

- Some people are not able to access services for assessment, diagnosis or treatment when they need to. There are long waiting times, delays or cancellations.
- We found that waiting times for outpatients appointments was longer than would be expected
- The system for booking outpatients was not working as would be expected and patients were not getting sent a letter with appointment details

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- There was no play specialist to work with children and develop play services as an integral part of the children's services.

However:

- The triage system run by the consultant of the week had been effective in keeping children out of hospital following calls from GPs.
- There was a good link between the community teams based at the hospital and hospital staff. This helped optimise the care that these teams could provide for their patients.
- There was a large play room for the children to use
- A side room had been specifically designated for oncology patients
- There was evidence of service planning to meet the ongoing needs of local families.
- Consideration and development of the services for children and young people with acute mental illness was taking place.
- Children with long term conditions had direct access to the children's assessment unit and could bypass their GP or the ED.
- Complaints management had improved significantly since September 2014. There was clear evidence of changes made to the service as a result of complaints.
- There was close working between community and acute children's services which allowed for effective communication and information sharing.

## Service planning and delivery to meet the needs of local people

- 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.
- Eastbourne District General Hospital (EDGH), as part of the East Sussex Healthcare NHS Trust (ESHT) provided a Short Stay Paediatric Assessment Unit, an Outpatients Department and also saw patients for day surgical procedures. Patients that attended EDGH did not stay overnight. Any patient that needed to be admitted were transferred to the Conquest Hospital in Hastings. This was where maternity services and the special care baby unit were located.
- 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 was being recruited to EDGH but was not yet in post. The HoN had requested an 'inreach' 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.

## Access and flow

- EDGH had 5145 short stay patients attend the SSPAU between May 2015 and April 2016. There were 1919 emergency attendances of which 313 were transferred to the Kipling Ward at the Conquest Hospital.
- The short stay paediatric assessment unit (SSPAU) had a facility where patients with pre-existing conditions such as diabetes could access the hospital at any time. This meant that a parent or carer could access the SSPAU at short notice without the need for a referral from a GP and they would not have to attend the Emergency Department.

# Services for children and young people

- The SSPAU would also take direct referrals from GP surgeries for children without pre-existing conditions and following attendance at the Emergency Department.
- The recently introduced 'consultant of the week' had received 13 requests for advice from local GPs. None of these children were admitted which meant that children were being managed appropriately within the community and hospital admissions were reduced.
- 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 about 18% of all appointments. Staff attributed this to problems in the booking system.
- The booking process for outpatient appointments was on the trust's risk register. The trust was 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.
- Where a child missed two appointments, this was referred to the safeguarding lead for follow up.
- 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.
- A senior member of the community team, which was co-located at the hospital, spoke of the good link between the ward and the community team and that being based in the same place improved the patient pathway.
- 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.
- The trust did not usually provide child specific operating lists but children were put early on adult lists to reduce the anxiety of extended waiting times.
- The trust monitored how frequently patients were delayed from transferring to the Conquest hospital because of a lack of availability of ambulances for emergency transfers. We were told that the assessment unit remained open for as long as it took for an ambulance to arrive which sometimes meant late transfers of children. The minutes of directorate meetings showed that there had been discussions with the ambulance trust about the transfer arrangements.

## Meeting people's individual needs

- Parents were encouraged to stay with the child in the anaesthetic room. We observed the anaesthetist explaining the procedure to the parent and child. However, the space was crowded and more hectic than was ideal for a distressed child. The room had not been adapted to make it less frightening for the child; no children's pictures, music or toys were seen.
- The paediatric recovery bay in theatres had patterned curtains and walls with animal stickers.
- Recovery nurses were observed to be at the patient's side post-surgery. They were able to explain to the child what had happened in theatre and what bandages and cannula were in place.
- The EDGH had a range of car seats available for those who may have needed one to use when taking their child or other children from EDGH to the Conquest Hospital. These could be used, for example where a family had arrived by ambulance or public transport and were then joined by a grandparent or friend who had a car.
- Blood tests were requested via the patients GP and the patient was sent directly to the ward where approximately five or six tests are carried out per day. Alternatively parents would ring in to book the date and time for the blood tests. This ensured that there would be enough paediatric trained staff taking blood in a paediatric friendly environment.



# Services for children and young people

- The nursing staff taking blood were experienced in distraction techniques. These children were often those who needed to attend frequently which meant the booking process allowed for staff to build a rapport with the children.
- Topical local anaesthetic cream was used routinely to reduce the pain and consequent fear of injections and cannulation.
- In the outpatients department there were separate waiting areas for older and younger children with toys available. There was also a feedback book available for parents and children.
- We talked with the continence team and the service they provided. They explained how there had previously been no service for children and felt that since the team was formed, they had developed an effective service. The provision of the team had allowed the staff to provide a lot of psychological support to parents. Staff spoke of how this psychological support allowed parents to feel empowered.
- 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."
- Age appropriate films were available for children in the unit, including for older children and teenagers. There was a play room available for children to use. This was large and had a range of toys available and a large safety gate. However, there were no play staff employed to lead and develop the play service.
- 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.
- There was a side room specifically designated to oncology patients and their families. This meant that patients receiving chemotherapy and their parents were able to be cared for in familiar surroundings and where the risk of cross infection was reduced.
- The Friston Unit had negotiated free parking for oncology and frequent attendees
- There was a comprehensive range of information leaflets available on the trust website that provided additional information to parents and children who had specific conditions or who had undergone specific surgery.
- 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 hospitals performance was displayed prominently in the ward areas. This includes NHS Safety thermometer information as well as performance in relation to cleanliness.

## Learning from complaints and concerns

- The trust had devised a complaint satisfaction survey which was implemented from September 2016. It was 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 would then be analysed on a monthly basis and included within the Patient Experience reports.
- 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.
- We saw changes made as a result of a complaint. There had been several complaints about the length of time children were waiting in the ED. In response the trust



# Services for children and young people

had employed a healthcare assistant with competencies in the care of children, who could record observations and provide other support. Feedback from parents had subsequently improved.

## Are services for children and young people well-led?

Good



We rated well-led as good because:

- Risk was regularly discussed and the areas that presented the greatest risk were clearly recognised and acted upon.
- Staff across a range of roles were positive about the recent improvements and the strategic direction of the trust as a whole.
- Non clinical staff reported how they felt fully involved as part of the wider team.
- Duty of candour was well managed and staff of all grades were able to clearly explain what it meant, and what should happen if something were to go wrong with the care of a patient.
- The practice educator, in place since 2015 had enabled staff to gain new skills and improve on the skills they already had.
- There was a Board level children's lead.
- Quality Walks enabled executive directors to see first-hand how services were being delivered. The findings from the walks were informing Board discussion.
- There was a clear strategy for the Women and Children's Health Directorate.

However,

- Whilst much work had been done on building a more positive culture and engaging staff at all levels, there was still work to be done in some areas, such as with the continence team.
- There was no leadership of play services.

## Vision and strategy for this service

- The vision for the service reflected the vision for the trust as a whole. They wanted to be the provider and employer of choice for patients and staff.
- There was a published strategy for the Women and Children's Health Directorate with clear priorities and measurable performance indicators.
- The future estate plans for the ED showed that there would be a four bedded bay with a waiting area for children. This area would also have a separate access point. This would avoid the need for children to be waiting in the same area as adults.

## Leadership of service

- The service was led by an 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 from senior managers to provide a better service to the patients.
- The majority of staff we spoke with reported good relationships with their immediate line managers. A few were less positive when speaking more generally about the way some services were configured, particularly where there was crossover between the acute and community services.

# Services for children and young people

- We spoke with one member of staff who had worked at the hospital for a significant period of time. They explained how they had felt well supported by senior staff when they wanted to reduce their hours and how they had felt supported by the whole ward team.

## **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.
- The Women's and Children's Directorate held monthly Internal Accountability meetings to review risk, staff survey results and operational policy.
- Minutes provided showed that the Risk register was updated formally before each meeting. New risks were discussed and escalation action was recorded.
- We were provided with the paediatric risk register. Each risk was scored and given a red, amber or green rating (RAG). The risk register was updated regularly.
- The register had identified the outpatient clinic as the biggest area of risk. Referral and ensuing appointments within the paediatric outpatient department was inefficient. This led to duplication of work, delayed and disorganised appointments and inconsistent care. Action was being taken to address this risk including work with an external review and interim mitigation of risk.
- 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.

# Services for children and young people

- Executive directors did Quality Walks where they visited different areas and spoke with staff and patients. The DoN had visited the Children's Development Unit and another Director had visited Friston ward in May 2016 and August 2016. We saw from Board meeting papers that the feedback from the Quality Walks was discussed and led to improvement action.

## Culture within the service

- We heard from nine non-clinical staff about how they felt part of the team and how they enjoyed working with the nursing and medical staff.
- Non clinical staff told us that they would raise any concerns they had and that they would feel supported if they did so.
- One senior member of staff reported that there had been positive changes in the recent past and felt that the organisation was better than it had been previously. They felt that the new CEO was engaged and communicated well. They told us how their own manager was always willing to provide time for supervision and how any issues raised were followed up and responded to.

## 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.
- 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

- Some staff in the community teams reported that senior managers had not been supportive of the role they undertake and would have liked them to have been more engaged with the work of the team and paediatrics more widely. However, other members of the community teams reported that there had been a noticeable improvement in senior management team which had led to concerns being followed up and responded to.
- Some of the senior nursing staff reported that due to the delays in getting ambulance transport from EDGH to the Conquest hospital, some staff stayed until after midnight when the unit closes at 9:30pm.
- 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 ambulatory pH (this is a test to establish the oesophageal acidity) procedure had recently undergone some changes. The changes had resulted in a much shorter report. The report had been reduced from six pages to two following a discussion between the ward sister and consultant which made it clearer and easier to read.
- The trust had implemented an internal rotation nurse who would work in both the ED and on the Friston Unit. A link had also been established between the Friston Unit and the CAMHS liaison nurse in the ED.
- The Practice Educator role, established in 2015 was embedded across the service and had allowed staff to access training and enhance their skills as well as contributing to service improvement through working groups.
- Clinical Preceptorship role had assisted supporting newly qualified and new staff to Paediatrics.

# End of life care

Safe	Good	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
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 Eastbourne District General Hospital, Conquest Hospital, and within community services. The community services were not reviewed on this inspection because at the last inspection they were rated good.

Eastbourne District General Hospital had 870 in-hospital deaths between April 2015 and March 2016. During this period 675 referrals to the palliative care team were recorded. Of these 484 (72%) were cancer, 170 (25%) non-cancer and 21 (3%) did not have a diagnosis recorded.

The end of life care service provided by the trust is working under a new format introduced in 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 Eastbourne District General location, we visited a variety of wards across the hospital including wards: Jevington, Seaford 4, Michelham, Hailsham 4, Seaford 3, East Dean, Sovereign and the emergency department. 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 17 patients at the end of life and 22 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records.

We spoke with 27 members of staff and observed the care provided by medical, nursing and support staff in the departments visited. We spoke with five patients receiving end of life care and three 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 previous inspection visit in September 2014, we identified concerns about the end of life care service. At that time, the service was rated 'Requires Improvement' overall. Specific concerns related to a lack of individualised care plans: New assessment and recording documentation were being developed but the interim arrangements were not sufficient to ensure individual patients' needs were being identified and met. The trust was not contributing to the National Care of the Dying Audit and patient experiences were not being recorded and used to inform services development. Patients receiving end of life care

# End of life care

were not specifically protected from the high number of bed moves taking place that impacted on the quality of care they received. Dying patients were regularly being cared for in an open bay on a busy ward.

## Summary of findings

Overall we rated the end of life care service at Eastbourne District General Hospital 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 quality indicators of the End of Life Care Audit – Dying in Hospital, 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 (2005) assessments and recording of ceilings of care (best practice to guide staff, who do not know the patient, to know the patients previously expressed wishes and/or limitations to their treatment) for patients with a completed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form.
- Patients did not have access to a specialist palliative support, for care in the last days of life in all cases, as the hospital did not have a service seven days a week.
- The specialist palliative care team at the hospital did not have a weekly multidisciplinary meeting to discuss all aspects of patient's medical and palliative care needs.
- The hospital did not have a rapid discharge process for end of life care patients to be discharged to their preferred place of death.
- The hospital did not monitor or record end of life care patient's referrals to the chaplaincy team.

# End of life care

- There was no formal referral criterion for the specialist care team for staff to follow. The specialist palliative care team did not respond promptly to referrals to assess the patient and plan care.
- 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 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 that we saw were all completed in accordance with national guidance.
- 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 medical team at the local hospice.
- A current end of life care policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.

We identified some improvements in the service but judged that it still needed further work and investment to ensure it could continue to meet the needs of the patients it served. There was better end of life care planning and recording of individual care needs and preferences.

We could see that discussions with patients and their relatives were now taking place around dying. All the DNACPR forms that we saw were correctly completed with clear reasoning and recording that the decision to withhold resuscitation had taken place. Previously, DNACPRs were poorly completed, with limited information as to why the decision had been made and whether there had been any family involvement.

The bed management arrangements had been revised since our previous visit and site managers were now clear that where a patient was receiving end of life care there was an expectation that they would be nursed in a side room. Movement of these patients was restricted and made only when all other possibilities had been considered.



# 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 could show appropriate hand hygiene 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 17 medical records and care plans of 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 wholly preventable incidents for which 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 did not report any 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 19 incidents relating to end of life care patients had been reported at Eastbourne District General 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. Eleven incidents were graded as level one; six incidents graded as level two, one as level three and one as level four. The level three incident related to a pressure sore acquired and the level four incident related to a failure to diagnose.
- Fifteen incidents were reported across the wards. There were four incidents reported regarding acquired pressure sores and three incidents regarding failure in documentation. There were four incidents reported regarding medicines. These related to a failure to administer prescribed medicine, a ward not having

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access to controlled drugs, more than prescribed medicine administered in syringe pump and a patient not receiving adequate pain relief. This meant end of life care patients did not always receive the appropriate medicines prescribed.

- Four incidents were reported regarding the mortuary. Two incidents related to deceased patients not being labelled correctly regarding infectious diseases, the appropriate moving and handling of a bariatric patient and organ donation.
- 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 (only include if there is a palliative care ward)**

- 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. This was a significant improvement on our previous visit when staff were unfamiliar with the national cleanliness audit process.
- We saw ward and departmental staff 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 Specification 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. 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 each 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

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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 did not see any cleaning schedules completed by housekeeping staff in accordance with the guidelines. This meant there was no guarantee the non-clinical areas of the mortuary were cleaned in line with the 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 except September 2016. This was explained to be due to staff sickness and an oversight by management and processes were in place to rectify this. We were assured the mortuary 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 an appropriate sliding board 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 a 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

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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 hospital's 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 that stock levels reflected 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.
- We were told the hospital's overflow ward (Seaford 2) often accommodated patients who had an end of life care plan. However, the ward did not have facilities for storing controlled drugs (CD's are medicines liable for misuse that require special management and are prescribed for end of life care patients). The ward was usually staffed by agency staff who were not permitted to authorise the dispensing of CD's. This posed a risk that end of life care patients would not receive medication in a timely manner.

## 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 17 medical records and nursing notes. All records were completed appropriately, recording evidence of discussions with patient or family and assessment of individual symptoms. However, only three records contained evidence of the patient being assessed for their psycho-spiritual care. The specialist palliative care team told us they assessed patient's spiritual needs as part of initial assessment and referred to the chaplaincy team as required.
- 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

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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 Cuckmere and Jevington wards.

- Until the new documentation was rolled out more widely, 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 17 medical records we reviewed, five 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 22 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. However, the forms were inconsistent with recording the patient's ceiling of care. Only five 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 appropriate syringe pumps.
- The induction programme did contain sessions by chaplaincy and the bereavement team. 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 subject the team was not compliant in were equality and diversity (67%).
- Training for the use of syringe drivers was mandatory for permanent nursing staff and was provided by the medical advice 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



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August 2016. We saw 524 staff had completed this between April 2014 to August 2016. We saw the records of registered staff who had completed the training on the wards we visited.

- We saw the completed induction forms for housekeeping and portering staff, including agency, which was specific to their role and responsibilities. Staff had an annual refresher training which was entered onto a database register which 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. 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 by clinical staff that the recognition of dying patients had improved and this had allowed for care to be provided in a more appropriate environment.

- 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 may not be 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 lead, a clinical lead for end of life care, a lead cancer manager, and a Macmillan lead cancer nurse. Staff specific to Eastbourne District General Hospital was made of one full time practice development nurse and the specialist palliative care team. The team was made up of two palliative care consultants (4.5 clinical sessions a week), and 2 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.

## 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 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.
- The bereavement office was staffed by two officers (one WTE and led by one WTE trust wide manager).
- The Patient Advice and Liaison (PALS) office had two staff.



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- 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. Some ward managers we spoke with raised concerns with the level of staffing. They told us that sometimes they were unable to provide adequate specific end of life care to patients.

## 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 quality indicators of the End of Life Care Audit – Dying in Hospital 2016, which 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 audit.
- 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 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 specialist palliative care team did not have a formal multidisciplinary meeting to discuss all aspects of patient's medical and palliative care needs.

- Management did not always support staff in their development as not all staff in the specialist palliative care team had received an appraisal.
- Not all patients had access to a specialist palliative support, for care in the last days of life, 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. Ward staff 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

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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 yet but 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 50% had only 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. Staff told us they were unsure of the robustness of the audit and queried the validation of the data.
- However, we did not see a 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 17 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 17 care plans we observed across the wards contained the nutritional screening assessment and showed where patients had been referred to the dietician.

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- 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 provided good mouth care for end of life care patients; this was actioned in a timely manner and was documented.

## Patient outcomes

- The results of the End of Life Care Audit – Dying in Hospital (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 End of Life Care Audit – Dying in Hospital, 2016. 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.
- Trust representatives 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 End of Life Care Audit commissioned by the Healthcare Quality Improvement Partnership.

## Competent staff

- Most of the clinical areas in the hospital had at least one end of life care champion known as 'link persons'. 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 the emergency department and East Dean and Sovereign wards. However, Hailsham 4 ward was 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 Eastbourne District General Hospital.
- Staff we spoke with on three of the eight wards we visited (East Dean, Hailsham 4 and emergency department) told us they had not received formal training in end of life care from the trust. Some junior staff told us they were not confident at recognising an end of life care patient. This could mean patients were not being recognised in a timely manner and receiving the appropriate service determined by national guidelines.
- We were told education for end of life care for all staff, except medical, was not mandatory. The trust had

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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 176 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 nor 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

- We were told the specialist palliative care team based at Eastbourne District General Hospital did not have weekly multidisciplinary meetings to discuss all aspects of patient's medical and palliative care needs. This had happened in the past and staff stopped attending. A palliative consultant had surveyed staff for their reasons and told us they had presented the findings locally and at a governance meeting. The consultant told us the trust was waiting for the hospital, hospice and community teams to stabilise before re introducing the meeting and were unable to give us a specific time frame.
- The specialist palliative care team had formed close and mutually helpful working relationships with the local hospice and other clinical teams in the hospital and community. For example, the acute pain team, bereavement officers, chaplaincy and the discharge team.
- Staff told us the hospital worked as an effective multidisciplinary team recognising an end of life care

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patient. 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.

- However, 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. However, staff we spoke with in two 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 training education causes 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 mortuary was staffed 7.30am to 4.30pm Monday to Friday. Within these hours collections were possible and viewing appointments were available to families. 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 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 three of the wards we visited (emergency department, East Dean and Sovereign wards).

## 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 22 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. This was a significant improvement from findings on previous inspection visits.
- The trust had a Policy and Procedure for Consent, 2015. This set out the standards and procedures relating to consent that the trust expects 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, directs staff on the practice and procedures that should be followed when an individual who lacked mental capacity and may have to be temporarily or



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permanently deprived of their liberty in their best interests. This was to ensure that staff were at all times 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 22 DNACPR forms, 11 were recorded as the patient not having capacity and had 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 were not able to explain the process and had limited understanding of the rationale.

## 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.
- A patient on Seaford 4 ward told us, “Everyone is lovely”. Their relative told us the specialist palliative care team nurse was wonderful and they, “Can phone them whenever I want”.
- A patient on Jevington ward told us, “Everyone has been extremely helpful”.
- Staff on the wards told us 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 approximately 20 cards and emails from bereaved families and departments thanking them for the professional service received. Comments included: “You were so supportive and helpful”, “You are doing a marvellous job” and “I am so glad mum was in your care to the end – it meant a lot to me”.
- The chaplaincy team gave us examples of compassionate care provided for end of life care patients. Examples included a dying patient who wanted to be baptised before they died and a gentleman who had no evidence of next of kin. The chaplain knew about the gentleman’s military past and advertised on social media asking for information. The result of this caused a large response of positive and helpful feedback and became an item on the local news.
- 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.



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- We saw two examples of cards and thank you letters displayed in the bereavement office. Comments included: “Sincerely grateful to you for your kind and sensitive help” and “Thank you so much for the lovely funeral you arranged it was so kind of you”.
- We were told the trust did not have a specific bereavement survey. However, since May 2016 the bereavement office collated feedback from a bereaved person 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. In June 2016, six comments were received and two were 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.
- The bereavement officers asked those making the comments if this information, both positive and negative, could be passed to the wards matron to be disseminated to staff.
- The hospital measured national survey information, for example the Friends and Family test (FFT), and used all patient feedback to guide investment plans, treatments offered and the overall patient experience. The FFT for the medical wards we visited were 100%.
- Staff provided emotional support for end of life care patients. We observed on the wards occasions when this occurred.
- 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 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 chapel was a space for patients and families to have a quiet time.
- 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 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.

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

- We spoke with five patients and three 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

### Are end of life care services responsive?

Requires improvement



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

- There was no formal referral criterion for the specialist care team for staff to follow.
- The specialist palliative care team did not respond promptly to referrals to assess the patient and plan care.
- The hospital did not have a rapid discharge process for end of life care patients to be discharged to their preferred place of death. There was a lack of good

# End of life care

quality data recorded. Additionally, the fast track continuing healthcare paperwork was not being completed in a timely manner to assist the discharge of end of life care patients.

- The hospital did not monitor or record end of life care patient's referrals to the chaplaincy team.

However:

- The specialist palliative care team work 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 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.
- 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.
- 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.

## Service planning and delivery to meet the needs of local people

- During the inspection we observed that the work of the specialist palliative care team was embedded 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 Eastbourne District General Hospital told us they receive between 50 and 60 referrals a month.
- We saw during the reporting period April 2015 to March 2016, 675 referrals had been recorded by the palliative care team. Of this figure 484 (72%) had a diagnosis of cancer, 170 (25%) were non-cancer and 21 (3%) did not have a diagnosis recorded.
- The trust collected data of patients who were receiving end of life care and who 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 may 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.
- We observed across the wards 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.

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- Relatives of end of life care patients were provided with free car parking, open visiting and encouraged to use the facilities on the wards. The emergency department had a relative's room.
- Michelham ward had recliner chairs and a fold up bed which could be used by relatives.
- 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 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 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 from a variety of faith traditions.

- 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. Details of services and special events were advertised on the chaplaincy notice boards and available on the hospital's web page.
- The wards provided bereaved persons 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.
- The hospital provided facilities for patients with a very high body mass. The mortuary had accommodation space for bariatric (severely obese) patients.
- 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.
- The bereavement office facilitated all arrangements required for the deceased. However, viewings of the deceased were arranged directly with the mortuary staff.
- The viewing room had a seating area. 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 artificial flowers in the areas which were supplied by the flower shop in the main reception.
- The mortuary had a storage area with 60 fridge and five freezer spaces for body storage. 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.

# End of life care

- The staff 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 and reduced the distress of relatives wanting to make funeral arrangements.
- We were told the trust had an advance care plan which supported a patient to develop their wishes and preferences. However, we did not see any evidence of this being completed by staff.

## Access and flow

- The hospital had a bed meeting daily which looked at immediate concerns in the emergency department and predicted bed needs. We were told 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.
- A patient discharged with anticipatory medication would allow qualified staff to attend and administer medication which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital. All patients on an end of life care plan were discharged from hospital with anticipatory medication which ensured that streamlined care was maintained.
- Eastbourne District General Hospital did not have a rapid discharge service for end of life care patients. 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. However we were not provided with information to corroborate this and the figures supplied showed that over 80% of patients were supported to die in their preferred place.
- We were told the trust was in the process of working with the local hospice to provide a rapid discharge service for patients requiring end of life care who had been admitted to the emergency department, medical/surgical and acute assessment units in Eastbourne District General 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. This service had been successfully implemented at Conquest hospital and a similar service was being arranged for patients at Eastbourne District General Hospital. However this was not yet in place 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. We saw the computer programme they used to record all visits and these were colour coded, for example those requesting regular visits and those the chaplaincy team had highlighted as in the last days of life.
- The chaplaincy team at Eastbourne District General Hospital told us they did not receive referrals directly from the palliative care team for end of life care patients, and therefore did not record these. However, they had recently been contacted by a member of the end of life care team who had asked if they wanted to be informed of patients who were recognised as at the end of their life.
- 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 was 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 trust had an emergency out of hour's viewing and access to the mortuary policy dated 2014. This gave clear guidelines and processes to follow for all staff to

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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.

- The trust had a system in place 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.
- 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 looked at a sample of 18 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.
- 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.

## 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



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'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.
- 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 lead.
- 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 overall service.

## 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.

## 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.
- 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

## Governance, risk management and quality measurement



# End of life care

- 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 trusts 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 trusts '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.
- 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.

## 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.

# End of life care

- 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 dying patients. 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 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, Eastbourne District General Hospital reported 0.2% sickness rate, 86.2% turnover rate, and no vacancies for nursing staff in the specialist palliative care team. There were no vacancies, staff turnover or sickness 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'.

## End of life care






- 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 utilised quality improvement methodology and frameworks. This would support the delivery of the service provided for patients and those closest to them.
- 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.

# Outpatients and diagnostic imaging

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

## Information about the service

Eastbourne District General 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 207,430 outpatient attendances at the hospital between April 2015 and March 2016.

The outpatient clinics are located in different speciality areas, this includes 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, 115,054 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 32 members of staff including managers, nurses, administrative staff and allied health professionals. We spoke with 13 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.

During our last inspection, we found the outpatient department was not being cleaned in line with the national specifications of cleanliness.

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 from July 2015, but had failed to meet it since March 2016.

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.

# Outpatients and diagnostic imaging

## Summary of findings

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

- At the time of inspection, there were 22,000 patient's x-rays waiting to be reviewed by a specialist in order to make a diagnosis.
- Staff numbers in the diagnostic imaging department were 33% below the number required to cover all examinations and the on call rota.
- The diagnostic imaging department did not clearly demonstrate or document the process of investigating incidents or follow its own incident reporting policy. The radiology manager did not have a clear understanding of reporting incidents under IR (ME) R.
- The diagnostic imaging department had not met the target for mandatory training, which included safeguarding training.
- The trust referral to treatment time (RTT) had fallen below the 92% standard from March 2016 onwards.
- The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.
- Morale was described as low by some staff 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.

However,

- The outpatient department had systems and processes in place to keep patients free from harm. Incident reporting was now embedded in everyday practice and there was evidence of learning from incidents.
- Infection prevention and control practices were in line with national guidelines. The department was clean and there was a newly refurbished reception

area. Staff adhered to the trust infection prevention and control policies. 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. Equipment checks were taking place and labels were used to clarify when equipment had been cleaned and was ready for re-use.
- 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. Records were available for clinics; the number of temporary records was monitored daily using the clinical administration dashboard. Less than 1% of appointments were held where records were not available, which was in line with the trust target.
- Records were accurate, legible, complete and were stored securely. The outpatient service was in the process of centralising the records store and planned to scan all paper records onto an electronic system.
- Safeguarding arrangements were understood and followed by staff. Training, to an appropriate level, was provided and senior advice was readily available.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement. The outpatient and diagnostic imaging departments participated in a variety of local and national audits to demonstrate compliance with best practise, professional standards and National Institute for Health and Care Excellence guideline (NICE) guidelines.
- The outpatient services had sufficient numbers of competent staff to provide their services. Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- There were differentiated outpatient pathways to meet the needs of different groups of patients. Particular consideration was given to meeting the needs of patients on cancer pathways.

# Outpatients and diagnostic imaging

- We observed good radiation compliance as per national policy and guidelines during our visit. 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 the ionising radiation (medical exposure) regulations (IR (ME) R, 2000).
- Consent was obtained and recorded in line with national guidance and the trust policy. Staff had a sound understanding of the Mental Capacity Act (2005) and how this impacted on their work.
- 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.
- Patient engagement had developed and hospital staff worked with the local Healthwatch, a patient experience group and local community to listen and work together to improve experiences.
- Staff in the outpatient department felt their managers were visible, approachable and effective.
- 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.

We noticed considerable improvements in the way the outpatient services were now being managed when compared to the findings from our previous inspection visits.

We reported serious concerns about both the availability and condition of individual medical records after both the September 2014 and March 2015 inspections. In March 2014 we saw that one clinic of 24 patients had run with seven sets of notes unavailable. We were told this was usual. The trust did not hold data relating to missing notes at the time of that inspection. From the current inspection visit we saw data was now

collated that the service was meeting the trust target of less than 1% notes missing. A new tracker system had been introduced and records storage had been moved offsite with a retrieval system put in place. The trust was in the process of introducing an electronic records system with all current records being scanned into the system before it went live.

The premises looked cleaner and some areas had been refurbished. 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. Staff were adhering to the trust policies on infection prevention and control.

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.

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%. 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.



# Outpatients and diagnostic imaging

## 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 inspection, there were 22,000 patient's x-rays waiting to be reviewed by a specialist in order to make a diagnosis.
- The diagnostic imaging department did not document incidents or follow its own incident reporting policy.
- There were 33% fewer staff employed in the diagnostic imaging department than should have been.
- Diagnostic staff had not achieved their mandatory training targets, or the targets for safeguarding children or adults.

However;

- Staff in the outpatient department 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 staff to provide care to patients.

## 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 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 outpatients and diagnostic imaging departments recorded 360 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 of incidents 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 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. 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 we spoke with had not experienced discharging duty of candour.
- At the time of inspection, the hospital had not reported incidents to CQC, in line with ionising radiation (medical exposure) regulations (IR (ME) R, 2000, since 2014. Following inspection, two reports were made to CQC relating to incidents, which occurred in June and September.
- Staff in the diagnostic imaging department showed us the incident reporting policy they followed for incidents where patients had been given an unintended dose of radiation. Section 15 of the departments, IR(ME)R 2000

# Outpatients and diagnostic imaging

medical exposures manual and standard operating procedures states: "Clinical Incidents reportable under IRMER 200: Exposures much greater than intended or unintended exposure to radiation not caused by equipment failure. It stated if a patient received a radiation dose much greater than intended or a patient is X-rayed by mistake, or a correct body part is X-rayed by mistake, a report must be made to the Care Quality Commission." Staff told us if an unintended exposure to radiation occurred, they would email the radiation protection advisor (RPA) for advice. An email response from the RPA would indicate how they would proceed. We were unable to see any evidence of advice being received from the RPA.

- In the last 12 months, seven incidents were recorded on the electronic reporting system which related to unintended exposure to X-ray or wrong body part being x-rayed. Two incidents had no outcome, three were closed because of the length of time taken to review and they both indicated patients were re X-rayed. None of the outcomes indicated there had been a discussion with the RPA. Over this time period it was not clear the diagnostic imaging department was following its own policy, investigating incidents fully or learning from them.

## 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 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.
- 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.

- Sanitising hand gel was readily available throughout the hospital. This was in line with epic3: 'National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England' (epic3) and HTM 00-09. We saw staff using hand sanitiser when entering and exiting clinical areas.
- 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.
- The most recent hand hygiene audit scored 100% for the outpatient and diagnostic imaging departments.
- We saw appropriately completed cleaning checklists in every treatment and clinic room. 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. Following clinic, staff cleaned all the equipment in the room and put a sticker on the door to indicate all equipment inside was clean and ready for use. We saw stickers on doors indicating this had been done.
- Some areas of outpatients used endoscopes (an instrument used to examine the interior of a hollow organ or cavity of the body); they 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 placed in a container, covered and sent to the sterile services department at the end of the clinic.

## Environment and equipment

- We saw 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 in line with Hospital Building Note (HBN) 12 (4.18) which recommends a space for physical measures to 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.

# Outpatients and diagnostic imaging

- 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 the main outpatient waiting area, the women's health clinic and in the diagnostic imaging department. All trolleys had daily checklists. The checklists were completed daily for the last two months. We saw appropriate equipment was available and all disposable equipment on the trolley was in date.
- 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 RPA, which were completed annually and complied with ionising radiation regulations (IRR), 1999.
- 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 PGDs 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.
- In diagnostic imaging, medicines used to perform scans were stored in a locked cupboard, in a locked room with key pad access. Only authorised, registered professionals had access to the medicine cupboard.

## Records

## 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 were 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 in the outpatient department 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.
- Drug cupboards in the outpatient department were locked, and registered nursing staff held keys. This was in line with National Institute for Health and Care Excellence (NICE) guidelines MPG2.
- 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.
- 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.
- 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 reviewed 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 archiving 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 used by staff which indicated confidential waste was managed appropriately.

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- At the time of inspection, the trust was part way through a major health records service improvement programme that included a radio frequency location based tracking system for patient records. This helped staff to locate records with the use of scanners and a computer system. The improvement programme also included the centralisation of the health records library in order to improve file maintenance, storage and access. There was a dedicated courier service to support the transport of records from the new facility to the hospital. The trust was planning to start the implementation of an electronic document management system (EDM) in autumn 2016. The plan was to scan historical and future records.

## Safeguarding

- 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 demonstrated where and how they indicated safeguarding issues on the computer patient booking system.
- Staff had received training in how to deal with patients who were victims of female genital mutilation (FGM). They were able to describe the process of reporting such issues, which were in line with Female Genital Mutilation Risk and Safeguarding Guidance for professionals, May 2016.
- We saw data which indicated 93% of outpatient staff had attended level one and two safeguarding children training which was better than the target of 90%. Ninety percent of outpatient staff had attended vulnerable adult safeguarding training, which was equal to the target of 90%.
- Data indicated 75% of diagnostic imaging staff had attended vulnerable adult safeguarding training, which was worse than the target of 90%. Seventy six percent of diagnostic imaging staff had attended level one and two safeguarding children training which was worse than the 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% of outpatient staff had attended mandatory training, which was above the target of 90%.
- However, 80% of diagnostic imaging staff had attended mandatory training, which was worse than the target of 90%. Staff told us they often missed training to cover for the lack of staff.

## 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.
- 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.
- 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.
- 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. Protocols and policies were stored on a shared computer file which staff had access to. Staff demonstrated their knowledge of where policies were kept.
- We observed good radiation compliance as per national policy and guidelines during our visit. The department

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displayed clear warning notices, doors were shut during examination and warning lights were illuminated. There was keypad entry to examination rooms and only authorised staff had access.

- 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 the ionising radiation (medical exposure) 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 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 the computer database 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.
- We saw pause and check signs in all examination rooms to remind staff to check a patient's details.
- 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.

- 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 staff in the outpatient department was determined through a review of clinic numbers and competencies of nurses required to support these clinics.
- A registered nurse was available in each area of outpatients. There were a mixture of registered nurses and health care assistants (HCA's). The department did not use agency staff. The hospital's own staff and nursing students who had attended a placement at the hospital worked as bank staff when required. We saw nurse staffing rotas which indicated there was always registered staff available in each outpatient department.

## Medical staffing

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

## Diagnostic imaging staffing

- The diagnostic imaging department had only two thirds of the staff they were established for. Managers were in the process of an overseas recruitment drive. They employed agency staff to cover some of the short fall.
- They provided an on call service for CT, interventional radiology, emergency department and theatres. Staff told us they had worked hard to cover the on call so far, but there were gaps in the rota for November and it was uncertain how this would be covered.



# Outpatients and diagnostic imaging

## Major incident awareness and training

- The hospital had a business management continuity plan which had been reviewed in August 2016. Staff were able to show us where this was located.
- Staff in diagnostic imaging had a fire 'walk through' recently. This involved going through the process of where staff and patients would be evacuated to in the event of a fire.

## 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 guideline (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 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 demonstrate compliance with best practise, professional standards and National Institute for Health and Care Excellence guideline (NICE) guidelines.
- The outpatient department had carried out a health records audit in line with professional standards which demonstrated the standards were being achieved.

- Local audits included hand hygiene audits and the assessment for competency of staff using glucose meters. These showed staff were demonstrating best practise in line with guidelines and operating procedures.
- The diagnostic imaging department demonstrated following NICE clinical guideline (CQ95), Chest pain of recent onset: assessment and diagnosis.
- The department contributed to the Royal College of Radiology, national audit of radiology systems alert for critical, urgent and unexpected findings.
- Staff attended multidisciplinary meetings regularly and audited the function of the meetings, which met with national professional guidelines.
- The diagnostic imaging department also audited the accuracy of reporting on a variety of scans. These audits showed staff that professional standards were being met and where extra training may be required.
- 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 examination.
- However, we noted some policies and protocols used in the diagnostic imaging department had not been updated since 2001. This indicated staff were not following the most up to date policies and procedures.

## Nutrition and Hydration

- Staff told us that if a patient experienced a delay in their appointment, they offered them a drink.
- We saw staff offering glucose drinks to patients who had not eaten in the morning and were feeling lightheaded.

## Pain relief

- If pain relief was required in the outpatient department, staff gave patients a prescription, which they took to the pharmacy department within the hospital.
- We saw nursing staff recorded pain scores when patients had waited because of transport delays. This was to identify any pain relief requirements.



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- In diagnostic imaging, staff contacted 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.
- Staff in outpatient areas had 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 that diagnostic imaging staff were registered with the Health Care Professions Council (HCPC). Managers checked the registration of their staff regularly.

## 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. Staff contacted service managers if a patient did not have an outcome.
- In the reporting period April 2015 to March 2016 the follow-up to new rate for Eastbourne District General Hospital was similar to the England average. The latest site figure in May 2016 was 2.3% similar to the England average.
- 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 can give medicine to patients for certain diagnostic tests. We saw certificates which confirmed staff were competent to do so.

## Competent staff

- Managers and staff told us extra staff were made available during the induction process so that sufficient time was allocated to get to know the area they were working in. Staff were moved through different clinical areas regularly to maintain their competency in a variety of skills. There was a system for assessing the competency of staff in several skills. We saw copies of competency certificates.
- 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).
- Staff told us they were able to access funding for external training and that this was positively supported by the hospital.
- Staff told us the appraisal process was beneficial in accessing additional training. We saw 90% of staff had attended appraisals in the last year which was equal to the target of 90%.

## 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.
- 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 could share their knowledge and expertise in planning the service and 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, to provide consultant-directed diagnostic tests and completed reports.
- The diagnostic imaging department provided a seven day, on call service.
- This was in line with; NHS services, seven days a week, priority clinical standard 5, 2016. This requires hospital

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inpatients to have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, CT and MRI and radiology consultants to be available, seven days a week.

## Access to information

- The computerised radiology information system (CRIS) stored patient data and was used for booking appointments.
- 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, 2005 and Deprivation of Liberties Safeguards (DoLS). 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.
- 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.

## 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.
- Patients 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.

## 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 3% who would not recommend a service. As 5% of all patients who attended the outpatient department completed the survey, care should be taken with the interpretation of these results.
- Patients we spoke with told us the care they received from staff at this hospital was good. They told us they loved the hospital and received great care. We saw staff dealing with patients in a kind and caring manner.
- Patients told us staff treated them with dignity and respect. We saw staff introduce themselves to patients and explain their role.
- The diagnostic imaging department waiting areas had been redesigned to maintain patient dignity.
- Entrances for inpatients and out patients had been separated. There were individual bays for inpatients to wait on beds, with screens, to maintain dignity. There was a separate waiting room for outpatients. Separate areas were available for patients to wait in gowns, so

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others could not see them. Patients told us they felt it was a proper waiting area. Staff felt the redesign offered more dignity for patients and the department was no longer a through fare.

- In diagnostic imaging rooms, there were separate areas for viewing scan results. None of these areas could be overlooked, maintaining patient's privacy and confidentiality. However two reporting rooms opened into the main waiting area and when the door was open, we could clearly see a diagnostic image.

## 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.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need.

## Emotional support

- Macmillan information and specialist nurses were available to support clinic staff when breaking bad news.
- Staff told us they had sufficient 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 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 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.
- Staff told us how they could access interpreters and bariatric equipment when needed.
- There were arrangements to ensure people living with dementia received appropriate care that met their needs.

## 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. Some clinics occurred on Saturday mornings on an ad hoc basis. This meant those with potentially serious conditions were seen in a timely way.
- Staff displayed clinic delays and waiting times on white boards. This meant staff communicated any delays to waiting patients.
- We saw comfortable looking waiting areas with refreshments and magazines available for waiting patients.
- There was a main outpatient reception area, with an area for patients to wait whilst queuing to speak to a receptionist. Receptionists had individual booths and conversations between staff and patients could not be overheard.
- We saw a quiet room was available in the outpatient department for use by patients and staff for breaking bad news.
- 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.
- The inpatient waiting area consisted of individual, curtained bays to improve patient dignity and respect.

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- The outpatient waiting area had a variety of seating available and space for wheelchairs. We saw baby changing facilities and an accessible toilet in the main waiting area. This meant that the needs of all sectors of the local population were considered
- Patients could access CT scan appointments from 8am until 8pm and weekend sessions were provided as required. This meant the local population could access services at a convenient time. 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.
- MRI scans were available from 8am until 8pm Monday to Friday. A direct access service was available for patients referred for an x-ray from their GP.

## 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 for 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 has 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 data from 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%. 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 into an

# Outpatients and diagnostic imaging

electronic one. Staff emailed the GP to indicate the referral had been received. The patient was then contacted by phone and offered an 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, though they did record six week diagnostic waits for CT, MRI and non-obstetric ultrasound.
- The most recent data dated from September 2016, indicated that 2.5% of patients waited less than six weeks for a diagnostic test. This was worse than the standard of 1%.
- The hospital also recorded the proportion of stroke patients being scanned within certain timeframes. The most recent data indicated they were better than the national average for this.
- 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. This meant patients coming from the ward would wait in a separate bay then move to the examination rooms. Outpatients would be moved from the outpatient waiting area to individual changing cubicles prior to their examination.
- In diagnostic imaging, paper referrals were received on paper into the department. The same day, referrals were put onto the electronic data base and taken by hand to the relevant clinician for triaging; 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. There were not specific slots identified for these patients. Staff told us they relied on cancellations to fit these patients into. This was not a reliable system to ensure patients would always have an appointment available at the right time.

- 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

- Any individual needs could be indicated on the patient administration system or the electronic document manager and staff demonstrated this to us.
- 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. Staff highlighted patients living with dementia to clinicians, by placing a blue butterfly on their medical records.
- 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 department.
- We saw adequate numbers of chairs at a variety of heights in waiting areas we visited. The hospital had several wheelchairs available for patients to use if required.
- 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.



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- In diagnostic imaging, wheelchair accessible changing cubicles, were available.
- All documentation could be provided in alternative formats including braille, audio and large print. Patients requiring communication assistance were asked at the time of booking an appointment whether they require 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. We saw cordless phones were available throughout outpatient departments to assist.
- 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.

## 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 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 and 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 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.
- 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. We 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.



# Outpatients and diagnostic imaging

## 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.
- We saw the trust's values were displayed across the buildings and appeared on the reverse of staff identification badges.
- As part of ESHT 2020, the clinical administration team had identified key 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.

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- 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 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.
- 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.
- We saw a variety of risk assessments, which included assessments of equipment, environment and substances hazardous to health. We saw staff had signed a sheet in the folders to indicate the assessments had been read.
- 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

- Staff overwhelmingly spoke positively about the executive leadership team. They felt they were visible and were positive about improvements occurring throughout the trust.
- The outpatients 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'. They felt they had not been consulted or kept updated with regard to the considerable structural changes that had occurred within the department.

## 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.

# Outpatients and diagnostic imaging

- The outpatient nursing staff supported and promoted the 6C's of nursing, which are Care, Compassion, Competence, Communication, Courage, Commitment. These core values form the foundations of the NHS England guidance, Leading Change Adding Value: a framework for nursing, midwifery and care staff.
- 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."
- Following breaking bad news, staff had a debriefing session. In addition to this, difficult cases were discussed at multidisciplinary meetings.
- 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.
- 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.
- Staff in diagnostic imaging had a daily briefing, weekly staff meetings and monthly staff meetings. However, staff in diagnostic imaging told us they were not consulted in the redesign of the department.

## Innovation, improvement and sustainability

### 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 outpatient staff engaged with the local schools and encouraged children living with learning difficulties to come in to experience what it was like to have various tests done, for example, blood pressure test. This was to enable children to experience hospital examinations in a positive way and make it less frightening for them if they ever had to come to hospital.
- 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.

- 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 practice 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 had also been 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.

## Outpatients and diagnostic imaging

- The team had 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.

# Outstanding practice and areas for improvement

## Outstanding practice

- 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 hospital 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.

# Outstanding practice and areas for improvement

- 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.

## 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.
- Ensure that play specialist staff are employed to lead and develop play services in all areas where children are cared for.

### Action the hospital **SHOULD** take to improve

- 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 provide for the specialist palliative care team at Eastbourne District general Hospital weekly multidisciplinary meetings to discuss all aspects of patient's medical and palliative care needs.
- 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.
- Develop and implement a programme of regular audits for end of life care.
- The trust should ensure audits of infection control practices in ED including hand hygiene are used to improve practice.
- Investigate and reduce the mixed sex breaches on surgical wards at EDGH. The reason for these should be documented in all cases.
- Continue to consider ways to improve staff recruitment and retention such that it meets the national recommended levels.
- Work with local stakeholders to address the delays to patient pathways and continue to progress towards meeting their referral to treatment time targets.
- The diagnostic imaging department should ensure they have a recent audit from their Radiation Protection Advisor.
- The trust should ensure hazardous waste management and disposal practices in the ED meet national control of substances hazardous to health guidance.

The trust should ensure nurse to patient ratios in the ED are managed in relation to the individual needs of patients based on acuity.



# Outstanding practice and areas for improvement

- The trust should ensure that RTT is met in accordance with national standards.
- The trust should ensure that standard for a patient receiving their first treatment within 62 days of an urgent GP referral is met.
- The diagnostic imaging department should ensure they are reporting incidents in line with legislation and demonstrate following their own policy.
- 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 and reporting times.
- The diagnostic imaging department should ensure staff attend mandatory training in line with the trusts target.
- The children's service should develop clear criteria for the transfer of patients by private car between sites.
- The children's service should ensure that children are not transferred to the Conquest Hospital late at night, through timely decision making and effective planning of the transfer.
- The children's service should ensure that outpatients appointments are not subject to cancellation and delays,.

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

Diagnostic and screening procedures  
Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

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.**  
Ensure that play specialist staff are employed to lead and develop play services in all areas where children are cared for.

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

Start here...

Where these improvements need to happen

Start here...