East Sussex Healthcare NHS Trust

Conquest Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Inadequate**
Accident and emergency	**Requires improvement**
Medical care	**Good**
Surgery	**Inadequate**
Intensive/critical care	**Good**
Maternity and family planning	**Inadequate**
Services for children & young people	**Requires improvement**
End of life care	**Requires improvement**
Outpatients	**Inadequate**

Summary of findings

Contents

Summary of findings

Overall summary

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

The trust serves a population of around 525,000 patients from across the East Sussex area. There are approximately 700 beds and 7,200 staff. The hospital provides a full range of DGH services to its local population although some services are only available on one site. Consultant led obstetric services, acute services for children and young people and trauma and emergency surgery are only available at the Conquest Hospital. The trust has links to larger hospitals in Brighton, Tunbridge Wells and London for some tertiary services.

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

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

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

Our key findings were as follows:

- We saw challenges with staffing in some areas. We saw poor management of medicines in a number of areas and practices that our clinical experts deemed unsafe.
- We found concerns relating to the under-reporting of clinical incidents. We found discrepancies in the approach to speciality-specific mortality and morbidity reviews. In some cases, these meetings were firmly embedded, but in others they had not taken place for at least six months. We identified concerns with medication management within the department and subsequently undertook a specialist pharmacy inspection as part our unannounced visits.
- The quality of the medical notes we viewed were unsatisfactory. Many clinics were running without patient health records and using temporary sets of notes. Health records were in a poor state of repair
- We were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the trust improved their waiting times and met with these targets..
- Staff had been unsettled by the changes brought about by the reconfiguration of services to single site delivery and were stressed, unhappy and keen to discuss their experiences of this change throughout our visit. Staff mostly acknowledged the reasons for the changes but felt that they had occurred with little consultation, without a good knowledge of their job roles, and without adequate support. There were examples of poor patient experiences as a result of the changes..
- At Eastbourne Hospital; the maternity services are provided as a midwife led unit through the consultant led maternity unit at Conquest Hospital is Hastings. All maternity services are reported in one report which can be found in the Conquest Hospital report.

We saw several areas of outstanding practice including:

- Consultant presence on critical care 7 days per week.
- Good leadership in ITU
- Nurse led discharge
- Introduction of VitalPAC

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

Importantly, the trust must:

- Develop a clear and explicit vision for their maternity services and a strategic plan to allow the vision to be achieved. The vision and plan must be created in collaboration with key stakeholders, staff and service users.
- Ensure that there are adequate staff, including managers, consultant midwives and labour ward coordinators employed to meet the recommended minimum standards detailed in Safer Childbirth: Minimum Standards for the Organisation and Delivery

Summary of findings

of Care in Labour, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Royal College of Anaesthetists (RCA), Royal College of Paediatrics and Child Health (RCPCH), 2007.

- Consider the needs of low-risk women giving birth at the Conquest Hospital and ensure that facilities and staffing are such that normal birth is actively promoted.
- Review staffing arrangements for the community midwifery service to ensure they are compliant with the Working Time Regulations (1998), which implement the European Working Time Directive into British law.
- Ensure that medical records and other sources of confidential personal information are managed such that the service is compliant with the requirements of the Data Protection Act 2003 and the guidance issued by professional associations and royal colleges.
- Improve the way information is collected and used. The governance and incident reporting structure must be strengthened and streamlined to ensure that data is sufficiently accurate and robust to be used to inform service improvements.
- Improve the security arrangements at the Conquest Hospital maternity unit.
- Improve the way handovers on the labour ward are managed.
- Ensure that all women in established labour receive one-to-one care from a registered midwife.
- Ensure that all staff have a sound understanding of how to obtain and record that informed consent has been sought before any clinical intervention.
- Take active measures to improve multidisciplinary team working at the Conquest Hospital.
- Review the tracking of records. The outpatient department were not tracking patient health records because this job had not been considered during the redesigning of the service. The location of medical records were often unknown and resulted in delays or temporary notes being used. Trusts have a responsibility to track all patients' health records (Records Management: NHS Code of Practice Part 2, 2nd Edition, January 2009).
- Comply with the Data Protection Act 1998. The outpatient department was not protecting patients' confidential data. Patient records were left in public, accessible areas without staff present.
- Review resuscitation equipment in the outpatient departments, as it was not all fit for purpose.
- Ensure that outpatients medicines are prescribed and dispensed in line with relevant legislation. The department had not ensured that when medicines were prescribed and dispensed, the prescription and dispensing complied with relevant legislation.
- Ensure that outpatients medicines are stored at the correct temperatures. They were unable to provide assurance that this medication had been stored at the correct temperature.
- Ensure that outpatients staff report incidents in accordance with trust policy and statutory requirements.
- Make sure the management of medicines within the emergency department (ED), including storage and recording of temperatures, is done in accordance with national guidelines.
- Make sure the privacy and dignity of patients is upheld by avoiding same sex breaches in the clinical decision unit (CDU).
- Conduct a trust-wide review of venous thromboembolism (VTE) compliance as a matter of urgency.
- Address our concerns regarding the emergency equipment checking.
- Conduct a trust-wide review of medication compliance.
- Review and improve the complaints handling process to ensure that the service learns and improves as a result.
- Review occupational health and HR support mechanisms and resources in place for staff who are on long-term sick leave, or who require support, to ensure the trust can meet its duty of care to its workforce.
- Conduct a trust-wide review of staffing levels to ensure that patient acuity and turnover is taken into consideration.
- Address the long wait for oral and maxillofacial surgery for adults with learning disabilities.
- Review medical cover on the Conquest Hospital site.
- Identify and address inappropriate staff behaviour toward patients, relatives and staff.

In addition the trust should:

- Improve infection prevention and control measures on the maternity unit at the Conquest Hospital.

Summary of findings

- Improve the facilities and pathway for women suffering pregnancy loss at the Conquest Hospital maternity unit.
- Ensure that medicines, particularly controlled drugs, on the maternity unit at Conquest Hospital are managed in accordance with the trust policy.
- Make comprehensive, written information available to women using services in relation to the choices of place of birth available to them.
- Improve breastfeeding support to new mothers.
- Ensure women who need to be transferred after giving birth are not separated from their babies.
- Consider the particular needs of vulnerable groups of women and babies within their catchment and provide adequate resources to meet those needs.
- Provide resources to accommodate the needs of women in early labour where repeated journeys between their home and the hospital may be inadvisable.
- Communicate more effectively with the local population to ensure they understand the services available and the reasons for decisions being made.
- Review the out-of-hours medical cover available on the site to ensure there are sufficient staff to meet the needs of all patients without undue delay during busy periods.
- Look at the system for reviewing serious medical incidents and ensure that there is oversight from doctors. Staff completing the reviews should have appropriate training to ensure that full in-depth analysis is completed and clear learning streams identified.
- Review how medical incidents are managed and escalated to ensure that the appropriate management staff are involved at an early stage to oversee actions and escalate and disseminate information appropriately.
- Review staff compliance of fully and accurately completing documentation and feedback to teams on good and poor practice. Accurate documentation was not being consistently completed on medical wards
- Should integrate executive-level staff with the workforce at a local level, allowing them to observe practice and assess the impact of changes at departmental and individual level. This will help to increase staff inclusion, confidence and empowerment.
- Should have strategies in place to improve outpatient waiting times consistently in all specialities. The central booking service was not always able to give patients appointments within the NHS England and clinical commissioning groups (CCGs) regulations (2012) 18-week targets.
- Ensure clear strategies are put into place to improve outpatient waiting times against the national average. The trust was falling below national averages with the two-week wait timescale for patients with urgent conditions such as cancer and heart disease.
- Ensure that patients are offered follow-up appointments within the timeframe considered clinically appropriate.
- Ensure that patients are managed effectively through the department; patients are sent to the correct areas of the outpatient department and are expected by staff in those areas when they arrive. Staff should be able to track patients' journeys through the department.
- Ensure that they are obtaining correct data regarding patient pathways and recording accurate data for 18-week and two-week waiting times.
- Consider reviewing some areas of the environment in A&E with regard to arrangements for supporting patient privacy and the overall security of the department.
- Ensure the implementation of pain assessments for patients in A&E. We saw poor use of pain measurement.
- Make sure any assessment of patients' capacity or best interest decisions are accurately recorded in patient records.
- Take action to ensure that staff receive mandatory training in line with trust policy.
- Ensure that patient information is available in languages other than English and in other formats so that it is accessible to people with disabilities.
- Make sure staff receive an annual appraisal in line with trust policy.
- Review their methods of sharing information with the population they serve to improve public engagement.
- Enable there to be end of life champions on every ward and deliver regular training to develop and maintain knowledge and skills. The trust-wide training strategy did not have end of life care embedded in it, at the time of the inspection.

Summary of findings

- Consider the implementation of McKinley T34 syringe drivers across the trust with mitigation plans to support the transition from Omnifuse syringe drivers.
- Ensure that discussion at the end of life steering group could include end of life incidents and cascade learning across the trust.
- Regularly review the quality of the Mental Capacity Act 2005 assessments and the need for assessment to be clearly document.
- Review the quality of nursing documentation to ensure it accurately reflects the care delivered with individualised care plans for end of life patients.
- Collect and consider the opinions of carers of patients receiving end of life care to support a continuous cycle of improvement.
- Review the support provided to the specialist palliative care team to ensure the resources enable them to achieve their ambitions for the trust. Improved leadership and administrative support is required.
- Consider expansion of the specialist palliative care team to enable face-to-face working seven days per week.
- Consider the introduction of an end of life electronic alert system across trust.
- Improve the profile of end of life care across the trust by introducing a standing trust board agenda item on end of life care and have a designated clinician as trust-wide lead for end of life, who understands what is needed and who is empowered to implement policy.
- Ensure that an integrated strategy for end of life care is put in place, as the trust is an integrated acute community trust.
- Audit the effectiveness of nurse-led discharges (trust wide) and the admissions (SAU at Conquest Hospital).
- Improve staff morale and seek ways of improving communication effectiveness.
- Review the quality of nursing documentation to ensure it accurately reflects the care delivered.
- Ensure all agency and transient staff have a full induction in clinical areas, which is formally recorded.
- Review medical cover at the Conquest Hospital.
- Address theatre efficiency across both sites and in all theatres.
- Engage in effective listening with staff to improve efficiency.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Not sufficient evidence to rate**
Are services responsive to people's needs?	**Requires improvement**
Are services well-led?	**Inadequate**

Summary of findings

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

Accident and emergency

Requires improvement

Improvements are required for the service to be safe, responsive and well-led.

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

People's needs were not always taken into account and met. The facilities and premises did not meet patients' needs. There was insufficient space in the department to accommodate the numbers of patients attending and the layout of the department did not promote patients' privacy, dignity and confidentiality.

Patients with mental health needs often waited too long in the department without the support of suitably trained or skilled staff. A room identified for accommodating patients presenting with mental health needs was not fit for purpose. We identified ligature points and potential missiles in the room, which had one door and was adjacent to the relatives' room.

Capacity issues within the department were included on the trust's risk register, identifying the risk of being unable to offload patients from ambulances into the unit. There were insufficient cubicles in the major and minor treatment areas for the number of patients being treated within them. Staff areas were congested and it was not possible for patients on trolleys to be moved around easily. We observed that patients categorised as 'minors' were left waiting for treatment if cubicles became congested with majors patients.

The triage area was a curtained bay in the waiting room. It had one entrance/exit, which could compromise the safety of staff or patients in the event of a person becoming aggressive.

The department was not secure. Although a 'swipe' card was needed to enter the locked doors of the treatment area, a door adjacent to the reception desk was unlocked. We used it to access the treatment area unchallenged on our arrival when we found the reception desk did not have a staff member present. There was no facility to 'lock down' the department to isolate it in the event of an untoward incident.

Medicines were not always stored securely or checked regularly which increased the risk of medicine misuse. Checks of the controlled drugs stored in the resuscitation area were not consistently recorded on a daily basis. This means potential

Summary of findings

medicine misuse might go undetected. Although the trust had recognised this concern and implemented a monthly compliance audit, we found significant levels of non-compliance in the records we reviewed.

The trust did not meet the College of Emergency Medicine (CEM) recommendation that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week. This compromised senior clinical decision making which could negatively impact the patient's pathway of care. Staff did not consistently record their assessment of patients' capacity to consent or decisions made in the best interests of patients who lacked capacity. Compliance with mandatory training required improvement to achieve a safe workforce.

The leadership and culture required improvement so that the delivery of high quality, person centred care was supported. Leadership roles had recently been restructured in the urgent care directorate. We found a lack of defined leadership "on the floor" of the departments. We found that staff were not actively engaged and staff satisfaction was not seen as a high priority. Staff were concerned about the level and speed of change implemented in the urgent care directorate within the trust. There was a limited approach to obtaining the views of people using the service and no evidence that changes were made as a consequence of patient feedback.

Staff in the A&E department followed accepted national and local guidelines. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs. The pathways were revised annually to ensure current practice. Patients were given timely pain relief although pain scoring tools were not used effectively.

There were insufficient paediatric nurses employed to provide 24 hour presence in the department, but this was being mitigated by additional training for staff. There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals.

Staff in the A&E department provided a compassionate and caring service. Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

Summary of findings

Medical care (including older people's care)

Good

Medical services provided at the Conquest Hospital were judged to be good. Some areas within the directorate require enhancing to ensure services retain a rating of good.

The concerns which required monitoring to maintain improvement were:

The level of medical cover during out-of-hours periods.

The review and analysis of serious incidents to ensure appropriate managerial oversight and dissemination of learning.

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

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

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

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

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

We saw areas of good practice, such as the use of a wireless monitoring and recording system to provide real-time information across multidisciplinary teams and alert staff if a patient's condition deteriorated. The trusts own integrated patient care document provided a comprehensive overview of the patient and their needs enabling staff to locate information easily and build an understanding of the patient as an individual.

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

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

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

Summary of findings

The transformation process which the trust had gone through had left many junior staff feeling disenfranchised, if not by the changes themselves then by the pace of the changes. They did not feel that their views were listened to outside their own departments.

Surgery

Inadequate

Our inspection identified concerns relating to the under-reporting of clinical incidents within the surgical department. We found a disparity in staff competence relating to the emergency equipment checks and a lack of consistency and continuity of the checks, which demonstrated that best practice guidance was not being followed. We found the approach to specialty-specific mortality and morbidity reviews were not consistent. In some cases, the review meetings were firmly embedded in practice and in other specialties the reviews had not taken place for at least six months.

We identified concerns with medication management within the surgical department and subsequently included a specialist pharmacy inspection in our unannounced visits. Our observations and conversations with staff revealed that the trust's infection control policy was not being adhered to. This was evident in all surgical departments throughout the trust, but most evident in theatres and on a ward round and involved staff working at all levels and disciplines throughout the trust.

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

We identified insufficient staffing levels in most of the surgical areas with main theatres and the surgical assessment unit being worst affected areas. Most surgical areas declared a deficit in their staffing levels and skills mix, which was being permanently managed through the use of bank (overtime) and agency staff or by regular staff working extra shifts.

There was a lack of evidence to demonstrate that temporary staff had undergone an induction in their particular clinical area, or that the trust's policies and procedures were explained to temporary staff. Where the same agency staff were employed for long periods of time in the same clinical area, there was no oversight of their training, appraisals or monitoring of their learning needs.

We identified the workforce were dedicated and committed to delivering quality care to patients. However, we noted staff were exhausted and under enormous pressure to deliver safe care in spite of chronic staffing shortages and the challenges of recent service

reconfiguration and senior management changes. We found that the staff shortages meant there was little time for staff to adhere to the trust's policies and procedures; for example incident reporting, mandatory drug checks and emergency equipment checks. We observed the nursing care was task orientated; it was not individualised or holistic in its approach, because of the unrealistic demands placed on staff to manage on low staffing levels, poor skills mix and an unpredictable, transient workforce. The NHS staff survey demonstrated very low staff morale and high staff sickness levels at the trust.

The trust had initiated some incentives that had the potential to makes services more effective and responsive to patient's needs. An example of this was the nurse-led admissions in surgical admissions unit (SAU), nurse-led discharges and the introduction of advanced practitioners who had specific skills to support the surgical services. However, there was a lack of quality assurance measures in place to monitor these incentives. This meant that we could not be sure that the measures taken by the trust had improved the quality of service delivered to patients. We saw the introduction of VitalPAC, a clinical software system, which is a valuable tool to monitor deteriorating patients. However, this was not always effective, as the trust relied heavily on agency staff that could not always use the device as they did not have log-on access.

We found all the clinical areas we visited to be clean and tidy, with cleaning records available to view. There was an ample supply of personal protective equipment (PPE) available for staff to use while delivering clinical care. We found the department supported the development of advanced practitioners who were trained to undertake specific tasks to support clinical care.

The staff who worked at the trust were found to be caring and delivered care that promoted patients' dignity and respect. We found the anaesthetic mortality and morbidity was very well attended, well-structured and facilitated learning. Consultants had their ward rounds embedded into their job plans. Staff on the surgical ward phoned patients who were discharged to review their progress.

Intensive/critical care

Good

The intensive care service uses procedures to ensure patients receive safe and effective care. Clinical outcomes were monitored, and practice changed where required improvements are identified. Staff were caring and compassionate, working to maintain the privacy and dignity of their patients. However, some improvements were required in relation to bed management processes, to ensure that patients did not remain in the intensive therapy unit (ITU)

longer than required, which can impact on privacy and dignity. Leadership on the unit is good, but a change to the clinical unit management team has led to a lack of discussion when it came to dealing with planning issues, such as the clinical environment.

Maternity and family planning

Inadequate

The maternity services provided at the Conquest Hospital, overall, were inadequate. Although maternity staff were, mostly, caring the service was inadequate for safety, effectiveness and being well-led. Responsiveness required improvement.

There were risks to women and their babies from a poorly managed service that had significant challenges with capacity. Individual staff and managers were working hard to maintain a reasonable quality of care in very challenging circumstances.

The lack of leadership capacity and high workloads meant some staff had become disengaged with the service and had high sickness levels. Staff worked long days without breaks and with little support; this was reflected in a high level of sickness absence that further compounded the problem.. This was particularly noticeable on the postnatal ward.

There were significant issues about the number of staff, skills mix of staff and the communication between professionals. Due to staff shortages the birth centres were sometimes closed reducing choice for women and increasing the risk of intervention because of labour in unfamiliar surroundings. Midwives were caring for high risk women in an environment with which the staff were often unfamiliar (not routinely working in this service); and with a team they did not know well; this could impact on patient safety.

The escalation policy for staff shortage was in almost daily use and was usual practice and, as such, was an unsustainable model for the staffing of maternity services. The trust failed to recognise the impact of their policy on staff and the consequent effect on the safety of the service.

We had some concern about the care women received when the consultants were not present and the ability level of some middle and junior-grade doctors. During our inspection visit, there were two incidents in one night after the consultant had left the premises. The unit was being covered by one senior house officer and a staff grade doctor at the time. One was escalated as a Serious Incident.

Security was not given a high profile at the Conquest Hospital and women and babies were at risk from breaches of the security arrangements.

The data provided by the trust was insufficiently robust to assure us that it provided an accurate representation of how well services

were being delivered. We saw examples of incidents (relating to areas such as controlled drugs management, infection prevention and control and data protection) that were not identified as such by staff and so not reported. This meant that these details were not reflected in the data shared with CQC.

The majority of medical records that we saw were incomplete and contained insufficient detail to demonstrate that good care was provided overall.

Daily incident review meetings were held, but failed to consider all the pertinent issues around incidents and so failed to identify all the learning from incidents.

Care and treatment provided was not always in accordance with trust pre-eclampsia policy and national guidance. Venous thromboembolism risk assessments were not always completed and patients were then not prescribed anticoagulants when needed.

There were a number of examples where informed consent was not obtained

Some specialist provision, such as the screening service, was good and responded well to the needs of couples facing the distress of foetal anomaly. Other aspects of the provision for specific groups of women and families were less developed and there was a lack of specialist midwives to provide expertise in the care of pregnant children, women who misused drugs or alcohol and other particularly vulnerable groups.

We received a number of reports of dissatisfaction with the midwifery service. Concerns were raised about the shortage of staff, being left alone for hours when scared and in pain. Having to waiting for long period of time and then to be sent home because of lack of medical staff available to see the patient. We received reports of poor aftercare with lack of staff to assist mothers caring for their baby and significant concerns about cleanliness.

There was a general theme from patients and staff that they were not listened to about their concerns.

Services for children & young people

Requires improvement

Staff we talked with demonstrated awareness of how to report incidents through the trust's reporting mechanisms. A paediatric risk register was in place, which identified current risks to the service.

We did not see a consistent picture of how children's services assessed and responded to patient risk. For example, we were told that patient acuity was measured through an audit tool, which measured daily patient dependency levels. We found this tool had not been completed on Kipling Children's Unit since February 2014.

Summary of findings

The corporate records management policy identified that records must be kept securely. We saw that, in some clinical areas, records had been locked away. We found a total of approximately 5,600 pieces of patient records filing outstanding, for example: assessment reports, discharge letters and referral letters. This could potentially put the patient at risk if full and accurate records are not available.

We found that incomplete records had been kept in five sets of notes reviewed on Kipling Children's Unit. The notes of daily living were incomplete and there was crossing out in the notes with no dates identified. We also looked at one more patient's notes and saw that no separate nursing risk assessments had been identified for that child, despite the child having complex needs. We saw that Meridian (a specialist spend recovery audit consultancy) records audits had been completed. The special care baby unit (SCBU) audit compliance score for August 2014 was 95%. The Kipling Children's Unit August feedback identified concerns relating to non-completion of sections, for example, consent to care and property. It was also noted that care plans had not been completed.

The children's clinical areas were kept clean and had been regularly monitored for standards of cleanliness. However, we were told that no key person was responsible for checking and cleaning the toys in children's areas. A toy-cleaning regime, toy policy or risk assessment had not been developed. Therefore, children could be put at risk if adequate checks and cleaning are not carried out on toys.

Pharmacy controls were in place; however, we found there was not a monitoring process identified for nurse prescribing.

The trust does not have an identified acute paediatrician lead for safeguarding children and young people or non-executive director who could champion children's rights at trust-board level. However, we saw that a dedicated children's safeguarding nursing team and processes were in place to safeguard children and young people.

We found shortfalls in staff attendance in mandatory training, which meant that staff skills and knowledge had not been regularly updated. We looked at what tools the trust had in place to recognise the sick child. We saw that the children's service used an early warning system developed regionally to detect a sick child or infant who required urgent/critical care.

We found a mixed picture regarding staffing within the clinical areas of the inpatient children's services. Staff told us that, as the ward was currently quiet, staffing levels had been "ok". We were told that, when the ward was at full capacity, staff would struggle to take their

two 30-minute breaks during the day shifts. They also told us that the staff on the short stay paediatric assessment unit (SSPAU) did not always take their breaks as there was only one trained nurse working on the SSPAU each shift.

Staffing of the children's outpatient department was not satisfactory, because there was not always a readily available registered children's nurse to oversee the clinics if the rostered outpatient nurse took annual leave. Staffing on some spans of duty within all children's clinical areas did not always meet national best practice guidance.

We found care was effective. Children, young people and parents told us they felt they received compassionate care with good emotional support. All, except one parent felt they were fully informed and involved in decisions relating to their own or their child's treatment and care.

The service did not currently have formal arrangements in place to respond to the transitional needs of all adolescents moving to adult services except for children with diabetes.

We found that children's services were well-led at ward level. There was a culture of openness and flexibility, which placed the child and family at the centre of decision-making processes. There were governance processes in place and risks were actively monitored.

We could not establish how open the culture was within the leadership team, in part, as some paediatricians continued to identify concerns relating to the reconfiguration. We found differences in opinion between paediatricians about the effectiveness of the reconfiguration. One paediatrician felt that the merger had improved care; the other paediatrician was less positive and was concerned about having to cover Eastbourne District General Hospital remotely for sudden infant deaths and abuse cases.

The children's services strategy is in development. Managers told us that the commissioner's strategy was being used to develop and inform the children's services strategy.

We saw that some innovative practice had taken place, which had resulted in the development of a neonatal transitional care service within the special care baby unit. We received positive feedback from one mother about this service.

End of life care

Requires improvement

The specialist palliative care team were available five days a week, with the hospice providing out-of-hours and weekend cover.

Summary of findings

Medicines were provided in line with guidelines for end of life care. DNACPR forms were not consistently completed in accordance with policy and there were no standardised processes for completing mental capacity assessments.

Training relating to end of life care was provided at study days. End of life champions were being introduced across the trust on the wards, however, uptake into these positions was patchy. Leadership of the specialist palliative care team was good and quality and patient experience was seen as a priority.

All patients requiring end of life care could access the specialist palliative care team. There was a multidisciplinary team approach to facilitate the rapid discharge of patients to their preferred place of care.

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

Outpatients

Inadequate

The outpatient services provided at the Conquest Hospital, overall, are inadequate. Although outpatient services were caring, they were inadequate for safety, being responsive and being well-led. Though service was inspected for effectiveness, but not rated.

The central booking service was not always able to give patients' appointments within the NHS England and clinical commissioning groups (CCGs) regulations (2012) 18-week targets. We were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the trust improved their waiting times and met with these targets.

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

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

Summary of findings

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

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

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

We found that the OPD was not protecting patients' confidential data, as they are required to by law, as per the Data Protection Act 1998. We found patient records in publicly accessible areas without staff present.

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

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

Summary of findings

Areas for improvement

Action the hospital MUST take to improve

- Develop a clear and explicit vision for their maternity services and a strategic plan to allow the vision to be achieved. The vision and plan must be created in collaboration with key stakeholders, staff and service users.
- Ensure that there are adequate staff, including managers, consultant midwives and labour ward coordinators employed to meet the recommended minimum standards detailed in Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Royal College of Anaesthetists (RCA), Royal College of Paediatrics and Child Health (RCPCH), 2007.
- Consider the needs of low-risk women giving birth at the Conquest Hospital and ensure that facilities and staffing are such that normal birth is actively promoted.
- Review staffing arrangements for the community midwifery service to ensure they are compliant with the Working Time Regulations (1998), which implement the European Working Time Directive into British law.
- Ensure that medical records and other sources of confidential personal information are managed such that the service is compliant with the requirements of the Data Protection Act 2003 and the guidance issued by professional associations and royal colleges.
- Improve the way information is collected and used. The governance and incident reporting structure must be strengthened and streamlined to ensure that data is sufficiently accurate and robust to be used to inform service improvements.
- Improve the security arrangements at the Conquest Hospital maternity unit.
- Improve the way handovers on the labour ward are managed.
- Ensure that all women in established labour receive one-to-one care from a registered midwife.
- Ensure that all staff have a sound understanding of how to obtain and record that informed consent has been sought before any clinical intervention.
- Take active measures to improve multidisciplinary team working at the Conquest Hospital.
- Review the tracking of records. The outpatient department were not tracking patient health records because this job had not been considered during the redesigning of the service. The location of medical records were often unknown and resulted in delays or temporary notes being used. Trusts have a responsibility to track all patients' health records (Records Management: NHS Code of Practice Part 2, 2nd Edition, January 2009).
- Comply with the Data Protection Act 1998. The outpatient department was not protecting patients' confidential data. Patient records were left in public, accessible areas without staff present.
- Review resuscitation equipment in the outpatient departments, as it was not all fit for purpose.
- Ensure that outpatients medicines are prescribed and dispensed in line with relevant legislation. The department had not ensured that when medicines were prescribed and dispensed, the prescription and dispensing complied with relevant legislation.
- Ensure that outpatients medicines are stored at the correct temperatures. They were unable to provide assurance that this medication had been stored at the correct temperature.
- Ensure that outpatients staff report incidents in accordance with trust policy and statutory requirements.
- Make sure the management of medicines within the emergency department (ED), including storage and recording of temperatures, is done in accordance with national guidelines.

Summary of findings

- Make sure the privacy and dignity of patients is upheld by avoiding same sex breaches in the clinical decision unit (CDU).
- Conduct a trust-wide review of venous thromboembolism (VTE) compliance as a matter of urgency.
- Address our concerns regarding the emergency equipment checking.
- Conduct a trust-wide review of medication compliance.
- Review and improve the complaints handling process to ensure that the service learns and improves as a result.
- Review occupational health and HR support mechanisms and resources in place for staff who are on long-term sick leave, or who require support, to ensure the trust can meet its duty of care to its workforce.
- Conduct a trust-wide review of staffing levels to ensure that patient acuity and turnover is taken into consideration.
- Address the long wait for oral and maxillofacial surgery for adults with learning disabilities.
- Review medical cover on the Conquest Hospital site.
- Identify and address inappropriate staff behaviour toward patients, relatives and staff.

Action the hospital SHOULD take to improve

- Improve infection prevention and control measures on the maternity unit at the Conquest Hospital.
- Improve the facilities and pathway for women suffering pregnancy loss at the Conquest Hospital maternity unit.
- Ensure that medicines, particularly controlled drugs, on the maternity unit at Conquest Hospital are managed in accordance with the trust policy.
- Make comprehensive, written information available to women using services in relation to the choices of place of birth available to them.
- Improve breastfeeding support to new mothers.
- Ensure women who need to be transferred after giving birth are not separated from their babies.
- Consider the particular needs of vulnerable groups of women and babies within their catchment and provide adequate resources to meet those needs.
- Provide resources to accommodate the needs of women in early labour where repeated journeys between their home and the hospital may be inadvisable.
- Communicate more effectively with the local population to ensure they understand the services available and the reasons for decisions being made.
- Review the out-of-hours medical cover available on the site to ensure there are sufficient staff to meet the needs of all patients without undue delay during busy periods.
- Look at the system for reviewing serious medical incidents and ensure that there is oversight from doctors. Staff completing the reviews should have appropriate training to ensure that full in-depth analysis is completed and clear learning streams identified.
- Review how medical incidents are managed and escalated to ensure that the appropriate management staff are involved at an early stage to oversee actions and escalate and disseminate information appropriately.
- Review staff compliance of fully and accurately completing documentation and feedback to teams on good and poor practice. Accurate documentation was not being consistently completed on medical wards
- Should integrate executive-level staff with the workforce at a local level, allowing them to observe practice and assess the impact of changes at departmental and individual level. This will help to increase staff inclusion, confidence and empowerment.
- Should have strategies in place to improve outpatient waiting times consistently in all specialities. The central booking service was not always able to give patients appointments within the NHS England and clinical commissioning groups (CCGs) regulations (2012) 18-week targets.

Summary of findings

- Ensure clear strategies are put into place to improve outpatient waiting times against the national average. The trust was falling below national averages with the two-week wait timescale for patients with urgent conditions such as cancer and heart disease.
- Ensure that patients are offered follow-up appointments within the timeframe considered clinically appropriate.
- Ensure that patients are managed effectively through the department; patients are sent to the correct areas of the outpatient department and are expected by staff in those areas when they arrive. Staff should be able to track patients' journeys through the department.
- Ensure that they are obtaining correct data regarding patient pathways and recording accurate data for 18-week and two-week waiting times.
- Consider reviewing some areas of the environment in A&E with regard to arrangements for supporting patient privacy and the overall security of the department.
- Ensure the implementation of pain assessments for patients in A&E. We saw poor use of pain measurement.
- Make sure any assessment of patients' capacity or best interest decisions are accurately recorded in patient records.
- Take action to ensure that staff receive mandatory training in line with trust policy.
- Ensure that patient information is available in languages other than English and in other formats so that it is accessible to people with disabilities.
- Make sure staff receive an annual appraisal in line with trust policy.
- Review their methods of sharing information with the population they serve to improve public engagement.
- Enable there to be end of life champions on every ward and deliver regular training to develop and maintain knowledge and skills. The trust-wide training strategy did not have end of life care embedded in it, at the time of the inspection.
- Consider the implementation of McKinley T34 syringe drivers across the trust with mitigation plans to support the transition from Omnifuse syringe drivers.
- Ensure that discussion at the end of life steering group could include end of life incidents and cascade learning across the trust.
- Should develop a system for do not attempt cardio-pulmonary resuscitation (DNACPR) orders to be checked on a regular basis to ensure compliance.
- Regularly review the quality of the Mental Capacity Act 2005 assessments and the need for assessment to be clearly document.
- Review the quality of nursing documentation to ensure it accurately reflects the care delivered with individualised care plans for end of life patients.
- Collect and consider the opinions of carers of patients receiving end of life care to support a continuous cycle of improvement.
- Review the support provided to the specialist palliative care team to ensure the resources enable them to achieve their ambitions for the trust. Improved leadership and administrative support is required.
- Consider expansion of the specialist palliative care team to enable face-to-face working seven days per week.
- Consider the introduction of an end of life electronic alert system across trust.
- Improve the profile of end of life care across the trust by introducing a standing trust board agenda item on end of life care and have a designated clinician as trust-wide lead for end of life, who understands what is needed and who is empowered to implement policy.
- Ensure that an integrated strategy for end of life care is put in place, as the trust is an integrated acute community trust.
- Audit the effectiveness of nurse-led discharges (trust wide) and the admissions (SAU at Conquest Hospital).
- Improve staff morale and seek ways of improving communication effectiveness.
- Review the quality of nursing documentation to ensure it accurately reflects the care delivered.
- Ensure all agency and transient staff have a full induction in clinical areas, which is formally recorded.
- Review medical cover at the Conquest Hospital.
- Address theatre efficiency across both sites and in all theatres.
- Engage in effective listening with staff to improve efficiency.

Summary of findings

Good practice

- The introduction of a transfer of care document which was used to provide all discharge information for the patient and for other healthcare professionals. The service also followed up discharged patients with their 50:50 nurse.

Conquest Hospital

Detailed findings

Services we looked at

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

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

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

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

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

Background to Conquest Hospital

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

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

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

melanoma is worse than average. Rates of statutory homelessness, violent crime, long term unemployment, drug misuse and early deaths from cardiovascular diseases are better than average.

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

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

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

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

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

We carried out this comprehensive inspection in September 2014. We held two public listening events in the week preceding the inspection visit, met with individuals and groups of local people and analysed date we already held about the Trust to inform our inspection planning. Teams, which included CQC inspectors and clinical experts, visited the two acute hospitals, community hospitals and midwifery led centres and teams working in the community. We spoke with staff of all grades, individually and in groups, who worked in acute and community settings. We also carried out two unannounced inspection visits after the announced visit.

* rate per 100,000 population

Why we carried out this inspection

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

Key Intelligence Indicators

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

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

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

• Proportion of staff receiving support from their line manager.

• Staff who thought the incident reporting procedure was fair and effective.

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

How we carried out this inspection

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

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

The inspection teams inspected the following eight core services across East Sussex Healthcare NHS Trust –

Detailed findings

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

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

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

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

We made an announced inspection of the Trust services on 10, 11, 12 September 2014 and an additional unannounced inspection visit to both acute hospitals on 23 September 2014. We interviewed clinical and non-clinical staff of all grades, talked with patients and staff across all areas of the hospitals and in the community. We observed staff interactions with each other and with patients and visitors. We reviewed records including staffing records and records of individual patient's care and treatment. We observed how care was being delivered. We held focus groups to listen to staff working in different areas of the Trust.

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

Requires improvement

Accident and emergency

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

Information about the service

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

Following a reconfiguration of the organisation between December 2013 and May 2014, general surgery, emergency and high-risk services, along with orthopaedic emergency and high-risk services were centralised at Conquest Hospital in Hastings. The Conquest Hospital in Hastings is a Major Trauma Unit and therefore receives only those trauma patients deemed suitable for this level of provision.

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

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

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

We visited the ED over two week days, during our announced inspection, and returned for an unannounced visit the following week. We observed care and treatment and looked at 27 treatment records. During our inspection, we spoke with 33 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We spoke with eight patients and their relatives. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

Requires improvement

Accident and emergency

Summary of findings

Improvements are required for the service to be safe, responsive and well-led.

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

People's needs were not always taken into account and met. The facilities and premises did not meet patients' needs. There was insufficient space in the department to accommodate the numbers of patients attending and the layout of the department did not promote patients' privacy, dignity and confidentiality.

Patients with mental health needs often waited too long in the department without the support of suitably trained or skilled staff. A room identified for accommodating patients presenting with mental health needs was not fit for purpose. We identified ligature points and potential missiles in the room, which had one door and was adjacent to the relatives' room.

Capacity issues within the department were included on the trust's risk register, identifying the risk of being unable to offload patients from ambulances into the unit. There were insufficient cubicles in the major and minor treatment areas for the number of patients being treated within them. Staff areas were congested and it was not possible for patients on trolleys to be moved around easily. We observed that patients categorised as 'minors' were left waiting for treatment if cubicles became congested with majors patients.

The triage area was a curtained bay in the waiting room. It had one entrance/exit, which could compromise the safety of staff or patients in the event of a person becoming aggressive.

The department was not secure. Although a 'swipe' card was needed to enter the locked doors of the treatment area, a door adjacent to the reception desk was unlocked. We used it to access the treatment area unchallenged on our arrival when we found the reception desk did not have a staff member present. There was no facility to electronically lock down the department to isolate it in the event of an untoward incident.

Medicines were not always stored securely or checked regularly which increased the risk of medicine misuse. Checks of the controlled drugs stored in the resuscitation area were not consistently recorded on a daily basis. This means potential medicine misuse might go undetected. Although the trust had recognised this concern and implemented a monthly compliance audit, we found significant levels of non-compliance in the records we reviewed.

The trust did not meet the College of Emergency Medicine (CEM) recommendation that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week. This compromised senior clinical decision making which could negatively impact the patient's pathway of care. Staff did not consistently record their assessment of patients' capacity to consent or decisions made in the best interests of patients who lacked capacity. Compliance with mandatory training required improvement to achieve a safe workforce.

The leadership and culture required improvement so that the delivery of high quality, person centred care is supported. Leadership roles had recently been restructured in the urgent care directorate. We found a lack of defined leadership "on the floor" of the departments. We found that staff were not actively engaged and staff satisfaction was not seen as a high priority. Staff were concerned about the level and speed of change implemented in the urgent care directorate within the trust. There was a limited approach to obtaining the views of people using the service and no evidence that changes were made as a consequence of patient feedback.

Staff in the A&E department were following accepted national and local guidelines. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs. The pathways were revised annually to ensure current practice. Patients were given timely pain relief although pain scoring tools were not used effectively.

There were insufficient paediatric nurses employed to provide 24 hour presence in the department, but this

Requires improvement

Accident and emergency

was being mitigated by additional training for staff. There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals.

Staff in the A&E department provided a compassionate and caring service. Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

Are accident and emergency services safe?

Requires improvement

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

The physical environment was not large enough or appropriately configured to accommodate and effectively care for the increasing numbers of patients attending the hospital.

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

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

Staff did not consistently record their assessment of patients' capacity to consent or decisions made in the best interests of patients who lacked capacity.

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

Incidents

- There were no Never Events in the ED at this hospital between April 2013 and August 2014. (A Never Event is a serious, largely preventable patient safety incident that should not occur if the available, preventative measures have been implemented by healthcare providers.)
- The trust reported two serious incidents to the Strategic Executive Information System (STEIS) relating to the ED at this hospital between April 2013 and March 2014. Two serious incidents were recorded in the period July to August 2014. One incident was a moving and handling incident involving a member of staff and the second incident was a fall where the patient involved sustained a fractured hip. The investigations were ongoing for these incidents. All serious incidents resulted in a root cause analysis and action plans were put in place to reduce the likelihood of similar events occurring in the future.

- Staff working in the ED told us they felt confident to complete incident reports and raise any concerns they had, but they did not always receive feedback about the incidents they reported. The number, category and severity of incidents were reviewed at the monthly directorate's acute clinical governance meetings.
- The trust's own analysis showed the "top five" incidents in acute and emergency medicine were: health records and other documentation, slips trips and falls, patient discharge and transfer, resources/staffing and medication errors.

Cleanliness, infection control and hygiene

- The department was clean and tidy. We saw support staff cleaning the department throughout the day and doing this in a methodical and unobtrusive way.
- The department had a range of equipment that was seen to be clean, and there was a system of labels to indicate that an item had been cleaned and was ready for use.
- Conquest Hospital scored 96.24% for patient satisfaction with cleanliness in patient-led assessments of the care environment (PLACE) 2014 surveys, which is around the national average.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between each patient and using hand sanitising gel. 'Bare below the elbow' policies were seen to be observed by all staff.
- The trust's Infection Control Team (ICT) completed validation hand hygiene audits in October 2013. The A&E department at Conquest Hospital achieved 40% compliance.
- The trust's NHS workforce scorecard for the acute and emergency medicine directorate in July 2014 showed that 72% of staff had attended infection control training in the previous 12 months.
- Side rooms were available for patients presenting with a possible cross-infection risk.

Environment and equipment

- Overcrowding was an issue at busy times in the department. This was exacerbated the department experiencing a 4% increase in attendance since April 2014. Capacity issues within the department were included on the trust's risk register, identifying the risk of being unable to offload patients from ambulances into the unit. There were insufficient cubicles in the major and minor treatment areas for the number of patients being treated within them. Staff areas were congested and it was not possible for patients on trolleys to be moved around easily. We observed that patients categorised as 'minors' were left waiting for treatment if cubicles became congested with majors patients.
- The triage area was a curtained bay in the waiting room. It had one entrance/exit, which could compromise the safety of staff or patients in the event of a person becoming aggressive.
- Side rooms were available for extra privacy for patients who might require it.
- The department was not secure. Although a 'swipe' card was needed to enter the locked doors of the treatment area, a door adjacent to the reception desk was unlocked. We used it to access the treatment area unchallenged on our arrival when we found the reception desk did not have a staff member present. There was no facility to electronically lock down the department to isolate it in the event of an untoward incident.
- A room identified for accommodating patients presenting with mental health needs was not fit for purpose. We identified ligature points and potential missiles in the room, which had one door and was adjacent to the relatives' room. Staff told us patients would not be left alone in the room.
- There was a small x-ray department within the A&E. This was well equipped and easily accessible from all areas of the department.
- We checked a range of equipment, including resuscitation equipment, which was accessible and fit for purpose. Equipment was clean, regularly checked and ready for use.

Medicines

- During our first visit to the department, we found that the door to the storeroom containing intravenous fluids was left unlocked, which increases the risk of IV fluids being tampered with or contaminated.
- Checks of the controlled drugs stored in the resuscitation area were not consistently recorded on a daily basis. This means potential medicine misuse

might go undetected. Although the trust had recognised this concern and implemented a monthly compliance audit, we found significant levels of non-compliance in the records we reviewed.
- Medicine administration records were completed in the patient records we looked at.
- The department used an 'Omnicell' system to store medicines securely in the minor/major treatment areas.

Records
- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'CAS card') was generated by reception staff registering the patient's arrival in the department to record the patients' initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- An 'integrated patient care' document was implemented for patients in the CDU, or where admission to the hospital was anticipated. The document was clear and easy to follow. There was space to record appropriate assessments, including an assessment of risks, investigations, observations, advice and treatment and a discharge plan. We looked at the integrated patient care documents for seven patients in the CDU and found they were completed.
- The trust's NHS workforce scorecard, for the acute and emergency medicine directorate in July 2014, showed that 46% staff had attended information governance training in the previous 12 months.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
- We observed that verbal consent was obtained for any procedures undertaken by the staff.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- The trust's NHS workforce scorecard for July 2014 showed that 83% ED staff who required training on the Mental Capacity Act 2005 and 80% of the ED staff who required training on Deprivation of Liberty Safeguards, had done so.
- Where people lacked the capacity to make decisions for themselves, such as those patients who had arrived into the department unconscious or under the influence of a substance, we observed staff following the principles of the Mental Capacity Act 2005 in making decisions in support of those patients care. However, patients' capacity to make decisions was not consistently recorded. The department's 'CAS card' included a prompt for staff to document the patient's mental capacity. This had not been completed in 23 out of the 25 patient records we looked at, although some of the patients had presented with reduced levels of consciousness, under the influence of a substance and with a history of mental illness.
- The mental health liaison nurses have an office based in the ED at Conquest Hospital and have a presence between 8am and 8pm, Monday to Friday. This expedited the referral process for patients presenting with mental health needs during these hours.

Safeguarding
- Staff spoken with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- Staff had access to patients' previous attendance history and to the child risk register**.** All children who attended were immediately checked to identify if they were 'at risk' within their home environment.
- In July 2014, the trust's NHS workforce scorecard for the acute and emergency medicine directorate showed that 76% of staff who were required to undertake training in level 2 safeguarding adults had done so.
- In July 2014, the trust's NHS workforce scorecard for the acute and emergency medicine directorate showed 51% of staff who were required to undertake training in level 2 safeguarding children had done so.
- In July 2014, the trust's NHS workforce scorecard for the acute and emergency medicine directorate showed 90% of staff who were required to undertake training in level 3 in safeguarding children had done so.

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

Requires improvement

Accident and emergency

Initial assessment and management of patients

- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival. Patients arriving in an ambulance were brought into the main treatment area. The nurse coordinator was given a detailed handover by the ambulance crew and, based on the information received, a decision was made regarding which part of the department the patient should be treated. Once transferred to a treatment bay, baseline observations were carried out and a triage category was calculated.
- The trust consistently met the target to receive and assess ambulance patients within 15 minutes of arrival in the 12 months leading up to March 2014.
- Patients who walked into the department, or who were brought by friends or family were directed to a receptionist. Once initial details had been recorded, the patient was asked to sit in the waiting room. Non-ambulance patients were assessed by a nurse in time order unless the receptionist thought that a patient needed to be seen urgently.
- We observed the triage of a patient (with their permission) and found it to be thorough and effective. The nurse had undergone specific training before carrying out the role and was able to request x-rays when indicated.

Management of deteriorating patients

- The ED used the Manchester triage system guidelines. This helped to determine the severity of the patient's injury or illness.
- The trust issued 'Standards for Monitoring and Recording Vital Signs (Recognising the Deteriorating Patient)' in November 2013. These standards state that all patients admitted into the trust, (including patients in A&E and outpatients departments when a decision has been made to admit) must have a trust observation chart commenced and physiological observations recorded at the time of their admission.
- We observed that the national early warning score (NEWS) and paediatric warning score (PEWS) tools were available for use in the department, but staff did not always use them. We found that NEWS was not recorded for every patient presenting in the department. Staff told us they made individual judgements about when it was necessary to implement the tool

Nursing staffing

- The trust reviewed nurse staffing levels in March 2014 in line with the guidance: 'How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability' by the National Quality Board. The trust's review adopted an approach where an evidence-based model (The Hurst Model) was used alongside professional judgement, to form a basis for the right skills mix and numbers, involving the ward matrons and heads of nursing.
- The skills mix for each shift included band 7 sister/ charge nurse grades, who were in charge of the shift, with band 6, band 5 nurses and healthcare assistants (HCA). There were also student nurses on placement in the department. During each day shift, the department was supported by nine registered nurses and four healthcare assistants. At night, this reduced to six registered nurses and three healthcare assistants. These staff covered the main A&E (resuscitation, Majors and Minors), triage and the CDU. We were told that the department was piloting redistributed staffing hours by having one less nurse on the day shift and one more on the night shift. This was in response to staff concerns about increased attendances at night. Staff were allocated to specific areas of the department for their shift, but could be moved around if one area became busier than another. In addition, an emergency nurse practitioner (ENP) was on duty on each day shift and a 'twilight' shift up until midnight.
- Handovers between staff were effective. Delegation was clear, and communication skills were good.
- We saw that the department had low reliance on bank (overtime) and agency staff to ensure that the unit was safely staffed.
- The community minor injury units (MIU) at Crowborough War Memorial Hospital, Lewes Victoria Hospital and Uckfield Community Hospital, were each staffed with one ENP and one HCA. We found that staff shortages in the minor injury units sometimes resulted

in the closure of the unit. Information provided by the trust showed it had been necessary to close one of the three units (for some or all of the planned opening times) on 25 occasions since 1 April 2014.

Medical staffing

- The trust employed five whole time equivalent (WTE) consultants. Consultant cover was provided daily from 8am until 7pm on weekdays and for six hours on Saturday and Sunday with an on-call rota for outside of these hours. The trust did not meet The College of Emergency Medicine (CEM) recommendation that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week.
- The trust reported a clinical vacancy rate of 8%. Consultant and middle grade vacancies in A&E were identified as risks on the urgent care directorate's risk register.
- We looked at the clinical duty rota which showed middle and junior grade doctors were on duty 24 hours a day in the department.
- Medical vacancies were covered by the hospital's own staff and moderate use of agency (locum) staff. Most of the agency cover was provided by regularly used locums, who were familiar with the department and staff.

Major incident awareness and training

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

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Staff in the A&E department showed good clinical practice following accepted national and local guidelines. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs. The pathways were revised annually to ensure current practice.

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

There were insufficient paediatric nurses employed to provide 24 hour presence in the department, but this was mitigated by additional training for staff.

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

Evidence-based care and treatment

- The A&E department used a combination of the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided and a range of clinical care pathways had been developed in accordance with this guidance. For example, we saw protocols available for fractured neck of femur, sepsis, stroke and haemorrhage.
- We were told trust/departmental guidelines were produced and revised by an ED consultant every year. We saw a copy of the printed 14th edition produced in August 2014.
- Comprehensive antimicrobial were available online with specific alerts of when to discuss with the microbiology department to protect against antibiotic resistance. We saw current ALS guidelines clearly displayed in resus along with criteria for a trauma call.

Pain relief

- We were informed that an assessment of pain was undertaken on a patient's arrival in the hospital as part of the admission process. This was supported by the care we observed. Staff consistently asked patients if they required pain relief and analgesia was prescribed and administered appropriately. We did not observe patients left in pain. However, when we reviewed patients' records, we found a pain score had not been recorded in five out of 10 patient records we reviewed for patients presenting with complaints of pain. We saw pain scoring tools relevant to the child's age in use for children.
- The ED participated in two College of Emergency Medicine (CEM) audits, which included the management

of moderate or severe pain. The management of patients presenting in moderate or severe pain caused by renal colic and the College of Emergency Medicine clinical audit into the management of fractured neck of femur.

- Seventy percent of patients who presented to the ED during 2011 and 2012 complaining of pain as a result of renal colic, had a pain scored recorded. This placed the ED between the upper and lower quartiles (quartiles are the values that divide a list of numbers into quarters) when compared nationally. The CEM standard was 100%.
- Forty percent of patients who presented in severe pain with renal colic were provided with analgesia within 20 minutes of arrival. This placed the ED in the upper quartile when compared nationally. The CEM standards recommend that 50% of patients presenting in severe pain with symptoms of renal colic, should receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes upon arrival to the ED. The department was also placed in the upper quartile for patients receiving analgesia within 30 minutes (60%) and 60 minutes (85%).
- Eleven percent of patients who presented to the ED during 2011 and 2012 in severe pain with fractured neck of femur were provided with analgesia within 20 minutes of arrival. This placed the ED between the upper and lower quartiles when compared nationally. The CEM standards recommend that 50% of patients presenting in severe pain with fractured neck of femur, should receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes upon arrival to the ED. The department was also placed between the upper and lower quartiles for patients receiving analgesia within 30 minutes (22%) and 60 minutes (56%).

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection. A hot drink dispensing machine was available in the CDU.
- The integrated patient care documentation booklet provided staff with a prompt to carry out a nutritional risk assessment using the malnutrition universal screening tool (MUST). We saw these completed for patients in the CDU.
- Following the assessment of a patient, intravenous fluids were prescribed and recorded, as appropriate.

Patient outcomes

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

Competent staff

- 20% of nursing staff had undertaken an A&E module at Brighton University.
- Three paediatric nurses were employed in the department; this was insufficient to meet the Standards for Children and Young People in Emergency Care settings standard for at least one paediatric trained nurse to be on duty over 24hours. This was included on the trust's risk register and mitigated by a rolling programme of staff completing a paediatric module in either emergency care or assessment.
- Children requiring specialist paediatric services were treated by paediatric doctors from the children's ward; this service was always accessible to A&E staff.
- The trust's NHS 'Workforce Scorecard' for the acute and emergency medicine directorate in July 2014 showed that 47% of staff had received an appraisal. This was the lowest performance for appraisal amongst directorates within the trust.
- The trust's quality and performance report for June 2014, showed that the medical appraisal status for clinical staff in the trust was 100%.
- We spoke with junior doctors, who told us that they received regular supervision from the ED consultants, as well as weekly teaching.

Multidisciplinary working

- There was effective multidisciplinary working within the ED. This included effective working relations with specialty doctors and nurses, social workers and GPs. We observed effective and collaborative interaction

between doctors and nurses during the inspection. Staff in the department told us internal multidisciplinary working (such as between specialties) was generally good.
- We saw good examples of multidisciplinary working with the hospital's team of Allied Healthcare professionals, whose role was to facilitate the early discharge of patients who may otherwise have been admitted to a ward while waiting for an appropriate care package to be organised prior to their discharge.
- We observed several handovers from the ambulance service to the A&E staff. They were well structured and ensured that all the relevant clinical information about the patients was properly conveyed.

Seven-day services

- The department had access to radiology support 24 hours each day, with full access to computerised tomography (CT) and magnetic resonance imaging (MRI) scanning
- We checked the rotas, and spoke to the medical team and senior nurses, who could show that there was a seven-day working approach, and that appropriate medical cover was in place, including out of hours and at weekends.
- General surgery emergency and high-risk services, along with orthopaedic, emergency and high-risk services were centralised at Conquest Hospital in Hastings in December 2013 and May 2014 respectively. We were told that A&E at Conquest Hospital had seen a 4% increase in attendance since April 2014.

Are accident and emergency services caring?

Good

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

Compassionate care

- Throughout the three days we visited the ED during our inspection, we saw patients being treated with compassion, dignity and respect. Patient feedback captured prior to and during our inspection was generally positive.
- Patients' dignity was respected during treatment and when they were being supported with personal care tasks; staff consistently used dignity curtains.
- Staff used patients' preferred names and spoke in an appropriate tone of voice when supporting people.
- At our listening events people told us they were satisfied with the care they received at A&E but they were unhappy about a lack of privacy at the receptions window on arrival in the department where confidential conversations could be overheard.
- Two questions in the Adult Inpatient Survey, CQC, 2013, related to people's experience in the A&E department ('While you were in the department, how much information about your condition did you receive? And: 'Were you given enough privacy when you were being examined or treated in the department?') The trust scored about the same as other trusts in response to both of these questions.
- The NHS Friends and Family Test is a single question survey that asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The score is calculated using the proportion of patients who would recommend the A&E department, minus those who would not recommend it, or who are indifferent. Conquest Hospital performed below the average for England for the NHS Friends and Family Test. In March 2014, it scored 37, compared with the average for England of 54, and in June 2014 it scored 30, compared with the average for England of 53. The response rate was 14.4% in March 2014, compared with the England average of 18.5%. The response rate was 27.3% in June 2014, compared with the England average of 20.8%.
- Between 1 April 2013 and 31 March 2014, the ED at Conquest Hospital recorded 12 complaints, which were attributed to poor staff attitudes.

Requires improvement

Accident and emergency

Patient understanding and involvement

- Staff had an understanding of the Mental Capacity Act and how assessments of a person's capacity were needed if there were reasons to doubt their level of understanding.
- During our visits to the ED patients and relatives told us that they had been consulted about their treatment and felt involved in their care. Patients told us they understood what had been said to them, and had felt informed about their care and treatment options. One relative said, "I've been here a few times with family members of all ages. They are always very efficient."
- Between 1 April 2013 and 31 March 2014, the ED at Conquest Hospital recorded seven complaints that specifically included concerns about poor communication.

Emotional support

- We observed staff giving emotional support to patients and their families. Staff made use of the designated relatives' room so that people had privacy when they were receiving upsetting news about their relatives' condition.
- Staff had access to the hospital's chaplaincy service and could request support when needed.
- Timely assessment and support was generally available for people presenting with mental ill health as mental health practitioners were based on site.

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

(for example, to feedback?)

Requires improvement

The A&E department requires improvement to ensure that people's needs are taken into account and met.

The facilities and premises do not always meet patients' needs. There is insufficient space in the department to accommodate the numbers of patients attending and the layout of the department does not promote patients' privacy, dignity and confidentiality.

Patients with mental health often wait too long in the department without the support of suitably trained or skilled staff.

Service planning and delivery to meet the needs of local people

- The trust restructured its A&E services between December 2013 and March 2014 so that Conquest Hospital receives trauma and high-risk surgical and orthopaedic emergencies. The A&E at Conquest has experienced a 4% increase in attendance since April 2014. The trust recognised the need to increase the number of cubicles in the department and has plans to extend the A&E to deal with the increased patient attendance, with plans for building work to commence before the end of the current financial year. Capacity issues are included on the departmental risk register. The trust has a capital bid with the Trust Development Authority (TDA) for expansion by December 2014.
- There was often insufficient space in the department to deal with the number of patients attending. We visited the department over three days; on one day we found all the cubicles (both minors and majors) occupied by majors patients. On another visit, we saw patients waiting on trollies in the corridor with ambulance staff because of insufficient capacity in the department. Delays in off-loading patients from ambulances was identified as a risk on the departmental risk register. An agreement was in place with South East Coast Ambulance (SECAM) Service to cohort patients in a designated area with trust staff providing senior assessment if the delay is greater than 30 minutes. Although most patients were promptly assessed on arrival, some patients arriving by ambulance were forced to queue in the corridor outside A&E because the department had no capacity. This compromised patient experience and put them at increased risk.
- The waiting area had adequate seating. There was a consulting area for triage and a separate room where patients could be seen by an Emergency Nurse Practitioner (ENP).
- The department had a separate children's waiting room within the main waiting area. However, it did not allow staff a direct line of sight to waiting children. This meant that the condition of patients waiting to see a doctor could deteriorate without staff being aware of it. We observed that several children waited in the main waiting area. One cubicle in the minors area of the department was allocated for paediatric use. In practice, although the area was prioritised for children, it was sometimes used for adults when capacity was an issue.

Requires improvement

Accident and emergency

- The arrangements for consulting with patients did not always maintain their privacy and dignity. For example, the triage area is a curtained bay in the waiting room which meant confidential discussions between patients and staff could be overheard. On one occasion we found the computer screen in the triage area displaying confidential patient information without a member of staff present. Patients who self-presented in the department had to book in with the receptionist who sat behind a glass screen. Patients were required to give details of their symptoms. This area was part of the main waiting room and people could easily be overheard.
- The Clinical Decisions Unit (CDU) accommodates up to seven patients in six curtained bays and one side room. It also has an area to accommodate one seated patient, who may be waiting, for example, for blood test results or repeat investigations before being discharged. Patients can be accommodated in the CDU for up to 48 hours, which means male and female patients might share sleeping accommodation. Staff demonstrated a sliding door, which could be used as a partition to create two bays to facilitate same-sex accommodation. However, the sliding door was completely transparent and offered no privacy. It was difficult to see how the door might be employed in practice, as the nurse station (with phones, computer access and patient records) would be behind it. The door was not used at any time during our visits. We observed male and female patients occupying the same area. Staff told us they 'do their best' to avoid mixed-sex accommodation by separating male and female patients. Staff told us they do not complete an incident report or keep a local record of any breaches. The trust's quality and performance report records nil breaches of mixed-sex accommodation in the last quarter. This arrangement did not comply with standards set out by the Department of Health's Chief Nursing Officer in 2009.

Access and flow

- An electronic system was in place for tracking how long patients had been in the department, to ensure they were treated in a timely way.
- **T**he flow of patients from the department into other parts of the hospital was generally good and was facilitated by a number of pathways the trust had put in place to ensure that patients spent as little time as possible in the department or bypassed it altogether. For example, the hospital had both surgical and acute assessment units and patients could be referred directly to one of those without needing to go to A&E.
- The government target is for 95% of patients in A&E to wait less than four hours to be admitted, transferred or discharged. NHS England A&E activity statistics for this trust showed the target was met for 95.2% of attendances in the quarter ending December 2013, 95.6% attendances in the quarter ending March 2014 and for 94.5% attendances in the quarter ending June 2014. Underperformance against targets by the Conquest and Eastbourne A&E departments were offset by consistent 100% performance by the three Minor Injury units (MIU) operated by the trust.
- Senior staff reviewed breaches. There were a number of reasons why patients breached the 4-hour target. These included lack of a bed on a ward; a delay in A&E review; a delayed specialty review, such as to a surgical team; a delay in transport; or a clinical issue leading requiring the patient to remain in the department longer.
- We found that the average length of stay for a patient in A&E (average per patient) was between 135 and 170 minutes. This was consistently higher than the national average of between 125 and 140 minutes (month by month for the year ending February 2014).
- Between 1% and 10% of emergency admissions via A&E waited between four and 12 hours from the decision to admit until being admitted. This was about the same as the national average (month by month for the year ending June 2014). NHS England winter pressures daily situation reports (SitRep) data between 4 November 2013 and 30 March 2014 showed the trust had nil occurrences, when ambulances waited more than 30 minutes to handover. There were nil occurrences of patients waiting on trollies for more than 12 hours.
- The percentage of patients leaving who left the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait) was about the same as the national average of between 2% and 3% (month by month for the year ending February 2014).
- The trust had a Hospital Intervention Team (HIT) who aimed to prevent hospital admissions and to facilitate early discharge. They worked in the gateway Areas – including ED and CDU. The team consisted of

occupational therapists, physiotherapists, nurses and adult social care workers. In September 2014 across the trust they were saw 318 patients and discharged 257 of them.
- An out of hour's primary care service is situated in the Fracture Clinic at the Conquest hospital. This promoted closer working and easy referral between the ED and primary care.

Meeting people's individual needs

- There were Dementia Friends Champions identified among the nursing staff to offer training support and advice to other staff in the department to support the needs of people living with dementia.
- Staff had not received training in meeting the needs of people with learning difficulties; however, staff spoken with were aware of 'passports' which included details of a patient's health and care needs, so that staff could provide prompt and appropriate care and treatment in an emergency. We observed sensitive and appropriate responses from staff when a patient with learning difficulties arrived in the ED with their carer.
- Patients who attended the department spoke many languages. Most went to the hospital with a family member who acted as an interpreter. This is recognised as not good practice. Telephone translation services were available for patients for whom English was not their first language and some staff spoke more than one language. Patient information and advice leaflets were available in English, but were not available in any other language or format.
- The mental health liaison nurses have an office based in the ED at Conquest hospital and have a presence between 8am and 8pm Monday to Friday. This expedited the referral process for patients presenting with mental health needs.

Learning from complaints and concerns

- Information about how to complain was displayed in the department. Information leaflets were available to all patients. They contained helpful information about how to access the Patient Advice and Liaison Service (PALS) and how to make a complaint. The department followed the trusts complaints policy.
- We looked at the trust's complaints report for 2013/14 and were provided with detailed information about each of the complaints received by the urgent care directorate. We noted that, overall, the trust responded to complaints in a timely manner, with 86% responded to in time. The trust identified the top five areas of complaint relating to the urgent care directorate were care, communication, pathways, attitude and discharge.
- Informal complaints could be received by any member of the team. These were dealt with by the most appropriate person. Staff were aware that if they could not resolve an issue they should advise the patient/ relative how to use the formal complaints policy.

Are accident and emergency services well-led?

Requires improvement

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

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

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

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

Vision and strategy for this service

- The trust defined their mission is to: "Deliver better health outcomes and an excellent experience for everyone we provider with healthcare services." The trust's defined objectives are to:
  - "Improve quality and clinical outcomes by ensuring safe patient care is our highest priority.
  - Play a leading role in local partnerships to meet the needs of our local population and enhance patients' experiences."
  - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable."

- Staff we spoke with during the course of our inspection were not aware of the mission or objectives of the trust when we asked them about vision and strategy.
- The general manager and head nurse of the urgent care directorate had been in post for several years and understood the current and future needs of the service, including the number of leaders, qualities and skills required. A&E medical staff expressed concern that the directorate's clinical leads did not have sufficient insight Emergency Care medicine as the directorate leads were acute physicians.
- At service level, staff understood that A&E was included in the trust's reconfiguration, but expressed concern about the level and speed of change implemented in the urgent care directorate within the trust. Staff did not feel engaged with the changes made.

Governance, risk management and quality measurement

- Monthly departmental governance meetings were held, during which, complaints, incidents, audits and quality improvement projects were discussed. Invitation to the meeting extended to band 7 nursing staff, who each had an area of responsibility for leadership. We looked at the department's risk register, which fed into the divisional and, ultimately, the trust-wide risk register.
- There was consistency between what frontline staff and senior staff said were the key challenges faced by the service. The risk register reflected what individuals raised as their key concerns for the service. Staff were clear on the risks and areas in the department that needed improvements.

Leadership and culture within the service

- A general manager had oversight for management of acute and emergency medicine for Eastbourne District General Hospital and Conquest Hospital, which included ED, medical assessment units and three minor injury units in the trust's community hospitals.
- Cross-site nursing leadership in the ED was provided by a senior (band 8b) Head Nurse. Two nurse service managers (with service-specific rather than site-specific responsibilities) were accountable to the head of nursing. Band 7 nurses coordinated the shifts in the department and had specific management responsibilities. This management restructuring had taken place a matter of weeks ago and had not been embedded. Service managers had been in post for two weeks at the time of our inspection. Many nursing staff we spoke with were aware of the recent changes, but had yet to meet their new service manager. Senior nursing staff told us it was a challenge to devolve responsibilities to band 7 nursing staff since the restructure. Staff working in the departments felt they lacked a nursing lead on the floor as there was no longer an identified nursing lead in the departments because service managers were service rather than site specific. This was also expressed by senior doctors who said, "It's difficult to know who's responsible for what, so we don't always know which nurse to go to."
- The clinical lead for the Urgent Care directorate across the trust's sites was job shared by two consultant acute physicians. Senior clinical ED staff expressed concern that there was no longer an Emergency Care Consultant lead in the department as this post was lost in the recent restructure. Consequently, Emergency Care Consultants felt the ED "had no voice" at leadership level.
- Staff told us that they felt valued by leaders "on the floor", but not by the organisation. Staff did not feel involved with the recent changes made to services. All the staff that we spoke with said that they enjoyed the work they did. Most staff spoke with a sense of pride about their local team and department, but expressed concern about the security of their posts following the changes implemented in the urgent care directorate within the trust. Staff morale in the department was variable and staff felt suspicious about the trust's future plans. The majority of staff we spoke with did not believe trust leaders were open and transparent. We spoke with several staff who felt cautious about speaking openly with us for fear of reprisal.
- The trust's quality and performance report for June 2014 showed high staff sickness levels in the acute and emergency medicine directorate at 5.3% for the month and 6.2% annually.

Public and staff engagement

- There was no evidence displayed in the department of changes made as a result of patient feedback such as 'You said, we did', NHS Friends and Family Tests or patient-led assessments of the care environment (PLACE).

Requires improvement

Accident and emergency

- Staff and patients we spoke with were not aware of any public engagement groups or other initiatives whereby input from patients was sought to help improve the overall A&E experience.
- A higher than expected number of the public contacted us before, during and after the inspection to raise concerns about the trust's reconfiguration. Some of their concerns related to the distance between the trust's sites which meant people had to travel long distances with a reliance on an inadequate infrastructure. We met with public action groups, who voiced their concerns, which included the welfare of staff as well as patients.

Innovation, improvement and sustainability

- Services at the trust were restructured between December 2013 and May 2014 so that general surgery, emergency and high-risk services, along with orthopaedic emergency and high-risk services were centralised at Conquest Hospital. The trust's in patient paediatric ward is also at Conquest Hospital so ambulances conveying sick children are received at Conquest. Posters in the department's treatment area showed the plans for improvement to the ED. A capital bid was being considered by the trust development authority for expansion by December 2014. The general manager told us the improvements were scheduled to be completed within the financial year.
- Junior doctors we spoke with told us they were not currently involved in any ongoing audit.

Good

Medical care (including older people's care)

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

Information about the service

Conquest Hospital provides acute medical services in partnership with the trust's other district general hospital based in Eastbourne District General Hospital.

Over the last 18 months, the trust has undertaken a transformation process, with services being centralised at one or other hospital, rather than providing smaller units at each site. Centralisation of services has seen Conquest Hospital become the centre for general surgery emergency and high-risk services since December 2013, and orthopaedic emergency and high-risk services since May 2014.

The trust provides a range of inpatient services, including acute stroke (Eastbourne), respiratory medicine and medical day care services. At Conquest Hospital we visited, Baird, James, Newington, Wellington and Macdonald wards, the endoscopy unit the acute admissions unit.

We spoke with 16 patients and relatives, 43 members of trust staff, including domestic staff, porters, nursing and medical staff. We observed the delivery of care and assessed the division's quality assurance processes as well as its local leadership, staffing and performance against both national and internal measures.

Summary of findings

Medical services provided at the Conquest Hospital were judged to be good. Some areas within the directorate require enhancing to ensure services retain a rating of good.

Concerns in wider learning from infection control issues from the Eastbourne site.

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

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

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

We saw areas of good practice, such as the use of a wireless monitoring and recording system to provide real-time information across multidisciplinary teams and alert staff if a patient's condition deteriorated. The trusts own integrated patient care document provided a comprehensive overview of the patient and their needs enabling staff to locate information easily and build an understanding of the patient as an individual.

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

At ward level, every patient was treated as an individual, integrated patient care documents enabled

Good

Medical care (including older people's care)

assessments to be completed and care and treatment tailored to the individual. The document also provided staff with a comprehensive picture of the patient, their needs and their acuity.

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

The transformation process which the trust had gone through had left many junior staff feeling disenfranchised, if not by the changes themselves then by the pace of the changes. They did not feel that their views were listened to outside their own departments.

Are medical care services safe?

Good

Overall we found that medical care was good.

Staffing levels for nursing and clinical staff were in line with national guidance. Safeguarding processes were well embedded in practice and understood by staff.

Staff understood the incident reporting process and incident analysis was used to inform and aid learning amongst teams.

The hospital was clean and equipment and was well maintained and kept ready for use.

We had concerns regarding numbers and qualifications seniority of doctors on duty throughout the night.

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

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

Incidents

- Conquest Hospital had not recorded any Never Events. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Between April 2013 and May 2014 the trust submitted 8756 incidents to the National Reporting and Learning System (NRLS). Medical specialities accounted for around 30% of the total number reported. The trust in the top 25% of reporting organisations reporting 8.8 incidents per hundred patients, the national average being 6.79 per hundred. NRLS reports include the qualifying statement, "Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problem is". Incidents including serious incidents were recorded on the trust computer based

reporting system. We were told that incidents were discussed and formed the basis of local management meetings. Learning was shared across departments and cascaded to staff during team meetings.

- During the period April 2013 to May 2014 the trust reported a total of 96 serious incidents to the NHS National Reporting and Learning System (NRLS). Medicine had accounted for 47 of these serious incidents during the last twelve months, of which, 19 related to falls or trips.
- We reviewed three serious incident reports relating to unexpected deaths, we found that, in one endoscopy case, the death had been incorrectly recorded as unexpected when it was clear from the notes that the death had been expected. When we spoke with the endoscopy consultant it became apparent that the papers had been filed without any referral to the consultant who would have been able to identify the discrepancy.
- Prior to our inspection, we had looked at information which the trust provided as part of national monitoring of standards. It had been identified that the trust had a higher than average number of dermatology deaths. During our inspection, we looked at the records regarding these deaths; we found that inaccurate clinical coding had resulted in the high figures. Elderly patients with multiple problems were recoded as having died from cellulitis and coded as dermatology. We were told that, when patients are admitted to the hospital, an initial diagnosis is entered into their record. If a patient passes away at the hospital, the initial diagnosis was used to code the death against that department.

Safety Thermometer

- We saw that information about the NHS national Safety Thermometer was displayed on noticeboards on the wards for the information of staff, patients and visitors. The safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care.
- Information relating to falls, pressure ulcers, and infection outbreaks was displayed for the information of staff, patients and visitors.
- The Safety Thermometer is reported at trust level, the number of incidents has remained relatively constant throughout the twelve months to May 2014, with falls showing a slight increase. One matron we spoke with said that, while falls were still a problem, as a result of placing vulnerable patients together in a bay which was more visible and with a higher staff ratio, they had reduced the number of unwitnessed falls; this meant that people had been tended to more quickly, mitigating the effects of the falls. The use of low beds and falls mats had reduced injuries associated with falls.
- The figures illustrate that during the period the trust had performed better than the national average in terms of harm free care. During this period East Sussex Healthcare NHS Trust averaged 94.15% of harm free care against a national figure of 93.4%
- 'All harm' refers to all types of harm reported in the period including new cases. 'New harm' refers to incidents since the last report was submitted. During the period the trust reported an average of 2.99% of new harm against a national average of 2.76%; however for the same period the trust reported all harm at an average 5.85% against the national average of 6.6%. This suggests that the trust identify and report high numbers of new issues (New Harm), but deal with them effectively reducing the numbers overall (All Harm).

Summary Hospital-level Mortality Indicator (SHMI)

- The Summary Hospital-level Mortality Indicator (SHMI) provides details of patient mortality at trust level across the NHS in England. The SHMI gives an indication of whether the mortality ratio of a trust is as expected, higher than expected or lower than expected when compared to the national baseline (England). The number of deaths includes both patients who died whilst in hospital and those who died within 30 days of being discharged.
- The most recent SHMI statistics prior to our inspection were released in July and represent the twelve months January to December 2013. East Sussex Healthcare Trust during that period had a higher than expected ratio of patient deaths. Of 57786 patients a total of 2749 died in or within 30 days of being discharged from the trust. This produced a SHMI value of 1.127, where a figure of 1 would represent expected mortality rates.
- The Health and Social Care Information Centre who collate the SHMI data does recognise that there may be an impact of the present SHMI methodology on the SHMI value for integrated acute and community trusts. This is because activity from both acute and community sites at integrated trusts is included in the calculation of the SHMI.

Good

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- The trust had a dedicated infection control lead based at Eastbourne District General Hospital who oversaw issues both there and at Conquest Hospital. However, when we asked them about a serious incident which had occurred at Eastbourne District General Hospital, they told us they had not been made aware by the infection control team. This meant that in this instance the trust could not be satisfied that proper escalation and analysis of the issues had been completed.
- We observed staff using aprons and gloves when assisting patients, or providing care. We saw that fresh aprons and gloves were used for each patient. The trust had a policy of using differently coloured disposable aprons for patients in isolation. Staff explained that, while all aprons and gloves were disposed of after each use, the different coloured apron was a constant reminder that infection into or out of those areas was a higher risk and greater priority.
- Some side wards had been identified as isolation rooms; there was information on the doors of these rooms to remind staff and visitors about the additional precautions they needed to take.
- Hand cleansing gels were available at hospital and ward entrances and inside all clinical areas. Signs were positioned to remind staff and visitors to use the gel. Hand-washing instructions were displayed at wash basins. We observed staff using the gel and most visitors were seen to make use of it also.
- All staff we spoke with were able to describe the issues, benefits and methods of preventing and controlling infection.

Environment and equipment

- All the areas we visited during the inspection were clean and tidy. Some wards had limited storage space, but managed to reduce clutter and avoid trip hazards so that people were kept safe.
- It was noted by the inspection team that the medical wards, and hospital in general, had a very calm atmosphere. Staff were attentive but unrushed, which put patients at ease.
- We saw that resuscitation trolleys were well maintained. Logs were kept with each trolley, which showed they had been checked by staff.
- In the hospital medical equipment maintenance department, staff we spoke with told us that the hospital technician responded quickly to any requests for repairs or replacements. Equipment such as specialist beds were available for loan from the hospital library store.
- The Macdonald Ward, which cared for elderly patients with dementia and other complex needs had, over a period of time permanently replaced most of its standard hospital beds with specialist beds, which meant people's needs could be met as soon as they arrived on the ward, rather than needing to source and replace beds on an ad hoc basis.

Medicines

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

Records

- The service used a combination of paper and electronic records systems.
- A high volume of the patients who used the hospital were elderly, some of whom had needed a great deal of support from health services, this resulted in them acquiring enormous sets of medical notes. When a person was admitted to the hospital all their medical notes were transferred from storage to the ward or department for the doctor and other clinical staff to refer to. Ward managers and clerks complained that this caused difficulty in ensuring notes were kept together, secure and safe. The removal of these from trolleys also represented a health and safety risk, due to the weight of some bundles. We were told that historic records were being scanned into the electronic system, but this was an ongoing process.

- We saw that the trust had introduced an 'integrated patient care document' this consisted of a 36-page booklet, which led staff through all the key information and considerations that they needed to complete with every patient. Sections were included on the front cover relating to the Mental Capacity Act 2005, and to the resuscitation status of the patient. This meant that all clinicians could see quickly and clearly what issues the patient might have which could complicate their treatment, or affect their care.
- Consultant's notes were produced on coloured forms, which were attached to the booklets. This enabled staff to locate any specific instructions about the patients' care quickly and easily.
- The integrated care documents contained risk assessments, which we saw had been completed when patients were admitted to the ward. Staff we spoke with described how risk assessments were updated if circumstances changed; reviews were conducted if patients remained in the hospital for long periods. This was evidenced in what we saw in the notes.
- Some patients had forms attached to their records which identified that they did not wish to be resuscitated if this treatment became necessary. This is referred to as a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) form. We saw that the forms were completed correctly and there was evidence of the involvement of family, patient and clinicians in the decision-making process. The forms were either completed by, or countersigned by, consultants.
- We saw that a nationally recognised quality tool for the recording of information known as Situation, Background, Assessment, Recommendation (SBAR) was being used. The information is used to assist in the safe transfer of patients, ensuring specific information is available in a set format. When we checked records we saw that SBARs had been fully completed for only six out of 16 patients, in a second area, we found only one out of ten records checked contained all the required information. This meant that staff receiving the patient might have to make additional enquiries about the patient in order to ensure appropriate care was given.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

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

Safeguarding

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

Mandatory training

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

Good

Medical care (including older people's care)

Assessing and responding to patient risk

- We saw how the integrated patient care documents were used by staff to identify risks to individual patients. Where risks were identified, intervention were put in place to mitigate or remove the risk. We saw how patients who had been identified as being 'at risk' of falls had the use of specialist beds, which could be lowered so that the patient lay very close to floor and if they tried to get out of bed unassisted, they would not fall great distances and injure themselves.
- Patients who needed a higher degree of attention and monitoring were, where possible, grouped into the same bays or areas so that staff had a clear view of them and could respond more quickly if required. One member of staff said, "I can't say we have less falls by grouping people together, but we have less unwitnessed falls."
- Staff on all the wards we visited had either undertaken, or were due to complete, dementia awareness training and there were Dementia Friends Champions throughout the trust who had undergone additional training and supported their colleagues.
- The hospital had a dedicated discharge lounge; however, staff in some areas explained that, where the patient to be discharged had dementia or might be adversely affected by being moved from the ward before going home because of the change in environment and unfamiliar staff, they would be discharged directly from the ward.
- The VitalPAC wireless system acted as an early warning system, alerting clinicians and nursing staff, as appropriate, to any unexpected changes.

Nursing staffing

- We found that the numbers and skills mix of staff on the wards was very good; meeting, and in most cases, exceeding national guidelines.
- Staff absences were covered by a combination of ward staff working additional hours and bank (overtime) staff being brought in. Bank staff are trained staff who are employed by the trust to provide cover in these circumstances. Using bank staff provides a degree of continuity for patients and for regular staff. If neither ward staff, nor bank staff are available, the trust will use agency staff.
- We were told that, if additional staff were required above the planned establishment, for instance, to provide one-to-one care of a patient, this was usually authorised and arranged quickly. Some out-of-hours cover could be difficult to arrange, not because of authorisation, but due to the availability of people willing to attend. In such cases, we were told that one-to-one cover was provided, but at the expense of the rest of the ward.
- Staff used a number of methods to assess and monitor patients in their care. Nationally recognised pathways of care were followed.
- Nursing staff and healthcare workers had access to the trust VitalPAC system. The NHS Technology Adoption Centre (NTAC), who recommended the system, describe VitalPAC as a clinical software system, which allows clinicians to use handheld devices such as an iPod Touch to record inpatient observations (such as pulse, blood pressure and temperature) at the bedside. The system uses the data input to calculate a national early warning score (NEWS) and a measure of risk for each patient. The system uses these scores to alert relevant staff to patients who may be deteriorating, as well as recording when the next set of observations should be taken, according to the patient's individual level of risk.
- Clinical staff can access patient observations from any computer, tablet, PC or mobile device with access to the hospital network.
- We did not witness a staff handover during our inspection; however, staff we spoke with described the process and had a clear understanding of the system. We saw patient boards on all the wards we visited. The boards were set out to show each bed and were colour coded to identify which consultant each patient was under. Other information was also displayed on the boards regarding individual risks as a reminder to staff.

Medical staffing

- Some services, because of their nature and frequent use, had remained as cross-trust services. Out-of-hours consultant cover was provided through a system of 'consultant of the week'. However, not all consultants, in all disciplines had agreed to provide cover other than at their own site. Nursing staff told us that some consultants who provided cover appeared to show a preference for their own patients, spending more time with them than others, although this had not been documented and could not be evidenced. None of the patients we spoke with complained of not having access to a consultant or doctor.

Good

Medical care (including older people's care)

- We had concerns regarding the numbers and seniority of doctors on duty throughout the night. We were shown evidence that only two junior doctors were available to cover the whole site. This included all the medical wards and the A&E department. This could potentially leave patients at risk if both doctors were committed. Not all junior doctors saw this as a concern but some felt more senior doctors with more experience on hand for advice would speed up diagnosis and improve patient flow and safety.
- Since the inspection the trust had clarified that there is a medical senior registrar and a medical senior house officer resident on call supported by a consultant who was on call from home. The medical night team also includes surgical, paediatric and anaesthetic resident doctors on call. In addition, the critical outreach team is available 24/7.
- We found that the skills mix of medical staff was good. The trust had slightly less consultant cover than the England average, at 36% compared to 38%, and a higher proportion of middle-grade doctors at 19%, compared to 9%. This meant that, overall, the trust had a larger number of less experienced doctors being supervised and mentored by fewer senior doctors. However, the level of competence, knowledge and understanding of doctors did not give cause for concern.

Major incident awareness and training

- Most staff had a good understanding of the trust major incident plans. They were aware of how to access the plans and what their role would be or who would be responsible for directing them.
- Part of our inspection plan had included inspecting Tressel Ward. When we arrived at the ward we found that it had been closed. We were subsequently advised that, following the recent transformation, Tressel Ward had been set aside to act as a winter pressures ward. This meant that the ward was maintained, ready to accommodate any increase in admissions over and above what the other wards could accommodate. When we spoke with the specialist medicine management team they told us that, while the ward was available, they were unsure how it would be staffed if it needed to be opened. They anticipated that agency staff would be required, but stated that it was not desirable to have a ward staffed wholly by agency. They understood the details were being finalised.

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

Good

Medical care services were effective.

Patients were cared for by qualified and skilled staff who used and understood nationally recognised pathways of care and followed National Institute for Health and Care Excellence (NICE) guidance.

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

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

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

Peoples' health was continually monitored using a combination of conventional and technologically-advanced equipment.

Evidence-based care and treatment

- Care and treatment were based on nationally recognised, evidence-based pathways and in accordance with NICE guidance.
- Audits were completed of procedures in all areas of the service. Not all audits were completed with, or reviewed by, doctors. We saw that an endoscopy 30 day mortality rate review had been completed by a staff nurse. Some of the information in the review did not appear to have been the subject of in-depth analysis.
- Further enquiries revealed that nurses on the unit complete a total of 38 individual reviews throughout the year. The nurses who complete the reviews do not have any formal training in how to complete them.
- Staff used a combination of conventional monitoring and recording of their patients' condition using the East Sussex Healthcare NHS Trust integrated patient care document, combined with a state of the art wireless monitoring and recording system, which enables trust-wide access to real-time information across multidisciplinary teams.

Pain relief

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

Nutrition and hydration

- Patients we spoke with told us they enjoyed the food they received. They said they had plenty of choice and could change their mind if they wanted to. When we spoke with one of the matrons, they told us that the provision of meals had changed. Previously, they had had individual dishes and were able to serve people exactly what they wanted, whereas now, the meals were already plated and just needed heating on the ward. They told us that some patients were unable to remember what they had asked for and when their chosen meal was provided they would reject it. They said they could always find an alternative, but it had been easier to please people prior to the new system. They told us that from a ward perspective the new system was no faster or easier than the previous system.
- Some people required there food mashed or pureed. The matron explained how mashed and pureed foods were presented on the plate to resemble their original form and colour, for instance carrots were pureed and them piped onto the plate in the shape of a carrot, this meant that the food looked appetising and familiar, which encouraged patients to eat.
- We saw that patients who required assistance to eat were highlighted on the ward boards as a reminder to staff.
- People were encouraged to drink fluids and we saw juice and water at most of the beds. Hot drinks were available on request. Patients told us that the nurses and healthcare workers were always encouraging them to drink.
- We observed people being assisted to drink where they were unable to manage for themselves.

Patient outcomes

- The national audit in relation to stroke patients, the Sentinel Stroke National Audit Programme (SSNAP), aims to improve the quality of care for stroke patients. Conquest Hospital does not have a stroke unit, the service was centralised at its sister hospital Eastbourne District General Hospital. SSNAP data shows a national average of 58.1% of stroke patients being admitted to a stroke unit within four hours of their clock starting during the period October to December 2013. A person's clock is deemed to have started when they first arrive at the hospital, or in the case of patients who suffer a stroke while in hospital, the onset of their symptoms. The trust rate of admissions within four hours for the same period was 77.7%.
- For the period January to March 2014 the national average had fallen to 57.8%, while the trust figure had improved further to 80%.
- Similar above average figures were achieved respecting the proportion of patients who spent the majority of their stay on a stroke unit, and the proportion of patients scanned within an hour.
- The Myocardial Ischaemia National Audit Project (MINAP) collects performance data from hospitals in relation to heart attack patients. We were shown data from the audit in relation to Conquest Hospital and its sister hospital at Eastbourne District General Hospital. We needed to consider the figures at trust level to see the impact which centralising services had provided. We saw that, by 2013/2014 trust-level performance had improved. For example, in 2011/2012, the England average for patients receiving treatment within 90 minutes of arrival was 92%; Conquest Hospital was below average at 89.7% and Eastbourne District General Hospital was below average at 89.4%. By 2013/2014 the combined trust percentage was 91.05%, some 1.65% above average.
- Figures for treatment within 150 minutes over 2011and 2012 were: England average 82.4%, Conquest Hospital better than average at 85.7%, and Eastbourne District General Hospital higher at 86.4%. By 2013/2014 the England average had fallen to 82.3%, while the trust average was 84.7%.
- The British Cardiovascular Intervention Society list Conquest Hospital in their 'excellent' category for completeness of data.
- Performance data also shows how improvements have been made at discharge with an appropriate care score of 93.8% against a sector average of 72%. One area where significant improvement had been measured was in discharge instructions. In 2010, the trust scored only 14.29%, whereas the figure at the time of the inspection was 93.75%. This had been achieved by the introduction

of a transfer of care document, which is used to provide all discharge information for the patient and for other healthcare professionals. The service also followed-up discharged patients with their 50:50 nurse. These are nurses who spend 50% of their time in the hospital and 50% visiting patients in the community, providing educational and psychological support to patients and their relatives.

- The National Diabetes Inpatient Audit for 2013 showed that Conquest Hospital performed better than the national average in most of the audited areas. However, as part of the transformation of the trust, diabetic services had been centralised at Eastbourne District General Hospital.
- We found that patients were assessed on admission and an estimated discharge date was determined in relation to their condition and personal needs. The demographics for East Sussex show that the population has a higher than average number of elderly residents. The region also has five of the top twenty deprived areas in the country. These factors both have an impact on the recovery of patients following injury or illness, which, in turn, is reflected in the length of stay which some patients face. Despite the difficulties with the demographics of the area, the overall length of stay was in line with the national average. Staff explained that the initial estimate of discharge could change depending on a patient's recovery rate, and where changes were made these were fully discussed with patients and relatives so that they understood the reasons. This was confirmed by people we spoke with. We observed staff on one ward liaising with social services regarding the discharge of a patient and arranging for an assessment to be completed for home care on their discharge. On another ward, we were present when a care home manager attended to complete an assessment of the needs of a potential resident to ensure the home could meet the person's needs.
- Standardised relative risk of readmission to Conquest Hospital was below average in most target areas, gastroenterology and cardiology being the exceptions.

Competent staff

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

Multidisciplinary working

- We saw evidence of multidisciplinary working throughout our inspection.
- Ward meetings were held on the wards each day to discuss any new patients or changes in condition of existing patients.
- One example of excellent multidisciplinary working had been introduced following analysis of a serious incident. A patient had been receiving inappropriate treatment, which, it was identified, could have been avoided had the endoscopy department been involved in the diagnosis. The trust policy is now that any tumour of 1cm in size is discussed at the multidisciplinary teams meetings to ensure all options are fully considered.
- The trust had introduced systems with the local ambulance trust to ensure that patients are taken to the appropriate district hospital in relation to the centralised services.
- Occasionally, patients have to be transferred between hospitals. This can occur when an initial diagnosis suggests one condition, but, on arrival, at the relevant assessment unit they are found to have a condition covered by a discipline which is based at the other hospital. Staff told us that such transfers were completed by ambulance. Best practice would require a

doctor to accompany the patient; however, these transfers were completed by the paramedic ambulance staff, as there were insufficient doctors available to allow one to complete the transfer.

Seven-day services

- Both Conquest Hospital and Eastbourne District General Hospital have EDs which are open seven days per week. Consequently, the assessment units and wards receive patients throughout the day and night, every day of the week. Consultant cover out of hours is provided on a shared basis and the trust has a consultant of the week who can be called to either site. We were told that not all consultants had consented to provide cover. However, there were sufficient consultants on the rota to provide cover.
- We were concerned by the number of doctors available in the hospital in the evening and overnight. We found that cover consisted of one junior doctor and one registrar for the whole hospital. This meant that, during busy periods, patients may have to wait to be seen by a doctor.
- Consultant presence on wards was good. The visibility of all doctors and consultants had improved as a result of the transformation changes which had taken place, reducing overall bed numbers and centralising some departments had increased the time available for doctors of all levels to spend time with patients. Nursing staff told us that they had seen an increased presence of doctors and observed that doctors had been able to spend more time with each patient.
- One consultant we spoke with was concerned about the financial implications of providing services seven days per week on a budget that had been set based on a five-day week. They told us that, realistically, they needed a 35% uplift in funding to pay for additional hours of specialist staff.

Are medical care services caring?

Good

Medical care services were caring.

All the staff we spoke with (cleaner's, technician's, doctors, nurses and healthcare assistants), conveyed a real passion for their work and believed they were providing the best care they could for the people of East Sussex.

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

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

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

Care and treatment were delivered in a way which protected peoples' dignity and privacy.

Compassionate care

- We spoke with a number of patients and their carers or family members during our inspection. We received unanimous praise for the care people had received. Nursing and healthcare staff were said to be "brilliant, incredible, wonderful" and many other complementary accolades. Patients told us that they were seen quickly, and knew which staff were looking after them. The Cancer Patient Experience Survey 2012/2013 confirmed these comments; out of the 34 criteria measured, the trust was in the top 20% of all trusts in ten areas, and in the bottom 20% for only one area relating to the degree of privacy afforded to patients.
- People told us that their privacy was respected. If clinicians wanted to speak with them in bay areas, curtains were drawn and voices lowered. People told us that they expected a loss of privacy in these circumstances, but they believed they could ask for a private consultation if they felt this was necessary. Staff confirmed that if a patient requested a private consultation they would accommodate this in a side ward or office. None of the patients we spoke with had considered they needed to do this.
- Patients told us that staff respected their dignity, any personal care or treatment was carried out with curtains drawn or if in a side ward with the door closed.
- We were able to speak with one patient who had experienced previous stays at the hospital. They confirmed that the care, treatment and the friendliness of the staff had been just as good on each visit.
- We did receive two comments to the effect that some doctors had displayed a degree of arrogance towards

patients. One patient commented, "They have a 'you can wait for me' attitude." However, the majority of people we spoke with were as complimentary of the doctors as they had been of the nursing staff.

- Patients at Conquest Hospital are asked to comment on the care they receive using the national NHS Friends and Family Test. This asks patients to comment on whether they would recommend the service to a friend or relative who had to have the same or similar treatment to themselves. We saw records on some wards which scored over 80% satisfaction rates.
- Patients were able to enter their responses to the NHS Friends and Family Test directly into the system using iPads, which were available on the wards. There were also comment cards available for those who preferred to write their responses.
- The trust do receive a higher than average number of complaints for its size, although the numbers of complaints have fallen over the last two years. Full analysis of the reduction has not been completed, but the consensus with staff was that waiting times had reduced and care was more person-centred now than it had been previously, and that these factors had made the patient experience more pleasant.

Patient understanding and involvement

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

Emotional support

- We spoke with a relative of a patient who had been admitted to the hospital following a fall. The relative explained how they had been out of the country when their relative was taken ill. They had been supported by staff on the ward, who had provided regular updates and had "bent over backwards" to provide support to both their relative and them. One issue had been that the phones available to patients did not receive international calls. Staff had arranged that at set times of the day when the area would not be busy, the patient could be brought to the nurse station and was able to receive calls from their relative. We were told how this had helped reduce the anguish of not being there with their relative.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Medical services were responsive to people's needs.

The trust had undergone a transformation process over the preceding 18 months, which had seen many services centralised. These changes had been effected under public scrutiny and independently verified as being in the best interest of local people.

Good

Medical care (including older people's care)

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

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

Use of the VitalPAC wireless system reduced the likelihood of recording errors and provided automatic warning of unexpected changes, or deterioration in health. Alerting the relevant clinicians and enabling speedy response and re-assessment of care.

Service planning and delivery to meet the needs of local people

- The trust has, over the last 18 months, undergone a massive transformation process. Many services have been centralised. The proposals were reviewed by external stakeholders and independent analysts, including the East Sussex Health Overview and Scrutiny Committee (HOSC) who agreed that the proposals were in the best interest of patients.
- At a local level, medical services at Conquest Hospital are tailored to meet the needs of individual patients. Multidisciplinary team meetings take place on the wards and teams prioritize their work according to the acuity of patients.
- Wards displayed bed allocation using colour coding to identify the consultant for each patient and additional information to remind staff of individual issues for that patient.
- Wards displayed charts showing the uniforms of the different staff that patients might expect to see. Staff wore lanyards with identification badges, the lanyards were colour coded and had the wearer's position or job title embroidered on. Staff told us that this had been really well received by patients who could understand what a person's role was and, therefore, had a better understanding of what was happening around them.
- Medical outliers were reviewed at trust level. Medical outliers refers to incidents where patients are not treated on wards most appropriate to their needs, but are accommodated in other wards. A consultant had responsibility for reviewing circumstances where this occurred in the trust and reported directly to the trust board.

Access and flow

- On admission to hospital an integrated patient care document is produced. This document itemises all the information about the person, their condition and includes personal information, which can assist staff in understanding the person's preferences and needs.
- Different pathways existed for patients admitted to the hospital, dependent upon the specialty concerned. We saw that individual specialities followed national guidance and NHS patient flow guidance. Staff told us that centralisation of services had made pathways to care easier for those specialities. Occasionally there had been issues with patients arriving at one location when the specialist treatments were based at the other hospital. Patients received appropriate treatment at the hospital they attended but where patients were admitted this led to transfers being required to house patients on the specialist wards. We did not see any statistics regarding the number of transfers.
- In addition to the two acute hospitals, the trust managed a number of smaller hospitals and community services, which enables patients to be discharged from the acute hospital while still receiving appropriate support outside the hospital.
- NHS England statistics on bed occupancy between April and June 2014 showed that across the trust bed occupancy had been at 77.6% against a national average rate of 88%. Healthcare information firm Dr Foster, says that when occupancy rates rise above 85% "it can start to affect the quality of care provided to patients and the orderly running of the hospital".
- Prior to the recent reorganisation bed occupancy had been below 85% since the latter part of 2013.
- Conquest Hospital worked closely with the trust's community-based services and with local GP services. In common with Eastbourne District General Hospital, GPs had access to test and diagnostic services at the hospital through direct referral. Community health framework meetings are held with stakeholders.
- Referral-to-treatment times were, in most instances, in line with, or below, national averages.

Good

Medical care (including older people's care)

Meeting people's individual needs

- We saw many examples of how peoples' individual needs were met during their care and treatment. We saw rise and fall beds in use for people who were prone to falls. We checked their records and saw that full assessments had been completed and the reasons documented as to why they needed this support. We saw specialist mattresses and beds being used to prevent vulnerable people developing pressure sores.
- We saw how each person was assessed on admission and comprehensive details were recorded in their integrated patient care document. The document covers all aspects of the patient's mental and physical health, their ability to understand and communicate and both their current and underlying health issues. Risk assessments form part of the body of the document and detail the individual risks to that person and guidance on interventions to reduce the risk.
- We observed staff using the VitalPAC wireless system to record information directly into the patient's medical records. This meant that recording errors from illegible writing or incorrectly completed charts were virtually illuminated. Staff showed us how the system could be interrogated to show charts and graphs over time, which enabled clinicians to monitor a person's health. The system was accessible from any computer terminal in the trust. The system also had built in alerts if readings were outside expected parameters, enabling speedy response and re-assessment of care.
- We did not encounter any patients with complex needs during our inspection. A matron we spoke with described the process on their ward when they have such patients. They told us that, where possible, side wards were used and, if required, additional staff could be requested through the head of nursing. Carers were encouraged to be involved with patients with complex needs to provide familiarity and continuity.
- East Sussex Healthcare NHS Trust has a diverse population and translation services are available to people whose first language is not English. Initially, staff will attempt to find a colleague or make use of patients family members who can translate, but if this is not possible telephone translation services are used to ensure people understand and are understood.
- East Sussex is recognised as a desirable location for retirement and attracts large numbers of people to the area to settle. This, combined with the increase in life expectancy, means that the area has an above average number of people who present with conditions associated not exclusively, but largely, with ageing. This includes dementia.
- Conquest Hospital has a dedicated ward, which is staffed by nurses and healthcare workers who are trained and skilled in dealing with elderly people and their needs. We spoke with a number of patients on the ward and with relatives. They all believed that the care and support they received was excellent. The matron described how patients on other wards who may have been admitted for other reasons would often be transferred to their ward when their condition had improved as they were recognised as being able to meet people's needs better.
- We were also told that patients with advanced dementia were often discharged direct from the ward rather than from the discharge lounge. This was done to prevent anxiety, as the patients could not cope with staff and an environment that was strange to them.

Learning from complaints and concerns

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

Are medical care services well-led?

Good

Medical services were well-led at local level.

Staff felt supported and able to approach their immediate supervisors or managers.

Good

Medical care (including older people's care)

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

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

Vision and strategy for this service

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

Governance, risk management and quality measurement

- Services were well run and staffing levels and skill mix were constantly reviewed. We did not attend a staff handover session but managers described the process of assessing the acuity and needs of patients on the wards and ensuring staff were made aware. Staff confirmed the process and we were shown how bay notice boards were used to display information as a constant reminder to staff of people's needs.
- We saw evidence in the form of minutes of meetings, which showed that regular team and management meetings took place. We saw how these meetings had been used to share information about complaints and incidents but also to share good practice and positive feedback.
- Staff understood their role and function within the hospital and how their performance enabled the trust to reach its goals.

Leadership of service

- Leadership at service level is very good. Staff told us that they were supported by their managers and department heads. Senior managers, matrons and heads of departments met regularly. Issues which required escalation were taken forward to the board and board-level issues were cascaded back down. All the staff we spoke with supported the visions of making services safer and better for patients; however, not everyone believed the trust was achieving its aim. Many staff, including consultants, were concerned about the cuts to, and centralisation of, administrative roles.
- We saw evidence of nursing numbers and skills mix being reviewed regularly. Wards had strong leadership from matrons and the director of nursing was well known to staff and seen in clinical areas.

Culture within the service

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

Public and staff engagement

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

Good

Medical care (including older people's care)

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

Innovation, improvement and sustainability

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

Inadequate

Surgery

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

Information about the service

East Sussex Healthcare NHS Trust provides care to a population of 525,000 people and is one of the largest healthcare organisations in the country. The recent service reconfiguration saw some of the acute hospital services moved from the Eastbourne District General Hospital to the Conquest Hospital site in Hastings. The trust's surgical department offered specialist surgical services across multiple sites. This included the Conquest Hospital, Eastbourne District General Hospital, Lewes Victoria Hospital and Bexhill Hospital.

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

Summary of findings

Our inspection identified concerns relating to the under-reporting of clinical incidents within the surgical department. We found a disparity in staff competence relating to the emergency equipment checks and a lack of consistency and continuity of the checks, which demonstrated that best practice guidance was not being followed. We found the approach to specialty-specific mortality and morbidity reviews was not consistent. In some cases, the review meetings were firmly embedded in practice and in other specialties the reviews had not taken place for at least six months.

We identified concerns with medication management within the surgical department and subsequently included a specialist pharmacy inspection in our unannounced visits. Our observations and conversations with staff revealed that the trust's infection control policy was not being adhered to. This was evident in all surgical departments throughout the trust, but was most evident in theatres and on a ward round and involved staff working at all levels and disciplines throughout the trust.

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

We identified insufficient staffing levels in most of the surgical areas, with the main theatres and the surgical assessment unit being the worst affected areas. Most

surgical areas declared a deficit in their staffing levels and skills mix, which was being permanently managed through the use of bank (overtime) and agency staff or by regular staff working extra shifts.

Agency staff were unfamiliar with incident reporting. They told us they could access the IT system to make a report but when asked to demonstrate this they were unable to do so. Trust policy states that incident reporting is covered during a departmental induction; however, there was no documentary evidence that these inductions had taken place. Staff we talked with assured us that induction records would be put in place with immediate effect. The Trust was also found to lack oversight of long term agency staff training, appraisals or monitoring of their learning needs.

We identified that the workforce were dedicated and committed to delivering quality care to patients. However, we noted that staff were exhausted and under enormous pressure to deliver safe care, in spite of chronic staffing shortages and the challenges of recent service reconfiguration and senior management changes. We found that the staff shortages meant there was little time for staff to adhere to the trust's policies and procedures. For example, when it came to: incident reporting, mandatory drug checks and emergency equipment checks. We observed the nursing care was task orientated. It was not individualised or holistic in its approach because of the unrealistic demands placed on staff to manage on low staffing levels, poor skills mix and an unpredictable, transient workforce. The NHS staff survey demonstrated very low staff morale and high staff sickness levels at the trust.

The trust had initiated some incentives that had the potential to makes services more effective and responsive to patients' needs. An example of this was the nurse-led admissions in surgical assessment unit (SAU), nurse-led discharges and the introduction of advanced practitioners who had specific skills to support the surgical services. However, there was a lack of quality assurance measures in place to monitor these incentives. This meant that we could not be sure the measures taken by the trust had improved the quality of service delivered to patients. We saw the introduction of VitalPAC (a clinical software system), which is a valuable tool to monitor deteriorating patients. However, this was not always effective, as the trust relied heavily on agency staff who could not always use the device as they did not have log-on access.

We found all the clinical areas we visited to be clean and tidy, with cleaning records available to view. There was an ample supply of personal protective equipment (PPE) available for staff to use while delivering clinical care. We found that the department supported the development of advance practitioners, who were trained to undertake specific tasks to support clinical care.

The staff who worked at the trust were found to be caring and delivered care that promoted patients' dignity and respect. We found the anaesthetic mortality and morbidity was very well attended, well-structured and facilitated learning. Consultants had their ward rounds embedded into their job plans. Staff on the surgical ward phoned patients who were discharged to review their progress.

Inadequate

Surgery

Are surgery services safe?

Inadequate

We have judged safety in surgery at the Conquest Hospital inadequate. We have concerns relating to incident reporting, the checking of emergency equipment and medicine management in the department and learning from incidents or performance measures.

There is limited measurement and monitoring of safety performance. We identified under-reporting of incidents within the surgical department. This meant that incidents, errors and near misses that occurred in the service were not being learned from and the risk of recurrence was not being reduced. We found an inconsistent approach to mortality and morbidity reviews and noted the general surgeons had not held a review since Jan 2014. There was evidence that not all incidents were not being reported, and therefore were not being learned from. We acknowledged that learning from falls poor pressure areas care was addressed appropriately.

We found a varying degree of understanding on the checking process for emergency equipment, in particular the trolleys carrying medicine and equipment for use in emergency resuscitations. The trust's 'bare below the elbow' infection control policy was not being adhered to by all grades of staff across all surgical departments and the staff we spoke to demonstrated an inconsistent understanding of the trust's infection control policy. We identified several other breeches of the trust's infection control policy during the inspection. For example, we had concerns about inadequate storage for contaminated operation sets and general waste in main theatres.

We identified concerns with controlled drugs (CDs) signed out for patient use with a lack of consistent daily checks across the surgical department.

Wards we visited did not have suitable areas for staff to prepare intravenous (IV) drugs. We saw staff preparing IV medication beside the nurses' stations/desk areas where they were constantly distracted by telephones ringing, patients and visitors and other members of staff requesting their assistance. This increased the risk of medication errors and was poor infection control practice. We reviewed a number of medication charts and identified several medication errors on each chart, ranging from low to moderate in severity. This raised concerns about the effectiveness of quality assurance relating to medication recording.

We also identified a disparity in different clinical areas relating to the checking of medication fridge temperatures and could not see evidence that medication was being stored at the recommended temperatures.

Compliance with the 'five steps to safer surgery' guidance was being audited regularly by the department and the records demonstrated good compliance rates. However, we questioned the robustness of the audit as there was no documentary evidence of the debriefing stage being implemented.

The areas we visited during the inspection appeared clean and Safety Thermometer data was displayed in public places for patients and relatives to view.

Incidents

- The trust had an electronic incident reporting system to aid the reporting of incidents. Permanent nursing staff were able to give us examples of how to report incidents, for example, incidents relating to pressure damage to skin and falls.
- During our inspection, we were told of numerous incidents that staff had not formally reported. Staff told us the reasons for the under-reporting included: low staffing levels, lack of feedback and learning from incidents and in some areas, a lack of computers to enable reporting. We also identified a disparity amongst support workers who did not report incidents, but relied on escalating their concerns to the person in charge, with an expectation that they would report the incident.
- Agency staff we talked with during the inspection told us they would report incidents on the electronic reporting system. When we asked them to demonstrate this they were unable to do so. Whilst we acknowledge the trust policy indicates that temp staff do not have access to the IT infrastructure and learn about the incident reporting process during their induction, no induction records were available to demonstrate these induction had taken place.
- Medical staff did not always report incidents. Some doctors we spoke with told us they did report incidents, while others perceived it to be a nursing responsibility.
- Throughout the inspection, we encountered different rationales for the under-reporting of incidents. We

witnessed the difficulty staff faced when short staffed in clinical areas, as their focus was on meeting patients' clinical demands, which took priority over incident reporting. We found staff felt disconnected from the importance of reporting issues because they did not receive feedback from incidents, or they felt that nothing changed as a result of reporting.

- We attended nursing handovers during the inspection and identified several incidents that should have been reported as incidents. For example: three patients had episodes where their medication had been missed because it was either not available or because of a prescription error. One patient who became critically ill during the night fell in the bathroom. Three patients were unexpectedly transferred from Eastbourne District General Hospital with no prior warning given to the ward staff, who were already struggling with a high level of patient acuity. This increased the demands on the already short-staffed team. We also learned that one patient admitted on the previous day had spent several hours in a treatment room because the ward did not have a bed available. These incidents had not been raised as incidents and reported. We also found other examples of incident under-reporting, such as a patient who received the wrong drug prior to surgery. Staff were aware of the error, but the incident was not reported on the trusts electronic reporting system. This was brought to our attention by the patient and his relative.
- ESHT policy suggested that medication omitted for a non-clinical reason is not reported via the incident reporting tool unless significant harm has occurred. However, In light of the serious concerns identified with medication management by the inspection and our concerns which identified a possible trend with missed medications resulting in mild to moderate severity, the trust may wish to revise its policy to improve and monitor its compliance with medication regulation.
- The trust reported nine serious incidents on the Strategic Executive Information System (STEIS) between 2013 and 2014. We noted that 55% (five out of nine) of the STEIS reported incidents were related to falls.
- There were no 'Never Events' reported in the last six months. A 'Never Event' can be defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
- We found evidence that incidents relating to falls and pressure area care were appropriately investigated and that the results from the investigation were fed back to staff and learned from. However, we were concerned that the culture of reporting and learning from other reportable events was not robust enough to ensure incident avoidance in the future.
- We found inconsistent approaches to mortality and morbidity review meetings. Mortality and morbidity meetings were established across the NHS to review deaths as part of professional learning and to provide the hospital board with the assurance that patients were not dying as a consequence of unsafe clinical practices. We were told that mortality and morbidity data was discussed at clinical governance meetings, but the minutes of these meetings did include details of the reviews at clinical unit level.
- We attended a mortality and morbidity meeting held by the anaesthetics department. This was very well conducted, with excellent attendance.
- However, the general surgery team had not had a mortality and morbidity review meeting since January 2014. This was not in line with national guidance or best practice recommendations.
- We reviewed the surgical registers held in theatres and found that they frequently were not signed with two signatures to indicate a completed swab count had occurred. However, during our inspection, we observed the theatre team undertaking a swab count at the end of a procedure, which did reflect best practice.

Safety Thermometer

- All clinical areas participated in Safety Thermometer reporting and those we visited displayed the information for patients and members of the public to see.
- Staff told us about the rationale and importance of collecting information for the Safety Thermometer and could discuss how it was used to improve the service delivered.
- The data we viewed included ward cleanliness, falls, pressure areas, MRSA & Clostridium difficile infection rates.
- There was some confusion about whether the board should display the infection rates, such as Clostridium difficile (C. difficile) and MRSA data for the whole hospital or just the individual ward areas.

Cleanliness, infection control and hygiene

- All the clinical areas we visited were cleaned to a high standard.

- Cleaning records were in place and with curtains changes recorded in line with the Trust policy.
- There was an ample supply of personal protective equipment (PPE) available for staff. We observed this being used appropriately in clinical areas.
- We noted a lack of clarity amongst staff regarding the trust's 'bare below the elbow' policy. We observed numerous staff in all positions and from every staff group in clinical areas not adhering to this infection control policy. We spoke to these individuals and found there was a lack of clarity and understanding about the policy.
- There were other examples of the non-adherence to infection control measures, including: staff wearing cardigans, full business suits and watches in clinical areas. We observed a consultant perform a digital rectal examination without washing their hands, a ward round where the team relied on hand sanitising gel only and did not wash their hands, a surgeon scrubbing up who did not use the correct technique. We acknowledge that hand sanitising gel was used, but it is not considered an alternative to hand washing.
- The trust collected hand hygiene data that demonstrated good compliance and adherence to national guidance. However, we are not confident that the audit reflected the poor hand hygiene practice we observed during our inspection.
- We noted that the trust's surgical site infection rates were reported nationally and were available on the NHS Choices website. It was unclear how the trust's general surgical site infection monitoring was undertaken, however, we noted that the orthopaedic specialty reported their infection rates regularly.
- We identified a concern relating to the storage of contaminated theatre waste outside an orthopaedic theatre. This potential risk was included on the trust's risk register. Adding this to the trust register did not mitigate the potential risk to patients. We identified this as a historic problem and found little action had been taken in an attempt to address the risk. This was not indicative of a safe culture.
- We observed theatre teams preparing surgical trolleys for surgical procedures. This was found to be a thorough process and reflected national guidance.
- Patients had their MRSA status checked at their preoperative assessment so that their status was identified before admission.
- We saw patients who had been isolated due to an infection being identified and witnessed. We saw that staff took the appropriate infection control precautions in this instance.

Environment and equipment

- We noted a potential health and safety concern relating to the ward areas in the Conquest Hospital where plugs were fitted in very close proximity to the sinks. Technical guidance for electrical fittings near sinks (2012) suggests: a standard electrical fitting (which is not splash resistant), should not be located next to a sink or drainer where it could be affected by splashing.
- We did a review of the equipment checks in the clinical areas we visited. In particular, the emergency equipment, such as resuscitation trolleys and defibrillator machine checks.
- We found there were discrepancies in the frequency and understanding of the checking procedures for the emergency equipment.
- An NPSA (National Patient Safety Agency) report recorded an incident on the 27/06/2014 resulting from the lack of emergency equipment to deal with an emergency situation. It states "the trolley did not have the intubation equipment".
- Junior staff were competent in completing a defibrillator check, but each clinic area undertook the checks at different frequencies.
- We identified a concerns regarding staffs ability to perform defibrillators checks. Some staff were found to have a very sound knowledge of the process, whilst others, did not. The Trust may wish to investigate this further.
- At the time of our inspection, we found that the emergency airway equipment to be used for difficult intubations did not have a checklist. This posed potential risks to patient safety if staff were unable to identify if emergency equipment was missing from the trolley.
- We found clinical waste being collected outside of a theatre in an area that was used as a patient thoroughfare for postoperative orthopaedic patients. Staff told us that the clinical waste area was attended to regularly by the porters. However, we found that the theatres only had five porters who were kept very busy supporting the frequent transit of patients and attending to other tasks. There was no assurance that

this area was attended to regularly. This was identified as inappropriate storage for contaminated waste and a potential infection control risk to patients, especially those who have just undergone orthopaedic surgery.
- CQC received information relating to a lack of equipment availability. We were not made aware of these concerns during the inspection. However, there is a reference to an incident that occurred on the 25 / 03 / 2014 on the NPSA report which states that essential equipment was not available to facilitate putting a patient into a prone position (is a body position in which one lies flat with the chest down and back up). This resulted in a 40 minute delay mid surgery. The NPSA report also states that the relevant equipment was found, the safety device for attaching it to the operating table was broke and the device did not meet basic infection control standards.

The trust may wish to explore equipment suitability and availability in theatres at the Eastbourne and Conquest sites.

Medicines

- Our inspection identified concerns with medicine management within the surgical department.
- We found that controlled drug (CD) registers were not maintained in line with local guidance. We found that some registers did not adhere to the double sign out policy for controlled drugs and some areas were not undertaking daily checks of their CD drug stock.
- We carried out random CD checks and found the stock balances to be accurate.
- During the inspection, we discussed our medicine management concerns with the staff in charge. Following our inspection of the main recovery area at Conquest Hospital, staff provided evidence that they had taken immediate action to address our concerns.
- In the main theatres we observed three different anaesthetic rooms where we found syringes of an anaesthetic induction agent prepared for use and left unattended. This was not line with medication management guidance and was a significant safety risk for patients and staff.
- We found that the wards we visited at Conquest Hospital did not have suitable areas for staff to prepare intravenous (IV) drugs. We witnessed staff preparing IV medication beside the nurses' stations/desk areas where they were constantly distracted by telephones ringing, patients and visitors requesting their assistance, as well as other members of staff.
- This was an unsafe practice, as, not only was there an increased risk of medication errors as staff could not concentrate on preparing drugs, but it raised concerns about poor infection control practice and the risk to patient confidentiality.
- During our inspection, we carried out spot medication audits in ward areas supervised by the ward pharmacists. We identified several medication errors on each medication chart, ranging from low to moderate in severity. This raised concerns about the system of quality assurance relating to medication recording.
- We also identified a disparity in different clinical areas relating to the checking of medication fridge temperatures. This meant that we could not see evidence that medication was being stored at the recommended temperatures.

Records

- We found that patient records contained the relevant risk assessments which demonstrated that patients were having their care needs risk assessed.
- However, we were concerned about the overall quality of patients' medical notes kept at East Sussex Healthcare NHS Trust.
- The majority of clinical notes we reviewed were in very poor condition with overfull files held together with multiple elastic bands. This meant that there was a high risk that patient sensitive data and important clinical records could easily be lost or filed out of sequence, affecting patient care.
- Patients were not protected from safe or inappropriate care as medical records were not kept in a safe and secure fashion. Information in the medical records was not systematically filed, held securely or could not be easily located.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We reviewed samples of patient records in each of the areas we inspected and these, together with the discussions with patients, confirmed that consent was obtained in line with trust policy.
- The staff we spoke with were able to demonstrate an understanding of mental capacity and told us when and how they would escalate a concern.

- We did not see completed mental capacity documentation during the inspection. However, the staff were able to demonstrate knowledge of the systems they would use should they identify concerns relating to a patient's mental capacity.
- Staff were less clear on what Deprivation of Liberty Safeguards were and their implications on nursing practice.

Safeguarding

- We saw the trust had a safeguarding policy in place, which reflected national guidance.
- Staff were able to demonstrate what constituted a safeguarding concern and the process in place to report issues.
- We were aware of the constant support given to the trust by the local authority adult social care team to investigate and learn from any safeguarding incidents.
- Staff told us that they were given feedback to aid learning from reported incidents regarding falls and pressure ulcers. However, staff were unable to give examples of learning from other incidents, such as safeguarding.

Mandatory training

- We found that local training records varied in most clinical areas. There were areas where the person in charge had a fully completed and up-to-date training matrix and could identify staff's learning needs and future dates for mandatory training.
- However, this was not the case in other clinical areas we visited. In particular, the main theatres.
- Staff told us that the current staffing levels frequently impacted on their ability to attending training.
- During the inspection, theatres had an audit day – this was a protected learning and audit presentation day for the staff. However, we found an 'extra' operating list running, which prevented staff attending the audit day.

Management of deteriorating patients

- Deteriorating patients had their conditions monitored by the use of a national early warning score (NEWS) system.
- The surgical department had implemented a VitalPAC (an electronic vital signs system) for monitoring deteriorating patients.
- When the NEWS indicated a concern about a patient's condition this was escalated and the patient was then reviewed by a doctor and/or a member of the critical care outreach team. This team were available on site until 2am and provided specialist nursing support and advice for patients and ward staff.
- After 2am, the covering on-call doctor provided medical support for these patients.
- We noted, from an early visit to clinical areas, the valuable support provided by the critical care outreach team to patients and the ward staff. There was evidence of consistent monitoring and specific instructions for staff to follow.
- During the inspection, we observed that theatre staff adhered to the 'five steps to safer surgery' guidance. We found the theatre list briefing and theatre checklists were carried out appropriately and effectively, which demonstrated good communication between members of the theatre team.
- We asked for evidence of the debriefing stage of the process and were told that this was done daily, but the recording was informal. There was no documentary evidence to suggest that this part of the 'five safety steps to surgery' was being undertaken regularly.
- Compliance with the WHO safety checklist was audited regularly and the records demonstrate good compliance. However learning and safety could be improved by auditing all of the 5 steps to safer surgery.

Nursing staffing

- All the clinical areas we visited in the Conquest Hospital had problems with staffing levels. Our observations of the workforce in action led us to the conclusion that staffing was generally overstretched. In the surgical ward areas in particular, we observed staff who were working at exceptional rates to deliver the care patients needed.
- Staff told us they frequently "missed their breaks" and "worked extra hours" to ensure patients got the care they needed.
- This was also vocalised by the patients we spoke with, who raised their concerns about the staffing levels, but frequently commented at how hard the nursing staff worked and how well they were looked after.
- When we asked patients and staff what they would change to improve the surgical services at the hospital, most people told us they would increase the staffing levels.
- We found that permanent staff were heavily relied upon to do extra shifts in order to fill the staffing gaps. When a permanent member of staff was unable to fill the gap,

the shift was firstly offered to the hospital bank to find cover. If cover could not be found, the vacant shift would be offered to an agency. Staff told us that it was not always possible to get agency cover and on these occasions staff "just managed".

- The trust used a staffing acuity tool to monitor nursing staff levels. However, given the observations of staff, patients and CQC during the inspection, we cannot be confident that the output from the trust acuity tools was being acted upon. For example, we visited one area where the staffing model was still running at four trained nurses, despite the acuity tool identifying patient acuity and high patient turnover that required five trained nurses.
- We observed nursing staff delivering safe care in this area, but it was at a cost to their own welfare by skipping breaks, working late and delivering task-orientated nursing care, due to the pressures placed upon them.
- We noted the skills mix in some areas was not ideal, as newly qualified nurses were relied on to support services. However, steps had been taken by the trust to support these staff members and the newly qualified nurses we spoke with felt confident that they were being supported by their immediate team.
- We saw that ward areas displayed their agreed and actual staffing levels alongside the Safety Thermometer data. These information boards demonstrated, during both announced and unannounced inspections, that staffing was not at the desired level.
- We found staffing in theatres to be of concern. The department was heavily reliant on agency staff to deliver its services. During both our announced and unannounced inspections, we found the emergency theatres and the obstetric theatres solely staffed by agency staff.
- This posed a potential risk to the department as there was no permanent employee with an understanding of current hospital policy and procedures overseeing the quality of the care delivered by the agency staff. We were told that the agency personnel used to staff these operating lists had been working in the department for "a long time".
- However, we found the department was unable to demonstrate the agency staff had received a department induction, had no oversight of their training records or learning and development needs. The agency staff we talked with was unable to demonstrate how they would report an incident on the hospitals reporting system. There is a potential risk to the department that incidents were going unreported.
- The trust reported its agency usage at 7.9%, which is higher than that national average of 6.1%.
- We received conflicting information regarding agency staff receiving inductions when they attended the hospital to work for the first time. There was no documentary evidence available in any clinical area to show evidence that inductions for transient staff took place.
- We were told that some agency staff had been on placements in the hospital for over two years.
- There was no evidence available to demonstrate that the department had oversight of mandatory training, skill competency, supervisions or appraisal records for agency staff who had long-term surgical department contracts.
- The trust was unable to demonstrate that bank and agency workers had undertaken an induction to the trust and the surgical clinical areas.
- The trust acknowledged a problem in recruiting staff and we were told they were looking to recruit staff from Portugal.

Medical staffing

- The staffing skills mix data from the trust showed the appointment of consultants to be below the national average (15% versus 23%).
- We found adequate consultant cover at Conquest Hospital. Consultants were on site from 8am to 5pm and provided an on-call service out of hours.
- The trust was heavily reliant on locum doctors to deliver its services. Locum use was running at 7.9%, which was above the national average of 6.9%.
- We attended a medical handover and found it lacked structure. However, we noted good communication during the handover. It had a good attendance, with three consultants present.
- We noted that the doctors at the ward round discussed all the patients, not just the ones that were admitted in the previous 24 hours.
- Ward rounds involve reviewing 60 to 70 patients as standard, this may not be sustainable long term, and may affect the quality of the rounds.

- The nursing staff and junior doctors from general surgery reported no concerns about doctor cover at this location. However, concerns were raised about the lack of orthogeriatric consultants in the department and the night-time cover in the surgical ward areas.
- Middle and junior grade doctors were on duty 24 hours a day in the department. We did not identify any concerns about this cover during the inspection.
- The NPSA alerts detailed the impact on occasions of alert dated 26/03/2014 reported that a patient was referred for a surgical review at 22:00rhs and did not receive one until 05:00. The delay resulted in the patient requiring a higher level of support. The data also highlighted other occasions where obtaining reviews for patients proved problematic.
- The trust may want to review its medical cover at both sites to ensure that it can provider a robust services where patients care needs are continuously met.

Major incident awareness and training

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

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

Requires improvement

We have judged the Conquest Hospital effective rating as 'requiring improvement'.

We found that the pain management service, with its current structure and staffing limitations, was unable to deliver an effective service to patients. Patients told us that they were unhappy with the way their pain was managed and that there were concerns raised about the difficulties patients faced when trying to access chronic pain services at East Sussex Healthcare NHS Trust. The recent reconfiguration affected the availability the epidural service, due to the lack of staff training and support. We spoke to a member of the pain team, who told us a teaching plan had been put in place and that a quality service would return to the Conquest Hospital. The trust has a duty of care to ensure patients have access to effective and efficient pain relief.

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

Nurse-led discharges were in operation in the surgical department. We were told that this meant that the process avoided discharge delays. We have no doubt that this is an effective and innovative way to relieve pressure on beds and speed up the discharge process for patients eager to return home. However, there was no evidence that the discharge process was being audited to measure the quality of the service patients received. During our inspection, we received information, complaints and concerns that indicated multiple errors were being made during the process. Examples of the complaints we received were: patients discharged home with someone else's discharge letter, discharge letters not received by GPs, Tablets to Take Away (TTA) not available at the time of discharge, receiving medication with someone else's name on the box and with the wrong administration information, as well as poor communication with the district nurses, which meant that patients did not receive the aftercare they required.

We identified a concern with quality measurement of patient's pathways and new processes in the surgical department. This meant that quality of service could not be measured effectively. It is important to have appropriate systems in place for gathering, recording and evaluating accurate information about the services delivered to patients. The lack of quality audit meant that the service was unable to improve as a result of learning from comments and incidents and was unable to measure the impact of pathways on the patients and service delivered. This was most evidence when reviewing VTE compliance, Nil By Mouth (NBM) pathways, nurse led discharges and the direct admission process used on the Surgical Assessment Unit.

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Evidence-based care and treatment

- The trust had a VTE policy in place that reflected national guidance. However, we did a sample audit with the supervision of the pharmacist in different wards and found that the VTE protocol was not being followed. This suggested that patients may not have received appropriate VTE prophylaxis and that national guidance was not being followed.
- The trust was not following national guidance for patients who are required not to eat or drink prior to surgery (nil by mouth). We found there was usually a blanket approach to nil by mouth status being used within the department. This meant that patients were without food and fluids for unnecessary and extended lengths of time, which did not reflect national guidance or demonstrate individualised patient care.
- The data demonstrated that the trust was not meeting its referral-to-treatment targets.
- We saw evidence of trust involvement in national audit programmes. However, we noted that audit activity within the department could be significantly improved upon. Staff reported not having enough time to engage meaningfully with audit processes.
- We found evidence that national guidance was being followed in the department and that hospital policies were based on NICE and the royal colleges' guidelines.
- We saw evidence in the care plans and notes we reviewed that demonstrated peoples' needs were identified and reviewed.
- The records we viewed demonstrated that the trust adhered to best practice guidance, such as NICE CG50 (Acutely ill patients in hospital).
- We found a general lack of quality monitoring in place in the department. The primary purpose of audit is to improve compliance with recommended standards. It is also an important tool to measure the impact of the services delivered and ensure that results are used to implement changes to clinical practice. Audit outcomes should lead to changes in clinical practice to ensure a high quality services.
- The trust may wish to review its current approach to audit to ensure the services delivered meet the recommended standards and can identify, monitor and manage the risks to patients who use the service.

Pain relief

- At the time of our inspection, the acute pain team consisted of one full-time band 7 nurse (who was also the matron of main recovery and responsible for providing a chronic pain clinic three times a week) and two part-time band 6 nurses. The specialist anaesthetic team lead had retired and the service was, therefore, reliant on the good will of a locum anaesthetic consultant and other colleagues to support the service.
- CQC was concerned that the pain team did not have the staff or resources to be able to deliver a specialised pain service across an acute surgical site.
- The pain service was unable to provide specialised pain management support for trust staff and was relying on the recovery staff and anaesthetic department to provide this support in clinical areas.
- The inpatients we spoke with during the inspection told us that their pain was adequately controlled and this was evidenced in the records we viewed.
- However, the CQC received information from the general public, which identified a theme relating to patients receiving adequate pain relief in a timely manner. For example, we were told of concerns relating to gaining access to chronic pain services when needed.
- CQC were made aware that the epidural pain service had been severely affected by the recent service configuration and by the retirement of the lead anaesthetist.
- We were told that the trust was taking steps to rectify the situation and that training for staff was being made available.
- However, CQC were concerned that the trust did not have contingency plans in place to ensure service continuity through the planned retirement of the team lead and service reconfiguration.
- Patients who attended preoperative clinical assessment had their preoperative and postoperative pain concerns discussed.

- We saw a dedicated and standardised pain assessment tool in recovery in place to measure pain and staff were able to demonstrate its use.

Nutrition and hydration

- Patients contacted CQC prior to the inspection to give their views about the quality of the food available at the Conquest Hospital.
- The trust recently changed its food provider and we found a positive response to the improvements in both the quality and variety of food available.
- Patients were asked for their daily food preferences and there was a sufficient range of meal choices available to them.
- People who required specific diets had their specific needs met.
- The trust provided a wide range of food to meet individual people's diary needs and could offer patients the option of a hot meal outside of the scheduled meal times.
- Patients told us during the inspection that they were happy with the quality of food available to them during their hospital admission.
- Comments received from patients included: "We had a lovey fish pie today," and, "The food was surprisingly good," and, "The food offered was a good choice, always hot and tasty."
- The staff told us they believed the quality of the food had improved and staff told us that they "would be happy to eat it."
- We found the notes we reviewed contained completed malnutrition universal screening tool forms, which was tool to identify adults who were malnourished, at risk of malnutrition, or obese. It also included management guidelines, which could be used to develop care plans.
- Where a risk was identified, we found that the appropriate measures were put in place to monitor that risk. These included regular weight measurement, food diaries, food supplements, and dietician input.
- Patients had their hydration needs monitored and, where a risk was identified, a fluid chart was implemented to monitor patients' daily fluid balances.
- However, we noted that patients were being kept nil by mouth for extended periods of time.

Patient outcomes

- We attended nursing handovers during the inspection. We found that, in some cases the quality of the handover was exceptional, with good structure and clarity, which demonstrated effective team communication. However, we found the quality and structure varied.
- We saw staff had access to relevant written handover sheets that contained important patient information that was used as a daily care guide and reference tool.
- Where medical patients received medical care on surgical wards, due to a shortage of medical beds there was a buddy system in place to ensure they received the medical care they needed. The nursing staff we talked to informed us that the system worked well and that patients received the care and medical reviews they needed.
- The trust contributed to national audits such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), the National Emergency Laparotomy Audit and the National Bowel Cancer Audit and we noted the results were in line with the national averages.
- This site was identified as a CQC outlier for biliary tract procedures. The trust conducted a review of the service and submitted an action plan, which was found to be in place.
- The Conquest Hospital contributed data to the annual National Hip Fracture Audit. It performed below the England average in six areas and above the England average in four areas.
- The surgery data obtained from the trust demonstrated a reduction in day surgical activity in the last six months of 2014 when compared to same six months in 2013. We are unsure of why day surgery activity in the trust has given its challenges to meet surgical RTT targets. The data therefore suggest that day surgery efficiency may have been affected by the recent service reconfiguration.
- The average length of stay at the Conquest Hospital is overall longer than the England average
- There were arrangements in place that reflected the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. This included handover of information between medical teams. This also included access to operating theatres, or diagnostics. The trust also participated in a 'trauma network' with another hospital and patients admitted with various traumatic problems were managed with combined input and decisions by specialty consultants as appropriate.

- Comparative outcomes by individual surgeons were published on the NHS Choices website.
- The data demonstrated that mortality in the Vascular speciality was within England average expected range.

Competent staff

- Staff records showed that staff had annual appraisals.
- The staff we talked to confirmed that they had received an appraisal and the appropriate level of training to be able to do their jobs.
- The personal identification numbers of qualified nurses were checked by their team leaders to ensure that staff were registered annually with the Nursing and Midwifery Council (NMC).
- Medical staff underwent an annual revalidation process to ensure their skills were current and relevant.
- Clinical supervision was not widely available in the surgical department.
- There was little opportunity to access training other than mandatory training, due to financial restraints and staffing pressures.

Multidisciplinary working

- We identified a multidisciplinary approach to care at Conquest Hospital. We found evidence of a multidisciplinary team approach to care in the patient notes we reviewed.
- We also observed a multidisciplinary team approach to the ward round that we attended. This meant that all relevant information was shared between healthcare professionals and others to ensure patients received safe and coordinated care, treatment and support.
- There were arrangements in place for the transfer of patients between the Conquest Hospital, Eastbourne District General Hospital and the other community sites.
- The physiotherapists and occupational therapists told us they had recently recruited staff, which would improve multidisciplinary team working within the trust.
- Surgical teams told us that the recent reconfiguration had improved multidisciplinary team working in the trust because “everyone has pulled together to deliver a service”.

Seven-day services

- There was consultant cover seven days a week at the Conquest Hospital. This included consultants being onsite during normal working hours and providing on-call services out of hours with consultant-led ward rounds at weekends.
- Physiotherapy services were available five days a week with a limited call cover provided at weekends.
- There was no weekend or out-of-hours cover for other therapy services, such as occupational therapy, dietician or speech and language therapists (SALT) teams.
- We found limited pharmacy cover over weekends.
- There was access to out-of-hours imaging services.

Are surgery services caring?

Good

We have judged the surgical services at Conquest Hospital to be caring.

Staff who worked in the surgical department delivered care that ensured patients had their privacy, dignity and independence respected. The patients we spoke with during the inspection were very complimentary about the staff and the service they received. They told us that they had their views and experiences taken into account and their care and treatment options explained to them. Some comments received were, “The nurses are fantastic and very hard working,” and, “I wouldn’t fault the care,” as well as, “They do a fantastic job, but they always seem short staffed.”

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

Concerns were raised with CQC regarding “staff attitudes”, which was perceived as “lacking empathy and understanding” and people also made reference to a “lack of communication”. The people who brought this to our attention were concerned about the environmental pressures placed upon staff. One person described an observation of a ward area as a ‘fire-fighting' approach to care delivery at the trust. We observed that staff interacted well with patients and each other and felt they did their best to make patients feel comfortable and cared for, given the demanding and difficult environments in which they worked.

Inadequate

Surgery

The friends and family test Trust data demonstrated that Surgery as a whole at the Conquest is meeting the England Average of 33% by scoring 34%. However, it's important to note that three out of six wards measured fall below the England Average.

Compassionate care

- We observed staff treating patients in a kind and compassionate way that promoted their dignity and respected their privacy.
- The staff we spoke with were noted as being resilient, hardworking and dedicated to delivering the best patient care they could.
- Curtains were drawn around beds when personal care was delivered.
- CQC received a number of concerns from patients who told us the care they received lacked compassion.
- Ward areas had 'You said, we did' information displayed on their noticeboards. We saw that patients had their feedback addressed and actions taken by staff were displayed. An example of this was the availability of ear plugs and hot meal choices after surgery. We also saw comments regarding steps taken to improve communication with the multidisciplinary team.

Patient understanding and involvement

- The patients we spoke with during the inspection were very complimentary about the care they received.
- They told us that they felt involved in their care planning and had access to enough information to make informed choices.
- Patients also told us they were treated with dignity and respect by the staff during their admissions.
- We saw there was a named nurse system in place, however, most patients were not aware of who their named nurse was.
- The NHS Friends and Family Test score for inpatient services in June 2014 was 67. This was below the England average for NHS organisations (73) and the Surrey and Sussex average score of 74.
- We noted that staff encouraged patients to complete the NHS Friends and Family Test feedback prior to discharge.
- The East Sussex Healthcare NHS Trust website also has the facility for patients to leave feedback.

Emotional support

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

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We have judged responsiveness in surgery to require improvement.

We identified that the theatre facilities were underutilised most days. The surgical lists did not start until 9am. This had a cost implication, as high numbers of agency workers were booked to start work from 8am. We also noted that the department had an audit day, which was considered to be protected learning time for staff. This was being used to run extra lists to increase capacity. We did not consider this to be an effective use of the audit days given the amount of staff who were not having their learning needs met.

Theatres relied heavily on agency staff to deliver a surgical service. We were told that some agency staff had worked in the department for over two years on long-term placements. This demonstrated that there was little incentive for agency workers to work for the trust in a permanent position and raised concerns that trust management were not responsive to the staffing crisis in theatres.

We saw that the theatres main reception only had three pre-surgery holding bays. These bays were unsuitable for

use and did not promote patient dignity or confidentiality. There was little or no room between trolley and beds in this space, which did not promote good infection control standards.

During the inspection, we spoke with patients, staff and the general public, who raised concerns about the multiple bed moves during their hospital stays. One patient we spoke with told us that they were moved four times in three days.

The department had implemented a nurse led discharge pathway. It had also implemented a direct referral service to the Surgical Assessment Unit. This meant that patients went directly to a ward area and bypassed the A&E department. However, neither of this process was monitored or subject to formal audit process to ensure that patients were receiving a good quality service. CQC received a large volume of concerns regarding the effectiveness of the discharge process in particular. The trust may want to review its current audit activity to ensure that the nurse led discharge programme can be a robust and successfully implemented.

There was a lack of evidence to suggest that the service listened to, or learned from complaints. We found that staff on the wards personally addressed patients concerns whilst on the ward. However, if a formal complaint was made then the learning from that complaint was not cascade to the ward staff. Staff were unable to give any examples of changes to the service as a result of a formal complaint. We were told that information regarding the trusts formal complaints system was not shared at a local level with staff. Senior nurses received an email detailing how many complaints their area received but this did not include an individual breakdown of what the concerns were, making learning from people's feedback very difficult.

We were made aware that a new shelving system had been installed in the theatre areas. Staff were pleased with the new system and storage area. They told us it had had made a great difference to the quality of the service delivered as they no longer had to send back unopened theatre packs damaged by the old shelving system.

The NHS Choices website also gathers feedback about services provided at East Sussex Healthcare NHS Trust. We noted that, when people complained on the website, they were responded to, and urged to contact the Patient Advice and Liaison Service department to discuss their concerns further. Conquest Hospital was rated at 3.5 out of 5 stars.

Service planning and delivery to meet the needs of local people

- The trust informed us that the rationale for the recent reconfiguration of services was to ensure the trust could deliver services that met the needs of local people. However, members of the local population raised concerns with us as they did not see the reconfiguration in the same way as the trust board.
- We had concerns as to how the surgical services would cope during busy times given our observations of the demands on staff during our announced and unannounced inspections. Staff appeared to be working at capacity with little in reserve to deliver any more. The staff we talked with told us they would work hard as a team, miss meal breaks and stay on duty for prolonged periods if it meant that patients were cared for.
- Staff told us how they had patients reviewed by a doctor to identify those who fitted the discharge criteria. This demonstrated that staff were proactive in discharging those patients assessed as fit for discharge.
- Theatre staff told us they would stop elective lists to ensure emergencies were treated in the event of unexpected demands on the service.
- The trust was in the process of training nurses as Dementia Friends Champions, to ensure staff could meet the care needs of this patient group. However, we noted there were too few trained dementia nurses on the orthopaedic ward.
- We found an outstanding surgical service for patients of the Jehovah's Witnesses faith, led and delivered by a very enthusiastic consultant surgeon with a special interest in this patient group.
- The trust had an inpatient learning difficulties specialist nurse team who provided "invaluable support" to patients, their carers and staff.

Access and flow

- We did not observe issues with patient flow within the surgical department during our inspection.
- However, we did identify concerns with the frequency of patient ward moves. This was suggestive of problems with flow and capacity throughout the department. Comments from patients included, "I was moved four

times in three days," and, "I was moved six times in six days." The staff we talked with agreed that multiple moves was a problem, but reported that it was "getting better".

- Staff reported a functioning discharge pathway for patients who returned to the wards. We did not identify any concerns regarding patient flow within the hospital during the inspection.
- Information we received form members of the public and staff regarding multiple bed moves and swift, but poorly implemented, nurse led discharges suggested there was continuous pressures on bed availability in the department.
- We found that theatres only had space for two patients in the check-in/holding area. However, an extra curtain rail had been added to the area to increase the spaces to three. The area was not large enough to support three patients safely, with little room between the trolleys and beds. We observed that there was no opportunity for any confidential discussion as patients were asked personal questions as part of the theatre safety checks before they were taken to the anaesthetics room.
- Main theatres had three porters to assist with getting patients to and from the wards. We were not confident that this number of porters was sufficient to ensure an effective flow to and from the theatre area, due to the amount of theatres and the constant flow of patients to and from the department and the frequent removal of clinical waste from the inappropriate waste storage area.
- We also reviewed theatre efficiency and found that theatres rarely started work until 9am. These continuous late starts led us to believe that the department was underutilised, leading to a reduced/lost benefit for patients.
- The trust reported that its bed occupancy rate was at 89%. The recommended NHS bed occupancy is no more than 85%.
- Patients were admitted to the surgical wards in different ways. Elective admissions were admitted via the preoperative area or via a surgical ward, emergency admissions came via A&E and the surgical assessment unit operated a direct paramedic and GP referral system once patients were accepted by the nurse in charge.
- The trust operated a nurse-led discharge programme. This was an effective and efficient approach to patient discharge. Discharge letters and medication records were produced electronically with copies sent electronically to patients' GPs.
- We observed a patient's discharge and found it to be satisfactory. The patient was given all the information they needed in verbal and written format, including a contact number to phone if they had any concerns. We were also made aware that the wards provided a daily phone clinic where nurses called patients discharged the day before to check on their progress. Where a nurse discharge was not deemed appropriate, patients were reviewed by a member of the medical team before discharge. However, there was no audit process in place to demonstrate the effectiveness and efficiency of nurse-led discharge programme, so we were unable to quantify how effective the process was.
- Staff told us about the numerous benefits to patients and the trust with the nurse-led discharge system. But, CQC received multiple concerns from patients and members of the public about the quality of the discharge process.
- The trust data suggest that it was meeting the standards for cancelled operations and emergency care.
- However, there was evidence from members of the public, and Trust data that suggested it was struggling to meet its Referral To Treatment times. This may suggest there are problems gaining access to surgical services.
- The data provided demonstrated that over the past four quarters, this trust has been better than the England average for cancelled elective operations being rebooked within 28 days.
- The trust demonstrated that 80% of fractured neck of femur patients were treated within the recommended 48-hour target. This meant that the trust was meeting national guidance. However, we did note that this patient group did not have sufficient access to orthogeriatric specialists. We were told that the trust was addressing this and were in the process of recruiting a specialist.
- We found that some of the surgical ward areas provided care for medical patients when there was insufficient capacity in the medical wards (medical outliers). We were told that the wards operated a 'buddy' system. This was where the surgical ward and medical wards paired up to improve the communication and continuity

of care for the medical outliers receiving care and treatment in surgical wards. We were told that this worked well and that patients received the same standard of care as on a medical ward. Patients were reviewed regularly by their medical teams and patients were transferred to a medical ward as soon as a bed was made available.

Meeting people's individual needs

- The trust had a robust and effective system in place to care for patients of Jehovah's Witnesses faith who needed surgery. The medical records demonstrated Jehovah's Witnesses patients were given information relevant to their faith to enable them to make an informed decision about their care and treatment. For example, in one set of medical records we also found an advance directive – a document expressing a person's wishes about critical care when he or she is unable to decide for him or herself. The patient, who was a Jehovah Witness, told us how satisfied they were with the individualised treatment received and way the service took their religious needs into consideration.
- We were told that the hospital had access to a translator via a telephone service. However, when we spoke with staff on the surgical wards they were unable to demonstrate the process of requesting the translation service. We found that some wards only had access to a suitable phone in the matron's office. This was difficult to access if the patient was too ill to walk and needed to be on a bed.
- We were told that the staff working at the trust provided the majority of the translation services to patients.
- The trust told us that they had a Language and Communication Policy and a number of agencies could be engaged to provide interpreting services to those patients whose first language was not English. However, our conversations with staff and observations on the day of inspection raised some concerns regarding the robustness of its implementation.
- The trust had a learning difficulties team who provide specialist knowledge and support for staff and relatives of patients who had learning difficulties. The support from the learning difficulties team was described by numerous staff as being "brilliant".
- Most areas had a dementia link nurse to provide support and advice to staff and relatives. However, the orthopaedic ward that cared for the majority of older patients with fractured hips and/or who were a high risk group for dementia had seven patients with a dementia diagnosis and only one nurse who had received dementia training. This was insufficient to meet the needs of patients with dementia in this particular ward area.
- We were made aware of the physiotherapy support available for amputees and the vascular team. Concerns were raised about the sustainability and quality of the service, given there was only 13 hours of allocated physiotherapy time to deliver inpatient care at two hospital sites and deliver a community service.

Learning from complaints and concerns

- We were told by staff when patients raised concerns on the wards they were dealt with and fed back to the team at a local level.
- However, if a formal complaint was raised with the complaints team or via the Patient Advice and Liaison Service, staff at ward or department-level were not involved and may not be aware of the concerns or receive feedback.
- One ward sister told us that each department was told about the number of complaints generated by their clinical area, but these were not broken down into specific categories and did not contain enough information to facilitate learning and improving the service.
- A large volume of people contacted the CQC before, during and after the inspection to tell us their experience of raising a concern at East Sussex Healthcare NHS Trust. The majority of the information we reviewed indicated that the complaints system was not working. The information received highlighted that the trust did not provide support for people who wished to raise a concern, and highlighted that there were problems in the way in which the trust handled complaints.
- We reviewed a sample of written responses from the trust, which were dismissive of people's individual concerns.
- People told us of their experiences in using the trust's complaints system saying they only wished to facilitate trust learning and drive service improvement. We were frequently told by people, "I don't want others to experience what I did."
- The NHS Choices website is also used to gather feedback about the service provided at the trust. We

noted that when people complained on the website they were responded to and urged to contact the Patient Advice and Liaison Service department to discuss their concerns further.

- The complaints process did not address people's concerns. We found the current complaints system was disorganised, inefficient and failed to aid learning or drive service improvement.

Are surgery services well-led?

Inadequate

CQC have judged this service to be inadequate.

We have made this judgement based on the evidence we obtained from staff as part of the inspections process, our observations and concerns raised by patients and members of the public. Although we recognised the need for change to the service structure, we had significant concerns about the pace of change, the lack of meaningful consultation with staff and little impact monitoring to measure the outcome of the changes.

The trust board had various documents available that suggested there was a vision and strategy for the surgical services. However, our findings in the surgical department identified concerns regarding the robustness and understanding of the strategy on the 'shop floor'.

The trust struggled to provide CQC with the relevant data to demonstrate compliance with the five domain areas. We were told that the trust sees itself as one provider of acute and community services and, therefore, performance data was amalgamated. This was not effective data management, as there was no information available on the individual services to identify areas of concern or drive improvement.

The staff group had lost faith in the organisational structure and leadership of this service. Major service changes were proposed and implemented, often without meaningful communication. When changes were communicated, the majority of the communication appeared to be conducted electronically. The majority of staff we talked with told us they had little faith in the board leadership. We found a culture of fear and intimidation existed when it came to raising concerns. One very senior member of staff broke down in tears while being interviewed by CQC and told us, "It's the first time that anyone has ever listened to me."

The staff generally felt supported by their immediate team leaders but felt "abandoned" by management above this level. Nursing staff felt very supported by the director of nursing (DON), whom we were told "listened and cared" about staff and their welfare. We asked staff if they were being listened to at DON-level, why was it that their concerns went unaddressed? Some staff said they did not know the answer, others responded with "her hands are tied" and "I'm not sure how supported she is at her level to make changes". Staff told us that they understood the financial challenges faced by the trust and were supportive of the need for change.

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

Members of public contacted CQC to express concerns about the standard of care at the trust, complaints handling, staff welfare and management at board level. We acknowledge that the recent service reconfiguration has caused distress in the community. However, CQC are unable to address these concerns as we do not have the regulatory powers to do so. CQC can only comment on the standard of care in the five inspection domains.

We did talk to staff that were very complimentary of the trust, its leadership, its achievements regarding the reconfiguration and their own teams' ability to deal with the challenges in light of the recent changes. However, this was from a minority of staff.

Vision and strategy for this service

- CQC recognised that the financial position of the trust and the recent surgical services reconfiguration had impacted the vision and strategy for the surgical services at East Sussex Healthcare NHS Trust.

Governance, risk management and quality measurement

- There was a governance board in operation at the trust. We are aware that it was subject to a recent reconfiguration and had acquired a new lead before the inspection.

- Staff we spoke with were unable to identify the governance structure or provide us with any feedback on its function, successes or any learning that had led to changes in practice.
- We found the mortality overview group were aware of the variable submissions of mortality and morbidity reports from the clinical units, yet no firm action had been taken to address this.
- We were not assured that clinical governance, risk and quality management was effective in this service and were not confident that the governance, risk and quality boards influenced or impacted at 'shop floor' level.
- Our interviews with governance leads indicated "there is a lot to do" in the trust.

Leadership of service

- We identified pockets of good clinical standards, but they were not applied throughout the surgical department. There was a perception amongst staff that this was because of the constant changes to leadership and the way changes were communicated.
- The surgical department had undergone recent changes to its management structure in the two weeks before our inspection. We noted that theatre's management structure was changed during the inspection. We asked staff how this was communicated and they told us it was via email and unexpected. However, the theatre staff told us they welcomed the change and felt the service would benefit from the change in leadership.
- Ward level managers were perceived as enthusiastic, supportive of their staff and the structural changes, however, most of the clinical unit managers we spoke to, had limited knowledge of the service they managed and the challenges it faced. They relied on the senior nurse management in each clinical area to answer the majority of the questions asked by CQC. We identified the lack of insight and organisational memory was a potential risk to the surgical service.
- Staff told us that things were changing all the time and it was impossible to keep on top of the changes. One nurse commented, "I've had three managers in three months and none of them were visible in the clinical area." We were concerned that the constant rapid and unplanned changes were having a negative impact on patients and staff.
- We found that staff in managerial positions were unable to demonstrate sound knowledge of the surgical service, its strengths and its challenges, due to the amount and pace of the change they had experienced.
- Staff told us that some managers did not receive a formal handover from their predecessors.
- We had concerns about the quality of the management handover process and were concerned about the current management's lack of insight in the surgical services they were responsible for.

Culture within the service

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

Public and staff engagement

- We had a significantly higher than expected level of contact from the public before, during and after the inspection.
- Some members of the public contacted us to tell us about their positive experiences at East Sussex Healthcare NHS Trust.
- However, the majority of contact with CQC was to raise concerns about the standard of care, ineffective complaints processes and the welfare of the staff.
- Examples included: medications/pain relief not being given, rehabilitation services not being offered, dissatisfaction with the complaints process, long waiting lists/times, ineffective patient discharges, low staffing levels and the effect on dignity, medications, pain relief and answering of call bells, operation delays, patient charts being completed incorrectly.
- We saw that the Trust had information about the surgical department on its website and encouraged feedback about its services.
- We also noted that ward areas had letter and cards on display which demonstrated that patients appreciated the care they received during their inpatients stay.

Inadequate

Surgery

Innovation, improvement and sustainability

- We found instances where the trust had worked innovatively to improve the services offered.
- For example, the trust implemented 'VitalPAC', which is a clinical software system that records and monitors patients' vital signs. It also took patients' NEWS into account and prompted the user to take action, such as requiring a medical review for a deteriorating patient.
- The trust had a staff awards incentive in operation. We spoke to a housekeeper, who was nominated for an award by the theatre team.
- A Listening into Action™ group had been set up to aid learning from incidents and patient feedback. This group encouraged people who raised a complaint to come and talk to healthcare professionals to give a first-hand account of their experiences. CQC was contacted by members of the public who contributed to this group who expressed their satisfaction with the learning that had occurred from their complaints.
- The surgical department had implemented nurse-led discharges.
- The pre-assessment clinic introduced a system that communicated patients' individual needs before admission for surgery. Needs were recorded in a letter and disseminated to the anaesthetic department, theatres, recovery and ward areas. This promoted effective multidisciplinary communication to promote individual needs and alleviate potential risks. Staff told us that this was a very valuable incentive-driven system by the pre-assessment nurses.

Good

Intensive/critical care

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

Information about the service

The Conquest Hospital critical care unit (CCU) is found within the surgical hub, with theatres nearby, radiology on the floor above and paediatrics below. There are two CCUs within the hospital, so for the purpose of this report the critical care unit is called CCU (ITU), as coronary care is also called CCU.

The unit admits adults and young people from the age of 16 years and children for stabilisation and transfer to a specialist centre. There are six intensive care beds and five high-dependency beds in two areas on the CCU (ITU). The beds are used flexibly to provide level 2 and 3 care, with ventilated patients largely cared for in the six-bed area, which has two cubicles for patients requiring isolation. All nurses are trained to care for level 3 patients and rotate between areas on a three-weekly rota. There is a critical care outreach service operating between 8am and 2am. Consultant cover is provided on the unit during the daytime, seven days a week, with a consultant on call, out of hours.

During the visit, we spent time on the CCU (ITU), which was very quiet, with two unventilated patients. We were unable to speak to any patients, but we spoke to two relatives and 19 staff. These included administrative staff, qualified and student nurses, matron, trainee doctors and consultants and managers. We observed the electronic care record of two patients. In addition, we received feedback from staff and patients at focus groups and listening events.

Prior to the inspection, and during the visit, we were provided with performance data relating to critical care. Intensive Care National Audit & Research Centre (ICNARC) data showed satisfactory outcomes, comparable to units of similar size and workload. Mortality data show slightly better outcomes than comparable units. Bed occupancy was below the national average, based on around 400 admissions per year, with occupancy levels falling over the summer.

Good

Intensive/critical care

Summary of findings

The intensive care service used procedures to ensure patients received safe and effective care. Clinical outcomes were monitored, and practice changed where required improvements were identified. Staff were caring and compassionate, working to maintain the privacy and dignity of their patients. However, some improvements were required in relation to bed management processes to ensure that patients did not remain in CCU (ITU) longer than required, which could impact on privacy and dignity. Leadership on the unit was good, but changes to the clinical unit management team had led to a lack of discussion to deal with planning issues, such as the clinical environment.

Are intensive/critical services safe?

Good

Critical care services used systems and processes to provide safe care. Consultants were present on the unit seven days a week and the nursing establishment provided recommended levels of care. Currently, nurse staffing is below the establishment, but the team were managing this to ensure appropriate levels of care. There were systems in place to recognise the deteriorating patient and to respond to their needs.

The service had had no serious incidents or Never Events in the past 12 months. Staff reported incidents, received feedback locally and were able to describe a number of changes in practice resulting from incident investigation.

The environment was clean and, although cluttered, had managed to reduce risks to patients. There was one electronic patient record used by all professionals working within the team, which provided an overview of current observations and treatment for all staff. There was an innovative electronic outreach system for tracking patient physiological data, which could be accessed by all CCU (ITU) medical staff from all parts of the trust site.

Incidents

- 'Never Events' are serious incidents, which should not occur if the appropriate systems and processes are in place. The trust reported that there had been none of these events in critical care between May 2013 and May 2014.
- The trust has reported no serious incidents relating to critical care on the Strategic Executive Information System (STEIS – the NHS reporting system for incidents) in the past 12 months. However, staff told us of one incident from April 2013, which was investigated and resulted in change of practice relating to chest drain management. There was evidence that this incident had been discussed at clinical governance and risk management meetings.
- One member of staff informed us that information following incident investigation was not fed back to people reporting incidents. Other staff informed us that the information was placed in a folder for staff to see. We viewed information on the nursing noticeboard.

- Staff told us they were familiar with the process for reporting incidents and used this appropriately. There were 70 incidents reported by the CCU (ITU) between August 2013 and July 2014, the most common of which related to medications, movement of patients to the ward in the evening and during the night and pressure area issues. We were provided with evidence of learning from incidents and changes in practice as a result.
- Nursing staff told us about an incident relating to a patient with a tracheostomy, which had resulted in significant changes in practice, including changes to equipment used.
- Staff told us that they were not formally capturing 'near miss' incidents, but issues arising were discussed at staff meetings on the unit.
- Staff told us that monthly morbidity and mortality meetings were in place. These were attended by medical staff and other members of the critical care team. Action points were recorded at the end of each meeting and learning points discussed.

Safety Thermometer

- NHS Safety Thermometer data was displayed on a board in the main corridor, with no new pressure ulcers (PU), catheter-related urinary tract infections (CUTI), falls or venous thromboembolism (VTE) occurring for the month prior to the inspection.
- NHS Safety Thermometer scores were good, overall, with only one pressure ulcer and one catheter-related urinary tract infection reported by the trust in the last 13 months. However, during the period August 2013 to July 2014, the incident log includes nine new pressure ulcers reported and treated during this period.
- Risk assessments for VTE and pressure ulcers were recorded on the electronic system, with records of action taken to mitigate these observed.
- Ventilator-associated pneumonia (VAP) was monitored and recorded, with only two instances of infection in the 12 months prior to the inspection.

Cleanliness, infection control and hygiene

- The unit was clean, with evidence of regular cleaning of equipment stored in the clinical area.
- Staff adhered to the policy relating to hand hygiene and 'bare below the elbow'.
- Protective personal equipment (PPE) was available at each bed space and was used by staff when carrying out direct care. However, not all staff adhered to the unit policy of wearing PPE when entering each individual bed space, outlined on the floor with red tape. Two members of unit staff and a visiting member of staff were observed entering bed spaces with no PPE.
- Hand washing facilities were situated at the opposite end of the ITU from the door, but hand sanitising gel was provided inside and outside the main unit door. In the high-dependency unit (HDU), the sink was nearer the door. Both sinks had PPE beside them. Monthly hand hygiene audits demonstrate 90 to100% compliance with local practice.
- The unit submits data to the Intensive Care National Audit and Research Centre (ICNARC) and has low levels of MRSA and C. difficile infection.

Environment and equipment

- The environment was limited by its size and a lack of local storage. The unit appeared cluttered, with equipment stored around the desk, making it difficult to move a bed from the far end of the unit to the door. We were told that additional storage facilities along the main hospital corridor had enabled prioritisation of equipment kept on the unit.
- Resuscitation and emergency equipment was available in the clinical area, with transfer equipment stored outside the clinical areas on the unit. This equipment was cleaned and checked on a daily basis.
- Paediatric resuscitation and transfer equipment was stored in a room close to the unit entrance and was checked once each week.
- The staff reported adequate equipment, although spare equipment was very old. Replacements had been requested through the capital replacement programme.
- Staff reported good support from The League of Friends, who funded the IntelliVue Clinical Information Portfolio (ICIP) electronic records system and other items.
- Blood gas equipment was maintained by a central Point of Care Testing Team, with healthcare assistants (HCAs) calibrating the machines as required. Reports of testing and calibration could be printed from the machine.
- The central electronics and medical engineering department (EME) team maintained all other electrical equipment and could provide a report to indicate when services were completed on request. Electrical testing stickers were found on all equipment checked.
- Materials management restocked consumables and managed rotation of stock as shelves were filled.

- Staff reported occasional difficulties with linen supplies, particularly over holiday periods. These are escalated up to the linen manager and reported on Datix.
- Manual handling equipment was available for both patients and large loads.
- There was a relative's sitting room, which was quite small, close to the main entrance of the unit. Access to the unit was restricted. A drinks and snacks vending machine was housed within the relative's room.

Medicines

- The blood gas machine was housed in the same room as the intravenous and dialysis fluids. As staff require regular access for processing blood specimens, this door was not locked and fluids were not stored securely. The matron reported that this problem had been recognised, was on the trust risk register and a solution had been identified. The risk register indicated that this issue was mitigated by the fluids being "stored in a store room within the secure area of critical care" and we were told there were no plans in place to create secure storage for fluids.
- Electronic prescribing was used through ICIP, which had a formulary attached and provided standardised prescriptions. This was reported to have improved prescribing and provided a simple system for locum doctors working on the unit.
- In CCU (ITU), medicines were stored safely and securely in an electronic cupboard requiring individual identification to access the system. In the HDU, staff were being trained in this system and drugs were stored in a locked cupboard.
- The electronic drug cupboard automatically recorded who had removed individual medicines. Locum doctors were provided with temporary access.
- Our review of controlled drug records indicated that staff adhered to policy on recording these medicines.
- Since August 2013, 12 medication errors were reported through the incident reporting system (Datix). These involved administration and recording issues. All were investigated and closed, with the exception of two that were reported in June 2014.

Records

- There was an electronic record (ICIP) for all patients in the CCU (ITU), which collected observations from monitoring, ventilation and blood gas equipment. There were plans in place to link the infusion pumps to the system in order to record fluids directly. Nurses reviewing information collected it before accepting and signing for the information on the system.
- A comprehensive daily record, covering all body systems, was completed for each patient during the midday ward round. This provided a complete record of treatment in the two records reviewed.
- Access to the ICIP system was via individual password.
- ICIP results included an assessment of high-risk patients, which was recorded weekly and updated as required. This used a System of Patient Related Activities (SoPRA), to identify the intensity of interventions required by individual patients. This provided an indication of the staff workload for each patient.
- Records were available for morbidity and mortality meetings, could be used for audit and were stored indefinitely.
- Until recently, ICIP was accessible to all clinical teams across the trust, in order to review information relating to patients discharged from the CCU (ITU). However, in CCU (ITU) the system had been upgraded to Word 7, which was not available to other teams. We spoke to one doctor, who returned to CCU (ITU) to review medication prescription and administration, as he was not able to access this information on the ward. We were informed of plans to update the remaining IT systems to Word 7, which would resolve this issue.
- Risk assessments were recorded for individual patients on the electronic system, including pressure area assessments and VTE risk.
- Backup paperwork was available on the CCU (ITU) if the electronic system was inaccessible for any reason.
- Nursing and medical discharge summaries and a care and treatment plan were printed off the system when patients were transferred to the wards. The medication chart had to be written for the ward prior to transfer.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- The CQC was required by law to monitor implementation of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and to report on findings. There was evidence that staff were aware of how the Mental Capacity Act 2005 related to their work.

- A concern regarding mental capacity was raised through the incident reporting mechanism. This provided evidence of reporting via safeguarding and Mental Capacity Act 2005 leads.
- Nurses were observed to explain care to patients prior to providing interventions.
- Staff used the trust policy for consent for procedures and surgery.

Safeguarding

- All staff spoken to reported completing training in safeguarding adults and children.
- Information regarding staff training was displayed on a noticeboard outside the matron's office. This demonstrated that all nursing staff had completed safeguarding training or had a booked date to complete this within a year of previous training. This was monitored closely by the education sister.
- There was evidence that safeguarding concerns were reported through the incident reporting system and escalated to the trust's safeguarding leads.

Mandatory training

- The education sister in CCU (ITU) planned the statutory and mandatory training for the year for all nursing and support staff. There was a plan on the education board and nurses confirmed when they had attended. Any nurses who missed planned sessions were rebooked.
- Evidence was provided that greater than 90% of nursing and support staff had completed statutory and mandatory training, with the exception of manual handling. Only 79% of staff had completed this training, but the remaining staff had dates booked.
- The resuscitation officers provided monthly training using the simulator in the management of critically-ill children.

Management of deteriorating patients

- The management of deteriorating patients was coordinated by the critical care nursing outreach team, with one nurse between 8am and 2am seven days a week. This team also provided training and education for clinical staff. This included training doctors and nurses in the use of the national early warning score (NEWS) tool and leading on tracheostomy training across the hospital.
- There were plans in place to increase the number of nurses to provide a 24-hour service.
- If a patient required ventilation in recovery, prior to a bed being available on CCU (ITU), an outreach nurse would care for the patient in recovery.
- The hospital used a NEWS, which is recorded and calculated electronically on a VitalPAC system. This was collected centrally and was accessible via the ICIP system in CCU (ITU) and iPod on the wards. There was a trial in place using a track and trigger mechanism to alert junior doctors to deterioration in patients' scores. This system was robust and was used effectively.
- Medical and surgical emergency teams were informed if the NEWS reached nine.
- We were informed that the trust was in the process of introducing an NEWS tool for use with children.

Nursing staffing

- The nursing establishment was sufficient to allowing staff to provide 1:1 nurse to patient ratios in CCU (ITU) and 1:2 in HDU. In addition, there was a supernumerary nurse-in-charge who did not have patient responsibility, but managed the whole unit.
- There were four vacant nursing posts and 0.3 of a vacancy for a healthcare assistant. One band 5 nurse was due to start in October and the theatre and support services clinical unit were planning to undertake a mass recruitment event.
- Nurse sickness levels were reported to be 7% at the time of the visit, due to both long and short-term sickness. This was usually around 4%. In addition, a number of staff were on long-term leave for other reasons, which made it difficult to achieve the nursing numbers required to keep all beds open.
- Staff reported that staff sickness and vacancies were rarely covered with bank (overtime) or agency nurses, as suitably qualified nurses were not available. This resulted in unit staff covering additional shifts with bank staff. Some staff reported that this could exacerbate sickness levels and back problems.
- The outreach nursing team had five posts to cover the clinical work and teaching. This was reported to be under review to enable provision of a 24-hour service.
- Consultants reported a highly-experienced nursing team who supported each other well. 49% of nurses had completed an intensive care course.
- Healthcare assistants were available to support nurses with bedside care and provision of supplies at the bed space. In addition, there was an audit lead and an education sister.

Good

Intensive/critical care

- Patient acuity was measured through the electronic recording system, which provided a workload assessment for each patient.
- Handovers were undertaken at the beginning of each shift, with a brief overview of all patients on the unit. Nurses received a more detailed handover of individual patients at the bedside, using the electronic record.
- Where possible, the rota supported a three week rotation of staff between CCU (ITU) and HDU to support continuity of care in each area.
- Staff were occasionally asked to cover shifts on the Eastbourne District General Hospital site, often at short notice. However, there was no formal rotation of staff between the two units.

Medical staffing

- There were six consultants in intensive care providing a seven-day service on the unit, with out-of-hours cover including three consultants based at Eastbourne District General Hospital. Consultants worked from 8am to 6pm in five-day blocks, on a 1:6 rota.
- There were insufficient doctors to provide a three-tier rota, so out of hours there was a consultant and a doctor in their second year of core training (CT2) for the CCU (ITU). Medical trainees rotated through the unit did not work on the out-of-hours rota.
- Overall, medical cover met the Intensive Care Society guidance for a unit of this size.
- The team reported good support from other teams, especially local paediatricians, for the occasional children admitted to the unit for stabilisation prior to transfer.
- Until recently, locum doctors were usually people who had worked on the unit before. However, this had changed and some trust-grade doctors had been used.
- The South Thames Retrieval Service (STRS) provides training once or twice each year for the whole team in the management of the critically-ill child.

Major incident awareness and training

- The staff reported adherence to the trust major incident policy.
- The matron told us that the unit manager would take responsibility and coordinate ITU activity in the event of a major incident, as local procedures would not involve evacuation in the same way as other clinical areas.
- Staff reported recent use of the business continuity procedure, when the unit was decorated recently and the service had to be reduced and relocated.

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

Good

Critical care services were effective.

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

Evidence-based care and treatment

- Doctors reported that the electronic patient record has led to improved audit processes. An example provided was the assessment of compliance with the guidance for ventilating patients with acute respiratory distress syndrome, which had led to the education of staff and changes in practice. The staff planned to re-audit this change in the future.
- Policies and practice were reported to be based on a mix of NICE and the Intensive Care Society guidance.
- New NICE guidelines were displayed on a noticeboard in the staff room, alongside information regarding complaints and CCU (ITU) performance and posters produced by nursing students and from the Sussex Critical Care Network.
- There was a National Confidential Enquiry into Patient Outcome and Death (NCEPOD) list operating during the day for minor problems.
- The unit had an audit clerk, who collated and reported patient and staffing information up to the audit sister, who coordinated the audit on CCU (ITU).
- Nurses reported being allocated to working groups, which met twice yearly to look at current guidance and practice relating to patient care, such as neurological conditions. Information gathered at these meetings was shared with other staff on noticeboards in the staff room.

Good

Intensive/critical care

- Staff reported the local policy for managing critically-ill children, which involved stabilising children under 16 an transferring them to a children's intensive care unit using the South Thames Retrieval Service.
- We were told of innovations in practice, such as the recent change in a new form of renal replacement therapy. The team informed us of how they had researched this change with colleagues in Europe and were now receiving visits from other UK centres interested in this treatment.
- The outreach nurses reported an audit of the NEWS system, which led to the increased education of staff and the introduction of the VitalPAC electronic early warning system, enabling doctors to access data through an iPod touch.
- The observation of a monthly anaesthetic audit meeting, identified that this was well attended and included discussion of morbidity and mortality, audit and college recommendations.

Pain relief

- Pain management was discussed as part of the daily CCU (ITU) ward round and management adjusted appropriately and recorded the discussion in the ICIP.
- Outreach nurses were involved in the management of pain for patients reviewed on the wards.

Nutrition and hydration

- Fluid balance and nutritional management, including malnutrition universal screening tool (MUST) scores, were recorded on ICIP for all staff to see. The unit used Hartmann's Solution IV Infusion intravenously, in line with recent published evidence.
- Staff reported that the food provided to patients who could eat looked more appetising since it was cooked in house.
- The unit had support from dieticians, who provided advice regarding appropriate nutrition and standard feeding regimens as required.

Patient outcomes

- Quality and safety information was displayed on a noticeboard near the entrance of the unit for staff and visitors to see.
- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. ICNARC data demonstrated outcomes similar to comparable units with a better than average mortality rate. However, the delayed discharge data indicated a significant delay in discharges from the unit. The team were aware of this and systems were in place to reduce these times.
- The incidence of VTE and urinary tract infections was low and there had been no recent pressure ulcers reported.
- Infection data showed low levels of acquired MRSA, C. difficile and/or ventilator-associated pneumonia (VAP) in the previous 12 months.

Competent staff

- Staff reported having regular appraisals and the nursing education board listed all nurses with appraisal dates. This showed all but those nurses on maternity leave had been appraised over the previous 12 months.
- We were told that appraisal in CCU (ITU) was based on the trust values and additional requirements for critical care. Managers informed us that 93% of CCU (ITU) staff were compliant with local guidance on appraisal and the remainder had booked dates.
- We were informed that consultants and junior doctors had an allocated 10 days per year study leave with agreed funds. However, this was not available for nursing staff, who may have been given study leave or funding. A number of nurses told us about practice-related courses that they had funded themselves.
- Junior doctors informed us of weekly training, planned by the senior trainees and attended by around 10 doctors each week.
- The unit supported nurses to undertake a post-registration qualification in critical care nursing. We were told that 46% of nurses had a critical care qualification and three places were funded each year, with an additional nurse funding herself in the current year. Information about the programme was displayed on the nursing noticeboard.
- The education sister and nurse mentors supported student nurses and staff on the critical care course.
- Student nurses working on the unit received a minimum of four weeks supervised practice and were encouraged to participate and assess advanced care under supervision.
- The CCU (ITU) used the Sussex Critical Care Network competence documents for healthcare assistants, new nurses and leaders.

Good

Intensive/critical care

- Staff raised concerns that they lost a significant number of critical care trained staff to larger units where more varied experience was available.
- A wide range of conferences and training events were advertised on the unit, including organ donation, care of the critically-ill child and The British Association of Critical Care Nurses events. We were told that attendance at these events was usually self-funded, but staff attending these events had led to changes in practice, such as the use of a board in each bed space for communication between patients and relatives.
- Staff of all grades reported concerns relating to the care of children as they only saw around 40 cases a year, with three in July 2014. There were systems in place for education and competence assessments, paediatric equipment and good links to a specialist intensive care service, but the potential admission of children remained a concern for staff due to the infrequency of admissions.
- Junior doctors underwent a standard induction process and took part in regular training.

Facilities

- The CCU (ITU) had limited space and did not comply with current building standards for CCU (ITU). The staff reported mechanisms to reduce the risks in this area and told us that early discussions about relocating the service to a more appropriate environment had taken place.

Multidisciplinary working

- Staff told us that they enjoyed working on the unit as it provided good support and teamwork.
- We were told about joint morbidity and mortality meetings with A&E, held every three to four months with feedback to other teams.
- The critical care team included physiotherapists, a dietician and a pharmacist who worked closely with the medical and nursing staff.
- Daily multidisciplinary ward rounds enabled discussion of practice among the wider team.
- The team reported good working relationships between critical care teams across site, with out-of-hours cover provided by consultants from Eastbourne District General Hospital and nurses covering the service across site as required.
- There were clear procedures in place for the transfer of adults and children to other services.
- Patients were invited to attend a three month follow-up clinic following discharge from critical care.
- A critical care outreach team provided support to the wards to manage deteriorating patients and identify patients who may have required admission to critical care.
- Staff were aware of guidance around organ donation and how to contact the organ donation team. Information was available on the unit.

Seven-day services

- Staff reported a recent change in the rota to provide consultant presence on the CCU (ITU) seven days a week between 8am and 6pm.
- Consultant rotas showed dedicated out-of-hours consultant cover for the CCU (ITU). We were told of plans to increase consultant numbers to a total of 15 to improve cover across the whole service.
- Consultant radiologists had access to PACS at home to provide advice as required.
- The team had access to physiotherapy, pharmacy and imaging out of hours.

Are intensive/critical services caring?

Good

During our visit, we observed staff providing care and communicating in a caring and compassionate way. Patients were provided with explanations about care and staff maintained patient dignity in a challenging environment. Written information was available for patients and relatives, but not in languages other than English. Staff actively sought feedback from patients following discharge and used this to improve services offered to patients and relatives.

Compassionate care

- During our inspection, we observed that patients were treated in a kind and caring way, being treated with dignity and respect.
- Nursing staff used screens and curtains to maintain the privacy and dignity of patients, with warning notices not to enter when curtains were drawn.

Good

Intensive/critical care

- The unit did not use the NHS Friends and Family Test, but had developed a local system for gathering feedback. Staff reported a limited response to this, but issues raised were discussed within the team to aid learning.
- Staff received feedback from the support group and follow-up clinic and used this to inform practice. Feedback and action taken was displayed on a public noticeboard in the unit.
- Relatives raised concerns about the time spent waiting to see a relative on the unit. Staff spoke to the family when this was raised with them. They reported that this was the most common concern raised and understood that this was a stressful time for families.

Patient understanding and involvement

- Patients were often not able to be involved in decisions about care when initially admitted to the unit. However, we observed staff explaining care to patients to help them understand. Explanations were clear and simple.
- Written information for patients, families and friends was available in the relative's room and in the intensive care unit. This included locally produced information and useful information provided by the patient support charity, ICUSteps (the intensive care patient support charity). All of this information was in English and staff told us it was not readily available in other languages.
- Staff told us of plans to place a patient orientation board beside each bed to outline key messages about treatment and provide a place for relatives to leave messages.
- Nurses were allocated to patients on a shift-by-shift basis, with the aim of providing continuity of care.

Emotional support

- We were told that the relatives room provided a private and quiet space for conversations with families.
- There was a six-weekly patient and relative support group, which was run off site. There were eight people at the last meeting and feedback was provided to the unit.
- There was a three month follow-up clinic for all patients discharged from CCU (ITU), which had a good attendance rate.
- Information about support and counselling services was available in the relative's room.
- Access to other professionals was available depending on individual patient need.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Good

The service was managed with the needs of the patient in mind and the recent reconfiguration had improved medical cover on the unit. Nursing resources were looked at across sites to ensure nursing numbers meet patient demand. There was a procedure for bed management within the critical care unit. Pressure on beds during busy periods had impacted on the number of patients whose discharge was delayed or who were discharged from the unit out of hours. Recently, improved procedures for monitoring bed availability in the ward and critical care areas had been introduced, to reduce the number of patients transferred to wards in out-of-hours periods. The impact of these procedures was unclear.

Staff were not able to respond to patient needs for bathroom facilities on the unit, accessing facilities on nearby wards. Staff were able to respond to the communication needs of patients in a variety of ways and had staff leads for patients with special needs. Procedures for managing complaints and concerns was used effectively to improve services for patients.

Service planning and delivery to meet the needs of local people

- The matron reported daily discussions with their colleague at Eastbourne District General Hospital, which would include issues, such as activity and staffing. Staff were moved between sites as required, depending on activity levels.
- Matrons from the theatres and support services clinical unit met every five weeks to explore a range of service issues, including complaints and quality monitoring.
- Staff reported a range of sources of funding for equipment and new initiatives, such as the VitalPAC early warning system, which they had been able to roll out across the hospital in a short time with a project manager.
- We were told that when the unit was very busy or was awaiting patient discharge to the ward, patients were occasionally ventilated in recovery until an ITU bed was made available.

Good

Intensive/critical care

Access and flow

- Depending on the level of care required, patients were admitted to either the CCU (ITU) or HDU rooms. As care requirements fell, patients were moved from CCU (ITU) to HDU.
- ICNARC data indicated higher levels of discharges from the unit in out-of-hours periods when compared with similar services. Datix information for the period August 2013 to July 2014 recorded 13 out-of-hours discharges. One of these was a delayed discharge due to lack of ward beds, but the remaining 12, due to the requirement for ICU beds. Nine of these were between 27 November 2013 and 14 March 2014 when bed occupancy was between 70 and 90%.
- The critical care unit risk register cites late discharge of patients to the ward as a problem with instances where patients had been discharged home from critical care beds. This had impacted on the quality of discharge planning, resulting in negative feedback through the NHS Friends and Family Test. There was a bed management policy and a process to monitor this through daily bed meetings four times per day and escalating concerns as they arose.
- Between May 2013 and April 2014, bed occupancy fluctuated between 40% and 90%, with an average around 65%, which was below the national average.
- There were 3.6 critical care beds per 100,000 of the population served.
- Staff reported 100% of patients were admitted within four hours of referral.
- There were no reports of surgery cancelled due to lack of beds on this site.

Meeting people's individual needs

- The use of VitalPAC to collect NEWS scores enabled outreach nurses to identify the sickest patients and prioritise them for review early in their shift. There was a protocol in place which indicated the level of review required depending on the individual patient scores from five and upwards. The outreach nurses reported that this has made their service more responsive to patient needs and improved medical involvement in using the NEWS tool and their response to the results.
- Relatives told us that the signage for the unit was confusing and they had originally visited the coronary care unit (CCU) and had to be redirected to CCU (ITU) (intensive care and high-dependency care). We found that some staff were unable to differentiate between the two units when we had asked for directions.
- The relative's room in CCU (ITU) had a vending machine offering cold drinks and snacks, which was filled once a week. However, during our visit, we observed that this machine was almost empty.
- One family informed us that they had waited in the relative's room for more than an hour without information about their relative. Nurses confirmed that this was a common complaint, which they had tried to address on a number of occasions, but admitting patients to the unit often took some time. Nursing staff usually informed relatives of this when showing them to the relative's room at admission.
- Staff told us that the recent reconfiguration of services was based on patient need. In critical care, this had improved medical cover across the service and enabled very junior trainees to be taken off the out-of-hours rota.
- There were no patient toilets or bathroom facilities in CCU (ITU). Staff informed us that patients who were awaiting discharge to a ward had to be taken to a nearby ward to use toilets and wash facilities, which they thought negatively impacted on dignity.
- Translation services were available by telephone, but the nurses used tablets with translation facilities for simple instructions for patients.
- There are two touch-type tablets available for use with patients with learning disabilities, to aid communication.
- There were learning disabilities and dementia leads on the unit to support staff with specific patients, such as those with complex needs.

Learning from complaints and concerns

- There had only been one formal complaint received relating to critical care between September 2013 and September 2014.
- Senior critical care staff reviewed all complaints.
- Staff reported that most complaints and concerns raised related to communication with relatives and availability of staff. Outcomes from complaints investigations were discussed with individual staff highlighting changes required with communication. Unit induction now included information regarding the importance of time spent communicating with relatives.

Good

Intensive/critical care

- Staff reported that they acted on concerns from patients and their families. Examples provided were concerns about sleep disturbance, which had resulted in providing a quiet period during the day and reminding staff to provide quiet, where possible, at night. In addition, visiting times had changed in response to complaints.
- Information reporting what action had been taken following concerns raised in CCU (ITU) was displayed on a noticeboard near the unit entrance for staff and relatives to see.

Are intensive/critical services well-led?

Good

Leadership on the unit was good, with effective multidisciplinary working and a supportive leadership culture. It would be difficult for staff on the unit to address some of the issues relating to the environment and discharge patterns without consistent leadership from the staff above them, which was not apparent during the inspection, due to the recent changes in roles. While the new leadership team required time to settle into their individual roles, it was important to provide leadership to CCU (ITU) to ensure that unit plans were coherent with trust plans for the future.

Vision and strategy for this service

- A future strategy to improve the environment for critical care services had been discussed, but these were not likely to be implemented in the near future due to other priorities.
- Medical leadership was strong, with innovation from the clinical leadership of CCU (ITU).
- The new senior management structure needed to be embedded for effective team working above unit level.
- Nurse leadership was currently in transition, making it difficult for the unit senior nursing staff to develop a future vision and strategy for the service.

Governance, risk management and quality measurement

- Some staff reported raising issues relating to risk to senior staff, but it was unclear whether these were acted upon, as staff did not receive feedback.
- Medical staff attended monthly morbidity and mortality meetings. Notes from these identified discussion of issues, but rarely identified areas of learning.
- Staff on the unit attended meetings of the clinical unit but were not present at meetings outside this area. For example, matrons within the clinical unit met regularly, but there was no forum for senior nurses to meet with colleagues from other clinical groups to share concerns and best practice.
- Information from governance meetings, safety data and audit information were all displayed on noticeboards for staff to see. Quality, safety and complaints information was available for visitors to see.
- The unit was part of the Sussex Critical Care Network, which enabled the staff to share learning and to learn from others.
- Risks relating to the bed management were on the risk register and monitored using trust procedures.

Leadership of service

- There had been recent changes in senior leadership roles within the clinical unit, which had led to some confusion among staff regarding who led on specific areas, such as nursing and service management.
- There was strong local leadership with the consultants and senior nurses working together.
- Staff described senior staff on the unit as approachable and supportive and reported being able to ask questions of colleagues. Many told us they enjoyed working on the unit.
- The nursing workforce was experienced and flexible, ensuring that the service could be sustained during busy periods or during the period of high staff absence they were experiencing at the time of the inspection.
- One member of staff told us that they had been largely left alone during the reorganisation because managers knew they would just “get on with providing the service”.

Culture within the service

- The staff appeared to be highly committed to the work they did, with some nurses having worked on the unit for many years.
- The culture encouraged staff to raise concerns both verbally and through the incident reporting system.
- The multidisciplinary team were observed to work well together.

Good

Intensive/critical care

Public and staff engagement

- Brief information about the intensive care units was available on the trust websites.
- Despite the 2013 staff survey reporting low levels of satisfaction with the quality of work provided, the staff on CCU (ITU) reported high levels of job satisfaction and engagement with the service.
- Staff acted on feedback received from patients and relatives, dealing with this proactively to improve services. Staff reported trying to increase the number of families providing feedback.

Innovation, improvement and sustainability

- Staff reported being able to bring ideas from conferences and courses to develop services on the unit.
- Staff were not deterred if funds for equipment were not available within the trust. They described applications to the League of Friends for the ICIP system, to the NHS for 'Safer Hospitals, Safer Wards' funds and NHS England technology funds for the VitalPAC early warning system with track and trigger facility.
- The change in renal replacement therapy provision was a new innovation in the UK, which had resulted in the unit receiving visitors from other centres.

Inadequate

Maternity and family planning

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

Information about the service

The East Sussex Healthcare NHS Trust maternity services were reconfigured after a group of consultant obstetricians wrote to the trust board detailing their concerns about patient safety. Initially, this was a temporary reconfiguration in July 2013, but, with the support of the clinical commissioning groups and the health overview scrutiny committee of East Sussex County Council, the arrangements were made permanent in July 2014. There was significant local opposition to the reconfiguration of maternity services, but it was not within the remit of the CQC inspection to comment on the commissioning arrangements.

The current arrangements were that a consultant-led unit (with a day assessment unit, antenatal and postnatal inpatient wards, a labour ward and special care baby unit) provided maternity services at Conquest Hospital, Hastings. There were also two midwifery-led units, with the one at Crowborough War Memorial Hospital being more established than the unit at Eastbourne District General Hospital, which was opened as part of the reconfiguration arrangements. Women could also choose to have a home birth and these, along with antenatal and postnatal care, were supported by community midwives. The trust cared for women during 3,329 deliveries in 2013 and 2014, with the majority of women giving birth at the Conquest Hospital. The Eastbourne District General Hospital maternity unit midwives delivered between 19 and 35 births a month, with most months seeing around 30 births.

All maternity services are reported under the Conquest Hospital as we found the overlap of services and shortcomings in one area impacted on all other areas of the service.

The inspection team for maternity services reviewed data that CQC hold about the trust and looked at information provided to us by the trust. We spoke with over 30 patients and their partners, grandparents, many members of local voluntary and campaign groups and members of the public. We met with staff of all grades, individually and in groups and interviewed senior staff. We carried out direct observation of care and treatment being provided on the maternity unit at Conquest Hospital, including in the obstetric theatre and in the maternity-led units. We reviewed patients' maternity records and other records being maintained on the wards at Conquest Hospital and in the midwifery-led units.

Inadequate

Maternity and family planning

Summary of findings

The maternity services provided at the Conquest Hospital, overall, were inadequate. Although maternity staff were, mostly, caring the service was inadequate for safety, effectiveness and being well-led. Responsiveness required improvement.

There were risks to women and their babies from a poorly managed service that had significant challenges with capacity. Individual staff and managers were working hard to maintain a reasonable quality of care in very challenging circumstances.

The lack of leadership capacity and high workloads meant some staff had become disengaged with the service and had high sickness levels. Staff worked long days without breaks and with little support; this was reflected in a high level of sickness absence that further compounded the problem.. This was particularly noticeable on the postnatal ward.

There were significant issues about the number of staff, skills mix of staff and the communication between professionals. Due to staff shortages the birth centres were sometimes closed reducing choice for women and increasing the risk of intervention because of labour in unfamiliar surroundings. Midwives were caring for high risk women in an environment with which the staff were often unfamiliar (not routinely working in this service); and with a team they did not know well; this could impact on patient safety.

The escalation policy for staff shortage was in almost daily use and was usual practice and, as such, was an unsustainable model for the staffing of maternity services. The trust failed to recognise the impact of their policy on staff and the consequent effect on the safety of the service.

We had some concern about the care women received when the consultants were not present and the ability level of some middle and junior-grade doctors. During our inspection visit, there were two incidents in one night after the consultant had left the premises. The unit was being covered by one senior house officer and a staff grade doctor at the time. One was escalated as a Serious Incident.

Security was not given a high profile at the Conquest Hospital and women and babies were at risk from breaches of the security arrangements.

The data provided by the trust was insufficiently robust to assure us that it provided an accurate representation of how well services were being delivered. We saw examples of incidents (relating to areas such as controlled drugs management, infection prevention and control and data protection) that were not identified as such by staff and so not reported. This meant that these details were not reflected in the data shared with CQC.

The majority of medical records that we saw were incomplete and contained insufficient detail to demonstrate that good care was provided overall.

Daily incident review meetings were held, but failed to consider all the pertinent issues around incidents and so failed to identify all the learning from incidents.

Care and treatment provided was not always in accordance with trust pre-eclampsia policy and national guidance. Venous thromboembolism risk assessments were not always completed and patients were then not prescribed anticoagulants when needed.

There were a number of examples where informed consent was not obtained

Some specialist provision, such as the screening service, was good and responded well to the needs of couples facing the distress of foetal anomaly. Other aspects of the provision for specific groups of women and families were less developed and there was a lack of specialist midwives to provide expertise in the care of pregnant children, women who misused drugs or alcohol and other particularly vulnerable groups.

We received a number of reports of dissatisfaction with the midwifery service. Concerns were raised about the shortage of staff, being left alone for hours when scared and in pain. Having to waiting for long period of time and then to be sent home because of lack of medical staff available to see the patient. We received reports of poor after with lack of staff to assist mothers caring for their baby and significant concerns about cleanliness.

There was a general theme from patients and staff that they were not listened to about their concerns.

Inadequate

Maternity and family planning

Are maternity and family planning services safe?

Inadequate

Maternity services were judged inadequate.

The service had areas that were not clean.

Staff of all grades failed to follow trust hygiene policy and procedures. Infection prevention and control was a concern at the Conquest Hospital, but not at the other sites.

We saw many examples of drug errors, poor medicines management practice and lack of appropriate controlled drugs governance.

Data was inaccurate and insufficiently robust to allow concerns to be identified and to measure how safe the service was. Daily incident review meetings were held, but failed to consider all the pertinent issues around incidents and so failed to identify all the learning from incidents.

Security was not given a high profile at the Conquest Hospital and women and babies were at risk from breaches of the security arrangements.

Incidents

- We have concerns about accuracy on data provided by the trust on babies Born Before Arrival (BBA). The trust has identified a small number of instances but there is evidence to suggest under recording.
- The trust had shown a previous increase in incidence of hypoxic-ischaemic encephalopathy (HIE). The trust had taken action, and the rate had fallen. However we found that the trust could have done more to reduce level further.
- The number of serious incidents across the maternity services was recorded as 12, having occurred in the four-month period from January to May 2013, prior to reconfiguration of the service. We were told that the level of serious incidents being reported fell immediately after reconfiguration.
- We found poor identification and recording of incidents. Staff working on the unit were uncertain about whether there was any guidance as to triggers. However there was a policy on the intranet. The head of midwifery told us there was a hard copy of the triggers available on the labour ward, but staff we spoke with were unaware of this.. As staff were not identifying and reporting incidents, the data about the number and seriousness of incidents was unreliable, learning from incidents was not robust and did not present an accurate picture of how the Trust was performing.
- When we spoke with staff, they told us that it was the responsibility of the band 7 matrons to decide what constituted an incident and the band 7's that reported it. The staff working on the maternity unit were unfamiliar with the trust policy and the band 7 matrons we spoke with were also uncertain as to the responsibilities of individual staff members. The culture of only 'band 7 nurses' reporting was likely to have reduced the incidence of incident reporting through formal channels, in accordance with the policy. This was particularly true of staffing shortages, which all grades of staff said they were not encouraged to report through the trust's reporting system.
- The Trust document, Maternity Incident News, dated 31 March to 27 April 2014 showed a total of 31 incidents reported over the month. It provided a brief oversight to staff about the level and type of incidents that were being reported. There were also some reminders to staff about trust policy and national guidelines.
- We identified a number of opportunities where the learning from incidents was ineffective and failed to reach staff with an opportunity to improve.
- The trust had not recorded or reported any Never Events during 2013/14. We saw two incidents relating to retained swabs which ought have been considered as never events.
- The record of Serious Untoward Incident detailed the care of a mother and baby during labour and the subsequent resuscitation attempt. The details enabled it to be cross referenced to the incident report log, where the record differed somewhat from the SUI report. The poor outcome was likely to have been the same, but there should have been more significant learning around the management of resuscitation and professional behaviour.

Cleanliness, infection control and hygiene

- The unit was visibly dirty and untidy, particularly the postnatal ward. We saw overflowing waste paper bins and cramped conditions that made cleaning difficult.
- A comment in the communication book on the labour ward dated 27 April 2014 read, "Please put placentas in

correct bin and on top of washing machine and NOT under the sink. The MSW found a rotting placenta smelling and not very pleasant." This was not reported as an incident and so there could not be any consideration of the level of risk this presented or any learning from the situation.

- On the postnatal ward, we inspected the milk kitchen that is used by parents to make up feeds for their babies. We found that the room was not reserved for use as a milk kitchen, but was a general kitchenette used for preparation of snacks and drinks. It was also used to heat the ward meals sent up to be microwaved. This increased the traffic and, consequently, the risk of transmission of infections to neonates. The surfaces and cupboard doors were dirty.
- There were instructions to staff and parents to write labels with names and dates on each carton of powdered formula infant feed as it was opened. We saw that there three cartons opened and none had a label.
- The temperature and cleaning records of the fridge that is used to store expressed breast milk were incomplete and showed limited monitoring of fridge temperatures and cleanliness by staff. On one date in August 2014, a temperature of nine degrees centigrade was recorded, which is in excess of the recommended storage temperature of below four degrees centigrade. There was no record of any action being taken.
- Resuscitation trollies were dirty. Dust had collected into a thick layer on trollies on the postnatal ward and the labour ward.
- In the operating theatre on the labour ward, we observed that some staff, including doctors, were not following national guidance of being 'bare below the elbow' when providing clinical care. One consultant walked into theatre wearing a suit without sleeves rolled up on the day of our visit. This oversight went unchallenged by the other members of the theatre team.
- We were provided with the trust policy as mitigation of this concern. The trust policy was not in line with the national guidance contained in Standards and Recommendations for Safe Perioperative Practice (Association of Perioperative Practice, 2011).
- Observation in the operating theatre showed that cleaning took place between patients. However, no Standard Operating Procedures or deep cleaning schedule was available.
- We observed one senior midwife providing direct care wearing civilian clothes, covered by a plastic apron. This was inappropriate from an infection prevention and control perspective, when the risk of contamination with bodily fluids was so high.
- Information on infection prevention and control displayed on the labour and postnatal ward by the Trust showed local audits results for July 2014. These stated that the unit had scored 100% for cleanliness and a hand hygiene audit that showed 100% compliance with hand washing good practice. It was difficult to see how these scores were accurate when there was documentary evidence that cleaning of equipment had not been carried out as required by local policies and the unit was seen to be dirty. For example, the 'Daily between patients check and clean list' showed that on 14 August no checks at all were undertaken and on 13 August 2014 there were no checks to ensure there were adequate supplies of alcohol gel, gloves and aprons or formula in the milk fridge.
- Several patients told us they thought ward was dirty. One woman on the antenatal ward said the midwives were ambivalent and that a used sick bowl had been left by the side of their bed for "hours".
- The Quality and Governance Performance Report dated May 2014 showed 77 % of staff had completed mandatory infection prevention and control training.

Environment and equipment

- Babies born in hospital should be cared for in a secure environment to which access is restricted. The labour ward and postnatal ward environment were not secure. On the first day of our visit, we noticed that an external door to the postnatal ward was propped open with a chair and on the second day an external door to the labour ward was open. The doors between the separate areas of the unit were kept open so that the entry points to each area gave access to all the other areas. This left women and babies on the ward vulnerable.
- We noted that two previous incidents of security breaches (October 2013 and May 2014) had occurred; but no learning from these appears to have taken place.
- We found concerns about the lack of immediate tagging and identification of babies at birth. There were several incidents recorded where babies were found not to be properly identified with tags.
- During May 2014, the postnatal ward was, for up to a week, without a supply of blood glucose curettes, which

are used to monitor the blood glucose levels of babies born to diabetic women, or where there are other concerns about the blood glucose levels of the baby or mother. The exact length of time without the curettes was difficult to ascertain as there were no records of action being taken; there were several entries that showed a lack of curettes over this time. A lack of basic monitoring equipment placed babies at risk of harm because it limited the midwives and other postnatal ward staff ability to follow the guidance to test the blood glucose level in a timely manner.

- Resuscitation equipment was available in all three of the units.
- On the postnatal ward at the Conquest Hospital, the daily and weekly checks of the resuscitation equipment were not always completed, as per the trust policy. A new sheet had been introduced a week earlier (at the beginning of September), but this was not completed each day. Previous forms were incomplete or undated. There was no evidence of action being taken where a shortfall in the equipment was identified.
- At the Eastbourne District General Hospital midwifery led unit, the checks were currently being undertaken as required. However, earlier checks were not always completed as an incident form dated June 2014 said, "Routine check of adult resus trolley revealed a large amount of expired items including drugs. Some expired years ago"
- We had no concerns about the checking or maintenance of resuscitation equipment at the Crowborough Birthing Centre.

Medicines

- The staff communication books on the postnatal ward and labour ward showed a shortage of drug charts over a period of several months. We were told that staff had resorted to using single dose drug forms to enable medicines to be prescribed for women and babies. This increased the risk of accidental duplication of doses, missed doses and prescribing errors.
- The trusts Medicines Management Policy Controlled Drugs states that Controlled drugs should be checked and counted a minimum of once a day and recorded within the Controlled Drug Record Book. We saw the Trust maintained a separate loose leaf sheet for each week's recording that was stored separately from the register. These sheets did not form a compete record of checks and failed to provide assurance that the controlled drug stocks were being monitored in accordance with the trusts own policy. On the postnatal ward, there was a single sheet begun on 1 September 2014, but this was not completed from 1 September 2014 to 5 September 2014. We asked to see sheets dating from before September, but were told these were not available. The controlled drug register contained a number of errors and unexplained corrections. These alterations included timings being changed and crossings out. We saw one error in the calculation of the amount of methadone stored for a patient that had not been identified by staff, or reported through the incident process. Some entries were not clearly written.
- An incident recorded in March 2014 showed that a patient had been discharged home on a Friday. The controlled drugs were checked on the Monday and found that the patient's own methadone was not in the cupboard, but had not been signed out of the controlled drug book, 110 mls in total was unaccounted for. While the midwives on the shift were certain the drug had been handed to the patient, the investigation into the possible loss of controlled drugs had still not been completed by June 2014.
- We also saw that the controlled drug register contained an inventory of a patient's personal drugs and money. An entry made in March 2014, showed a named patient as having £187.14, NHS vitamins and FeSO4. This was not an appropriate use of a controlled drug register.
- We noticed that the pre-eclampsia trolley was left in the corridor with a broken vial of labetalol on it, a drug used to treat high blood pressure, one of the main concerns in pre-eclampsia. If the trolley had been needed in an emergency, the appropriate drug would not have been available. The situation also raised concerns about the safe disposal of contaminated sharps. We noticed later in the day that the trolley had been restocked.
- The maternity unit did not have a ward pharmacist. A senior pharmacy manager told us that there were significant staffing shortages in the pharmacy department and that they had 12 whole time equivalent vacant posts.
- Pharmacists were not routinely checking the discharge medication against the inpatient drug chart.

Records

- The majority of the 23 records that we saw were incomplete and contained insufficient detail to demonstrate that good care was provided overall. One

record from the labour ward, for example did not name the midwife caring for the woman, had no preferred name recorded, nor details of the next of kin although, subsequent to the inspection, the trust advised that this information is recorded in the antenatal booklet that is also present on labour ward. It was unclear why a trust form would have a space for specific information if it were not necessary.

- Other records had no growth charts completed in antenatal records, and another had no partogram. We saw one maternity record that included a loose scrap of paper in a cellophane envelope. This handwritten note said, "Patient A was booked with number X123456 but this has been merged with X678910. Please use X678910 as this is used for research". The MRSA screen for this patient had the incorrect patient record number on the results form. We saw several incident forms that related to patients having more than one hospital number.
- We noticed that of the 23 records that we reviewed, very few had risk assessments for determining the risks women faced related to **v**enous thromboembolism (VTE), a condition where a blood clot forms in a deep vein. The risk assessment of VTE risk was complicated because the notes were subdivided into different booklets for each stage of care (antenatal, intrapartum and postnatal) and required the information to be carried forward from the previous section. We saw that one woman had no recorded VTE assessment and had been started on anticoagulant drugs inappropriately.
- We looked at the clinical notes for a woman who had a third degree tear repair. The notes were inadequate and confusing.
- One incident record, dated July 2014, noted that a midwife had found that a patient had both a normal caesarean dressing and a pressure dressing in situ, despite no documentation of a pressure dressing being applied within notes and no handed over documentation regarding how wound healing would be noted. The midwife had presumed the wound should be visible (for example, dressing off) but the two surgeon's notes on the repair of the wound and aftercare differed completely. The patient was left with severe blisters from the dressing. The action from this incident suggested that the notes were, "reviewed and amendments were added after checking".

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Records showed that one patient complained that she had her waters broken against her wishes during labour. No mention was made of the lack of informed consent.
- We saw that a number of women made complaints about lack of informed consent before procedures.
- We observed that most staff sought verbal consent before providing care or carrying out examinations. Most records of women who had surgical deliveries contained a completed consent form.

Safeguarding

- The safeguarding midwife recognised gaps in the provision and was putting measures in place to reduce the risk to women and children. The safeguarding midwife met with the paediatric liaison health visitor twice monthly, this allowed communication to be passed on to other health visitors where there were concerns. One example of where the safeguarding allowed staff to recognise a gap was in cross-boundary working. There was a risk that vulnerable women and children from East Sussex as well as women choosing to give birth in Brighton or Kent may not have appropriate plans put in place and shared with the teams in other counties. Regional meetings had been set up to establish clear pathways.
- Midwives completing the booking form asked questions to identify where women had particular needs around substance misuse, mental health and social circumstances. If the midwife felt it was necessary, an additional support form (ASF) was completed and sent to the safeguarding midwife. Copies of this form were sent to the woman's GP and health visitor. The safeguarding midwife maintained a database of all ASFs, which were rated according to need using a simple Red, Amber, Green (RAG) coding.
- An alert appeared on the computer if a member of staff entered the name of a woman with an ASF. At the time of the inspection, these forms were kept in a folder on the labour ward at Hastings, this was recognised as being less than ideal by the safeguarding midwife, we were told that the trust was "trying to move it to an electronic format".
- Once children's services were involved (for any mother or baby with a child protection plan) a maternity action plan (MAP) was completed. These were bright yellow and very easy to see. When a MAP was generated, a note

was made on the electronic database, but the whole document was not available to see. The MAPs were kept in a folder on the postnatal ward, but staff on the ward could not show us where (this was despite having a very young mother on the ward). The MAPs were also kept in a folder on the labour ward at Conquest Hospital, or at the midwifery-led units. Copies were sent to the community midwives, the triage team on the day assessment unit and clinical midwifery managers. A copy was sometimes sent to the ambulance provider where a woman was close to term, with a removal order on the baby.

- The community midwives completed referrals to the local authority social services department, where necessary, and attended safeguarding meetings. We saw from records that the community midwives updated the ASF at 28 to 32 weeks. We also saw copies of minutes of meetings where community midwives identified any necessary action and noted when it was completed.

- Safeguarding information was not always shared effectively, nor did staff have a good understanding of safeguarding and this placed children and vulnerable adults at risk. We listened to a handover on the postnatal ward where the midwives said they did not know why a woman had an ASF completed (despite knowing the mother was a child with a baby on the special care unit).
- An incident dated July 2014 showed that a woman with a baby, less than a day old, had decided to take the baby home against advice. The woman had mental health problems and was refusing to stay in hospital for help with feeding and neonatal withdrawal observations. She had no infant formula at home, but had bottles and steriliser. The midwifery staff gave the mother a carton of formula to take home, but an on-call paediatric doctor refused to come and carry out a baby check, despite being made aware of the degree of risk to this baby. The mother signed the form to discharge the baby against medical advice and left the unit at 5am. The incident review stated there were no safeguarding or capacity issues.
- The minutes of a meeting of the WRASH Nursing and Midwifery Advisory Group dated 19 November 2013, showed that the percentage of staff that had completed safeguarding training was 70%. The Quality and Governance Performance Report dated May 2014 showed that the number of staff completing adult safeguarding training level 2 was 68% and that the clinical staff completing level 3 safeguarding children training was 79.4%.
- The training for all maternity staff was at level 3 (which incorporated level 1 and 2 competencies). The data referred to in the WRASH report related to the whole clinical unit and not just maternity staff. In May 2014 the compliance for maternity staff for level 3 was 91.8%.

Mandatory training

- We were told that practical multidisciplinary skills drills were held monthly on the labour ward. We looked at the notes from one such drill and saw that the notes had been recorded on a scrap of paper with no patient details and that this was stapled into the patient notes. We could not see any learning from this drill.
- Mandatory training rates were reported through the Quality and Risk Performance Report. We had concerns this may not reflect the full picture

Management of deteriorating patients

- We saw numerous examples of where deteriorating patients were not cared for in an appropriate manner.
- One woman who complained about midwifery care and complications that she developed following a caesarean section and that she was not given appropriate care commensurate with her high-risk condition because of a lack of escalation to senior staff. The outcome and action section of the log recorded, “The senior student midwife who provided care in labour was at the end of her training and was indirectly supervised by a senior midwife.” The action failed to comment on why a student midwife was left with responsibility for a high-risk woman. Neither did it record whether a supervisor of midwifery investigation took place.
- We observed that the staff in the labour ward theatre were following the World Health Organization’s (WHO) ‘Five Moments for Hand Hygiene’ guidelines and using a perioperative checklist to ensure that the theatre team had sought consent, identified the patient and clarified the operation prior to commencing surgery. Records seen showed that the WHO checklists were generally well completed.

Midwifery staffing

- Safer childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) states, “To ensure 24-hour management cover, each

labour ward must have a rota of experienced midwives as labour ward shift coordinators who are supernumerary to the staffing levels required for one-to-one care." At the Conquest Hospital, the labour ward coordinator was not supernumerary. Generally, a band 7 matron was in charge of the maternity unit at Conquest Hospital. They were never supernumerary and usually had to provide management cover to the postnatal and antenatal wards, in addition to their clinical role on the labour ward. On some shifts, a band 6, less experienced midwife was left in charge.

- The same guidance recommends that, "There should be one whole time equivalent consultant midwife for each midwifery-led birth centre" and that the labour ward of a consultant obstetrician-led unit should have two consultant midwives to every 3,000 births per year. The Trust did not have any consultant midwives.
- The National Quality Board (NQB) sets out clear expectations for providers of NHS services when planning services. From speaking with midwifery staff and from data collated on the incident reports, we can see that this guidance was not being followed. Expectation four of the guidance is that, "Nursing, midwifery and care staff have a professional duty to put the interests of the people in their care first and act to protect them when they consider they may be at risk." We found that the Trust was not meeting this expectation in that staff did not feel supported or able to raise concerns. When they did report understaffing it was seen as an issue with the individual rather than a systemic failure of the organisation.
- Numerous examples of staff reporting the impact of low staffing levels were seen in the incident reports.
- The impact of poor staffing was seen across the entire service with the escalation policy requiring staff to move from one location to another at short notice, including during a shift. The journey from Eastbourne to Hastings takes over 45 minutes each way and it is 36 miles from Crowborough War Memorial Hospital to Hastings. Staff were reluctant to move as frequently as required, as it resulted in extending their working day by over two hours.
- A letter from the assistant director of nursing and head of midwifery to all midwives at the Trust dated 22 July 2014, highlighted that, in order to maintain a safe service the escalation plan needed to become "business as usual". The trust was operating with nine whole time equivalent posts unfilled and a further ten midwives on sick leave or maternity leave. It provided evidence that the Trust was struggling to provide cover and that they were reliant on community midwives, midwifery managers and supervisors of midwives to cover clinical shifts. It stated that the birth centres had to close sometimes, reducing choice for women and increasing the risk of intervention because they are forced to labour in unfamiliar surroundings. The letter also mentioned that midwives were forced to work in unfamiliar settings, which resulted in them caring for high-risk women in an environment and with a team they did not know well. This was a significant safety risk.
- We saw, from staffing rotas held on the ward and discussion with staff that the escalation policy was in almost daily use and was no longer an escalation plan, but usual practice and, as such, was an unsustainable model for the staffing of maternity services. The heavy reliance on agency and bank staff coupled with staff being moved to work in unfamiliar environments resulted in an unsafe service that left staff demoralised and demotivated. The Trust failed to recognise the impact of their policy on staff and the consequent effect on the safety of the service.
- Community midwives were affected by the need to work their shifts and then to provide 'on-call' cover to the service. We saw several examples of midwives working excessive hours because of this rostering arrangement. One midwife that we met had worked a twelve-hour shift and then been called before midnight to assist with a delivery at the Eastbourne District General Hospital midwifery unit. They had been up and working until after 5am and as their next work day started at 8am, they slept for two hours at the maternity unit rather than drive home and have no sleep at all. Other midwives confirmed similar stories and talked about shift patterns where they were so tired they felt unsafe to work.
- The risk register for the service had identified community midwives being required to work hours in excess of the European Working Time Directive as a problem, but had not acted to reduce their hours.
- When we spoke with midwifery managers they told us that the level of understaffing was mainly due to an inability to recruit midwives to the South Coast. Information on midwifery vacancies from other trusts sited on the South Coast showed us this was not necessarily the case.

- A senior manager told us that the turnaround team brought in to address the budget deficit had reduced the midwifery establishment and that the Trust maternity services were now funded for one midwife to 25/26 births.
- We were also told that registered nurses were being used within the trained staff complement, which, although it provided additional capacity to care for postoperative women, reduced flexibility, as they were unable to perform some essential midwifery roles and could not be moved around the services in the same way a midwife could.
- Data we hold on the trust suggested that the number of midwives employed was in line with England averages as one midwife to every 29 births, but that was fewer midwives than we were told were employed by the trust. We remain unclear as to who was included in this calculation.
- We asked for documentary evidence of how the Trust had used the Birthrate Plus tool as a basis for calculating their midwifery staffing needs, as senior managers told us. At the time of writing the report this had not been provided.
- We met with a group of supervisors of midwives, who told us of their concerns about staffing level and the low morale and high stress levels that had developed as a consequence of this. They confirmed the excessive hours midwives had to work with a requirement for them to complete overnight 'on calls' after a 12-hour shift.
- On one day of our inspection visit, we noticed that all the theatre staff were agency staff.

Medical staffing

- Safer childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) states that, "Outside the hours of consultant presence, we would expect, as a minimum, that there would be physical ward round at least twice daily during Saturdays, Sundays and bank holidays, and once on the evenings. National Patient Safety Agency data suggests that a higher percentage of severe incidents occur from about 8pm to 4am, probably when consultants are not present. The evening ward round, therefore, should be as late as possible, perhaps around 10pm". We were told by senior staff and midwives that consultants carried out physical handovers each morning at weekends. Evening handovers were conducted by telephone around 5:30pm. This meant that the trust was not meeting the published best practice standards from the Royal Colleges, despite having adequate consultant hours to do so.
- We observed a consultant anaesthetist, who was providing cover for the labour ward, answering the telephone, attending to the ward intercom system, opening the door to visitors and greeting a patient when they arrived on the ward before showing them to a clinical room to await a midwife. This would not have been necessary with adequate administrative support.
- The merger of the two consultant-led units onto a single site at Hastings had increased consultant presence on the labour ward and this had impacted positively upon patient safety. There was a rostered 72-hour consultant presence from 8.30am until 9pm Monday to Friday and 8:30am until 2pm on Saturdays and midday on Sundays. National guidance and minimum standards set by the Royal Colleges recognises this is well in excess of most consultant-led units and the Clinical Negligence Scheme for Trusts adopted standard of 40 hours. From discussion with staff and direct observation, we are unclear whether this consultant cover represented an actual presence on the labour ward, as is now recommended.
- During our inspection visit, there were two incidents in one night after the consultant had left the premises. The unit was being covered by one senior house officer and a staff grade doctor at the time. One incident resulted in a perforated bladder and a baby needing transferring to a neonatal unit outside the Trust. This was escalated as a Serious Incident.
- The skills mix of the medical staff at Conquest Hospital showed the same level of consultant grade staff (34%) as the England average. It was in the lower and middle grades that we saw a difference. There was a higher proportion of middle career doctors employed (32%) compared to the England average of 8%. These middle career doctors had completed at least three years as a junior doctor. The proportion of medical staff of registrar grade (34%) was less than the England average of 51%. This meant that there was, overall, a higher proportion of less experienced medical staff available and that the out-of-hours provision was likely to be covered by more junior doctors.

Inadequate

Maternity and family planning

Handovers

- Safer childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) suggests that clear lines of communication are required to ensure optimal birth outcomes. We observed the medical handover on labour ward. It was chaotic and failed to ensure staff were taking over responsibility for patients had a full awareness of their needs. The medical staff handover was separate to the midwifery staff handover and there were no explicit and transparent lines of communication between the two, although a midwife may have been attending the medical handover, this was not clear from our observations. No medical staff attended the midwifery handover.
- There was a sheet available for staff to sign to indicate their presence at the handover; most signatures were not completed. We were told that the consultant, labour ward registrar and midwife in charge of labour ward 'sign in' to the communication book to indicate their presence at the handover. During the two weeks preceding the inspection visit, there were no consultant signatures and about half of the registrar signatures were missing.
- The handover was performed in a public area of the labour ward and could be overheard by patients in rooms closer to the central desk. We were told that patients were asked not to leave their rooms during handover. We observed a visitor arriving on the ward and standing amidst the handover for such a long time that we felt the need to intervene and reassure them that staff would attend to them shortly. All the staff present completely ignored this person who could hear all the details of the handover.
- Junior medical staff did not pay attention to the handover; there were at least three conversations going on during one handover that we watched. The consultant carried on speaking, but very few of the assembled team were listening. This was compounded by the constant interruption of telephones and door bells ringing and midwives talking, in the course of their work, in the same place as the handover.
- Postnatal ward handovers were calmer and more effective, although the midwife handing over seemed uncertain of some key information about patients. This included how many days a woman needed antibiotics for and the pathway for the baby of a diabetic mother (which resulted in uncertainty as to when blood glucose checks were needed).
- We heard about another baby at the handover on the postnatal ward where the midwives did not know the reason a baby had been transferred to the special care unit after delivery. This reduced their ability to provide support to the mother.

Major incident awareness and training

- The Trust had a business continuity plan and the escalation policy for maternity services gave guidance as to the priorities for maintaining services.
- We saw an overuse of the escalation policy to manage staffing levels.

Are maternity and family planning services effective?

(for example, treatment is effective)

Inadequate

Maternity services were not effective. There was clear evidence that key national guidance (such as the Royal College of Obstetricians and Gynaecologists Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) was not being followed, particularly in relation to one to one care in labour and the deployment and skills mix of staff.

The Trust staff did not adhere to NICE Clinical Guidance (CG55) and separated transferring mothers from their babies in the immediate postpartum period.

Staff were uncertain and failed to follow the RCOG Green Top guidance around the management of postpartum haemorrhage.

The trust staff did not adhere to the NICE Clinical Guidelines (CG70) on induction of labour.

The trust performed poorly in the National Neonatal Audit Programme 2012, being rated red for all ten key performance indicators.

The was a clear lack of understanding of what compliance with the requirements of the Data Protection Act 2013 and professional record-keeping guidance entailed.

Inadequate

Maternity and family planning

Local audits were either based on insufficiently robust data or the data was not analysed fully to enable effective learning from the information gathered.

The professional working relationships were not good. We also had concerns about the knowledge and skill of middle-grade medical staff.

Evidence-based care and treatment

- The standard of record keeping and storage of data was not clear, rigorous and precise. Neither was there evidence of good working relationships within the multidisciplinary team.
- There was no comprehensive written information available to women at the Eastbourne District General Hospital maternity unit, although the midwives spent time in discussion with prospective patients about the risks and benefits of a midwife-led unit. Crowborough Birthing Centre had better written information available.
- The trust failed to follow Nursing and Midwifery Council record-keeping guidance. We saw that on both the labour ward and the postnatal ward that the staff maintained a communication book. These were not stored securely, but were readily available on the work surface of the central nurses' station. Healthcare records for individual, named women were written in the book with personal details, including details of their address and phone numbers, their reason for contacting the unit and even the timing of the feticide procedure they had undergone. Another person had details of social services and police involvement recorded, along with the details of the child protection plan for their baby. This was an entirely inappropriate way to store details of such personal information. We spoke with both junior and senior staff who were unaware of the significance of with this.
- The Quality and Governance Performance Report dated May 2014 showed that just 54.9% of staff working in women's health or children's services had completed mandatory information governance training
- We observed good leadership from a consultant anaesthetist in the obstetric theatre. In relation to the World Health Organization (WHO) surgical safety checklist 2008. The full team attended the team briefing and we observed clear explanations of the risk involved and precautions needed.
- Records seen on the postnatal ward had properly completed WHO checklists. The use of the checklist reduced the risk of errors as patients were prepared for theatre and the operation.
- We spoke with, and saw, the records of one woman who had been told she must deliver on the consultant-led unit as she was high-risk due to her taking a low dose of selective serotonin reuptake inhibitors (SSRIs), a type of antidepressant. This should not be an indication for delivery at a consultant-led unit as it did not impact on the risk of the mother or her baby and so increased the likelihood of intervention for a low-risk woman. We were told by several women that they had no choice about where they should deliver, despite being low risk.
- We also heard from other women who felt pressurised to have their babies on the midwifery led unit, against their wishes.
- Safer childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) states that, "The underpinning principle of midwifery care in labour and the foundation of Birthrate Plus is that labouring women receive one-to-one individual care by midwives throughout established labour. At Crowborough Birthing Centre and Eastbourne District General Hospital midwifery unit women did receive one-to-one care in labour. However, this was not always the case at Conquest Hospital, where some labouring women reported being left unattended for "long periods". Day assessment unit midwives reported caring for labouring women alongside antenatal women.

Pain relief

- We saw that pain relief postnatally was offered at drug round times and not necessarily offered in-between rounds. We heard midwives explaining that a woman had "missed" her analgesia as she was off the ward during the drug round.
- Women who had booked to give birth at the midwifery-led units needed to transfer in labour if they wanted an epidural. The level for transfers was low, overall, which suggested that alternative pain management strategies were employed successfully by staff in the midwifery-led units.

Inadequate

Maternity and family planning

Nutrition and hydration

- The infant feeding midwife was often taken back to clinical practice because of staff shortages. This meant she had reduced time to carry out training for other staff, or to do anything to improve the breastfeeding support to women.
- The proportion of babies born at less than 33 weeks gestation who were receiving their mother's milk on discharge from the neonatal unit was 14% compared to a national benchmark or 58%
- The minutes of the joint obstetric and perinatal morbidity and mortality meeting held on 27 June 2014 showed discussion of a case where a baby was found to have kidney anomalies antenatally. While they were transferred out to specialist care appropriately, the record showed that on day one the baby was not feeding well. No regular measurements of urine output were recorded and the baby became dehydrated and was commenced on nasogastric feeds with a weight loss of 7%. The handover communication was not adequate.
- The Quality and Governance Performance Report, dated May 2014, showed that the number of women who felt they had not had information about infant feeding was 37%.

Patient outcomes

- The Trust was not an outlier for maternity services.
- There were 17 emergency caesarean sections carried out in the period 3 February 2014 to 16 February 2014. The Maternity Incident News for this period showed that 11 of these were justified and six (37.5%) were not considered necessary, on review. some women were having caesarean sections unnecessarily with the increased risks this posed.
- The data we hold on the trust showed that the proportion of women having normal deliveries was in line with the average for England (60.5 compared to 60.4%). The level of elective caesarean sections was slightly lower at 10.2% compared to the national figure of 10.8%. The proportion of women who were having an emergency caesarean section was also below the national figure (13.0% compared to 14.8%). Instrumental deliveries were slightly higher than the national average (13.6% compared to 12.8%).
- We were supplied with the audit application for the National Pregnancy in Diabetes Audit (NPID), which was due to be completed in December 2013.
- In general, the services at the trust were rated about the same as other trust maternity services in the CQC survey of women's experiences of maternity services.
- A trust audit of women requiring induction of labour (IOL) at East Sussex Healthcare NHS Trust was conducted following reconfiguration of services (May 2013 to May 2014). There is little evidence that the data was used effectively to bring about service improvements. We saw from data within the audit that the trust had compared the information and used it to demonstrate the increased safety post reconfiguration of the services, but had failed to recognise the position of the trust in relation to other trusts and how this information might be used to improve services. Whilst not outliers, the induction of labour rates and the rate of caesarean section following onset of spontaneous labour were amongst the highest in the country.
- Records from the Eastbourne District General Hospital maternity unit showed that the timings around transfers were well documented and provided sufficient detail to demonstrate that responsibility for any delays in transfer were due to the ambulance service and not the unit. We were shown that the time taken for an ambulance to arrive was between a matter of minutes if an ambulance was close by and it was a real emergency up to four hours, where a woman needed suturing for a third-degree tear. There were clear, well understood criteria for transferring women antenatally or in labour. With first-time mothers it was often related to a request for an epidural, rather than a problem.
- Overall, data from the midwifery-led units was much more accessible and was used to demonstrate the quality of care. Staff benchmarked the information they collected against national data. They also used it to demonstrate the risks and benefits of a maternity-led unit. For multiparous women, less than 5% of women needed to be transferred in the intrapartum period. The midwives could tell low-risk mothers who had given birth before that there was a greater than 95% chance of them having a normal delivery at the unit and that 39.6% of all women had a water birth between April 2013 and March 2014.
- The data collated by the midwifery units relating to the outcomes for women who transferred was not considered from the perspective of what this data meant for the consultant-led unit at Hastings. Neither was there comparison with midwifery-led care for low-risk women at the Conquest Hospital. We saw data

that showed that for women who transferred in labour from Eastbourne District General Hospital to Conquest Hospital that the rate of some assisted deliveries had doubled from the previous year. We saw that the proportion of caesarean sections for these women rose from 3% in 2013 to 2014 to 6.3% in the year to date. There were similar increases in the rate of ventouse extraction (3% to 6.9%) and forceps deliveries (2.7% to 5%). While this might not have been indicative of worse care, it certainly bore investigation and consideration as to why the rates had changed quite so much.

- The trust did not perform well in the National Neonatal Audit Programme 2012. For example, 100% of eligible babies should receive retinopathy of prematurity (ROP) screening, in line with national guidelines. The national Neonatal Audit Programme 2012 showed that 46% of babies were screened. All the Key performance indicators were rated Red (Below NNAP standard).

Competent staff

- Midwives asked to move from one of the midwifery-led centres to the Conquest Hospital maternity unit felt they lacked the understanding of local policies and practices to provide safe care and were unsupported. This was truer of Crowborough Birthing Centre midwives who had been established and working in a midwifery-led unit much longer than the Eastbourne District General Hospital midwives who had moved from a consultant-led unit more recently. We were told that midwives had not received any orientation to the Conquest Hospital maternity unit.
- The group of supervisors of midwives who we met with told us that there was no capacity for line managers to undertake the annual appraisals because the staffing arrangements did not allow time. This confirmed what local managers told us.
- The arrangements put in place to support staff moving from a consultant-led unit to a midwifery-led unit, where staff were required to practice more autonomously, were inadequate. One midwife told us, “It happened overnight. One day it was consultant-led and dominated and next it was just us.” There were just two study days arranged to ensure midwives and support workers were prepared for the very significant change in responsibilities. We spoke with a band 7 midwife who had one day preparation and a band 6 midwife who had no preparation at all.
- The issue of midwives working long days without a break and of community midwives being on call after long days impacted on competency as well as safety. The Royal College of Nursing says that, “The Working Times Regulations are not specific about the length of a shift, but generally require workers to have an 11-hour rest period between working days.”
- We saw examples of poor decision making by junior and middle-grade doctors. One example was a note from a middle-grade doctor that advised stopping the drug that was being given to reduce the risk of fitting in a woman with pre-eclampsia at 11am. The decision had to be corrected by the consultant during the ward round that evening. We also spoke with two staff grade doctors and judged that their understanding of basic obstetric care was poor. We asked the staff-grade doctor (who performed instrumental deliveries unsupervised) to describe classification of third-degree tears; they were unable to do so.
- The minutes of the Joint Obstetric and Perinatal Morbidity and Mortality meeting held Friday 27 June 2014 showed discussion of a case of an intrapartum stillbirth that was escalated and investigated as a Serious Incident. We saw the discussion that followed; but we subsequently asked a middle-grade doctor who was working on labour ward about interpretation of cardiotochograph readings and looked at their documentation of the findings and assessment. They were poorly considered, recorded and incorrect. This demonstrated that the lessons from the incident in June 2014 had not been learned effectively.
- We saw one situation where there was an estimated blood loss of 1000ml. There was no evidence of recording how this amount was arrived at or of any measurement of loss during delivery or subsequently in theatre. The Postpartum Haemorrhage, Prevention and Management (Green-top Guideline No. 52) from the Royal College of Obstetricians was not being followed by Trust staff.
- Notes from the Minutes of the Joint Obstetric and Perinatal Morbidity and Mortality Meeting held on 25 July 2014 showed that, “Feedback from the registrars and junior doctors was that the theatre staff had not previously done a set up for trial instruments and this was sometimes the case out of hours.” This demonstrated to us that the high levels of agency and bank theatre staff had a direct impact on the quality of patient care and outcomes.

- The same notes showed an intrauterine death of a baby. The record showed that there was a static measurement over 18 days and should have been acted on. Two consultants present "felt that in this case the static measurement should have triggered a referral for growth scan". There was limited action, which included a consultant agreeing to circulate and discuss data on the effectiveness of using customised growth charts with the unit. Another consultant agreed to feedback to midwives. There was no suggestion of wider midwifery-led learning from this event, despite there being a senior midwife present.
- The Quality and Governance Performance Report dated July 2014 showed that 61.5% of staff had received an appraisal. This was also the figure quoted in the Trust Performance Report in June 2014.
- The Trust Performance Report June 2014 showed that all medical staff had an annual appraisal.
- When we spoke with junior medical staff they told us that their training was good and that they had plenty of opportunity to carry out supervised procedures. One trainee said they had performed over 70 caesarean sections under the direct supervision of a consultant obstetrician.

Equipment

- Only one Sonicaid was available on the delivery suite. The recording midwife said, "It is difficult to listen to a baby's heart rate when more than two women are in labour."
- There were numerous entries in the labour ward communication book that showed an ongoing issue with a shortage of baby blankets. Less frequently, there were also shortages of blankets for women to use. These equipment shortages entailed staff spending time tracking down resources to provide care rather than actually providing care.

Facilities

- The labour ward was not differentiated for high and low-risk women who wanted midwifery-led care. The rooms were not soundproofed and women in labour could be heard throughout the unit. There was only one birthing pool available and this was often not accessible to woman who wanted to use it as the room was not reserved for low-risk women.
- A lack of single rooms on the postnatal ward resulted in young girls being placed in a bay with other women rather than a single room with open access to their parents and partner. They were not cared for as they would be on a children's ward.
- Women whose baby was in special care or who had been transferred also suffered as a result of a lack of single rooms. They were placed in bays where all the other women had their babies with them. Some told us they found this distressing.
- The consultant-led unit at Conquest Hospital struggled to cope with the number of women giving birth. We saw and heard about delays due to overcapacity and women 'held' on the labour ward, due to a lack of postnatal beds. One woman who transferred from Eastbourne told us, "We went to Hastings; it was packed, I had to stay on labour ward as they had no beds and they also told her she couldn't go back to EMU as they didn't have any beds either."

Multidisciplinary working

- Communications between hospital and community midwifery services and other involved professionals such as GPs and health visitors was not always effective and left women and their babies at risk because routine checks and tests were missed. One incident showed that the community team had not been informed of the patient's discharge from Conquest Hospital, and, as a consequence, they did not receive any postnatal care from community midwives until day six, when the patient sought assistance. In June 2014, a similar incident occurred when a birth notification form was not delivered to the health visitors immediately after birth. As a result, a new birth visit did not take place until the baby was five weeks old.
- In August 2014, there was another incident when a woman should have had a health visitor antenatal visit. No paperwork was received and so the mother and baby were unknown to health visiting services until after the baby was born. A lack of clerical support to midwifery teams across the trust inevitably resulted in failures of administrative systems when already pressurised midwives had to complete all the necessary paperwork.
- An incident dated November 2013, showed that a woman was discharged home from the delivery suite within six hours of birth. The community midwives had

not been informed and were unaware that they needed to provide care. The review of this incident suggested it was due to new paperwork being introduced the previous week.

- Poor relationships between midwives and medical staff at the Conquest Hospital site resulted in a lack of team cohesiveness and awareness of the difficulties and stresses each 'side' was facing. In January 2014, a junior doctor reported being upset and felt bullied by midwifery staff to complete work. They said it was not the first time this had happened and that they were upset and unable to continue work for that day on the unit. This reduced the available medical cover to the unit to the detriment of patients.
- A recent incident report of how medical and nursing staff handled a difficult clinical situation; which we saw showed poor professional relationships impacting on patient care.

Seven-day services

- The consultants did visit the wards each morning at weekends, but they did not lead a late afternoon or evening physical handover. The consultant rota showed that there was an on-call consultant at all times.
- At the Conquest Hospital there was access to key services, such as emergency imaging and paediatric support out of hours. At the midwifery-led units the few women who needed additional support or investigations were transferred to Hastings.
- The pharmacy service was available from Monday to Friday and on Saturday mornings.

Are maternity and family planning services caring?

Good

The staff of the maternity services were trying to provide a caring and compassionate service in difficult circumstances.

We met many really kind, committed and experienced midwives who were passionate about providing good care across all parts of the service. Those working in the community or midwifery-led units clearly found it easier to see the positives in the work they were doing and had greater capacity to provide more personalised compassionate care. All the operational staff we met wanted to ensure women had a good experience and felt well supported.

- Patients that we spoke with told us that they received kind and sensitive care from the midwives. We observed one midwife answering the telephone and giving patient, gentle responses to the person seeking advice.
- We listened to another midwife speaking on the telephone to a woman who was bleeding at home. The call was handled very sensitively and provided accurate information in a way that did not unduly frighten the woman. We then observed that the midwife made sure all the necessary arrangements were in place to receive the woman on the ward. The same midwife met the woman and her partner on arrival, introduced herself and showed them to their room.
- We heard a number of individual examples from women both about poor care they had received.
- Women we spoke with and feedback we saw from the two midwifery-led units was extremely positive. We talked to one father who wanted to give a substantial amount of money to the midwives at one birth unit for the staff to use personally as he and his partner were so impressed by the care they had received; the midwives put it immediately into the fund to improve facilities at the unit for the benefit of future patients.
- Data provided by the trust in response to the question, "How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment?" showed that patient perceptions about postnatal care were much higher for the midwifery-led units, and the Crowborough Birthing Centre in particular. The scores for care at the Conquest Hospital were much lower.

Patient understanding and involvement

- The Royal College of Midwives published guidance says that, "Attendance at antenatal classes is associated with less use of pharmacological pain relief during labour," (Hetherington, 1990). One person who worked with a local voluntary organisation told us, "Until June this year, the organisation was commissioned to deliver the NHS antenatal courses for the trust. They were well evaluated and we worked very well with the maternity managers to deliver this service to parents. They were stopped to save money and they said that numbers were going down – although we did not see evidence of

this. Parents now have to access to online information, which does not help disadvantaged groups (who possibly don't have access to a computer or have a disability) and reduced the access to postnatal contacts which they would have made at antenatal sessions."

- Minutes of the WRASH nursing and midwifery advisory group meeting dated July 2014, said, "It was also agreed that, if several women are going home on the same day, they should be spoken to at the same time by a midwife so that the discharge information does not have to be repeated. COC [consultant on call] to inform the matron on the FSW of this new process." This system may have saved time for midwives, but failed to ensure the confidentiality of women and depersonalised the service to a series of tasks to be completed rather than providing patient-centred care.

Emotional support

- Many patients at Conquest Hospital reported kind and caring midwives working hard to provide satisfactory care. Some reported "ambivalent midwives" and a few "grumpy" midwives.
- The birthing units received entirely positive feedback with many women telling us they received, "fantastic care" and that they "felt really safe and supported". Eastbourne District General Hospital maternity unit had not been open as long as Crowborough Birthing Centre, but those women who chose Eastbourne District General Hospital told us they were pleased that they had.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Requires improvement

Maternity services at the trust were not responsive. Staff were often very busy which meant they struggled to provide individualised care at Conquest Hospital, where much of the work remained task-centred. The midwifery-led units provided more personalised care on a one-to-one basis, but this was being affected by the need for staff to support the wider service needs and move to the Conquest Hospital unit. A similar situation was happening with the community midwifery services, who were often called into the labour ward.

The repeated temporary closures of the midwifery-led units due to staffing shortages at Conquest Hospital had a negative impact on the perception of local women about the birthing centre. Women who might be considering the Crowborough Birthing Centre did not want to take the risk that it would be closed, they said the preferred to know where they would have their baby and so chose to book elsewhere. Senior midwives told us that the number of women booking at Crowborough Birthing Centre had declined since there had been several closures of the unit to move staff to Hastings.

The maternity unit at Conquest Hospital was constantly busy. This affected the other midwifery-led units and community as staff were removed from these to try and meet the minimal staffing levels in Hastings. There was an escalation policy, but, as it was in use most days, it limited the amount of flexibility. Women were having inductions delayed; one-to-one care in labour was not being provided and the service had very little capacity to react to unforeseen circumstances.

Discharge of patients were delayed due to lack of staff to carry out a final review.

Problems related to staffing were compounded by postnatal women remaining on labour ward and requiring ongoing care from the labour ward team when they could be moved to the postnatal ward.

The data we hold on the trust showed that there were more young mothers (less than 20 years of age), giving birth at the trust (5.4%) compared to the England average of 3.9%. We could not see that there was any provision made to meet the needs of children and very young mothers while they were pregnant or in hospital. No specialist teen midwife was employed. Staff spoken with were unaware of the need to provide provision for children who gave birth; they were unclear about the importance of child safeguarding referrals for very young mothers. We were told that the booking midwife would create an additional support form (ASF) and this would generate a maternity action plan (MAP), but there was no local policy about meeting the wider needs of very young mothers.

Services for bereaved parents needed further development to bring them up to an acceptable standard.

Services for groups with particular needs were not well met, with few specialist midwives offering support for hard to reach and vulnerable groups.

Inadequate

Maternity and family planning

There was a lack of learning from complaints and a failure of the trust to listen and respond to the fears and anxieties of the people it served. Poor communication with the public (including campaign groups) meant few people understood the real advantages of midwifery-led care to most pregnant and postnatal women and their babies.

We received a number of reports of dissatisfaction with the midwifery service. Concerns were raised about the shortage of staff, being left alone for hours when scared and in pain. Having to waiting for long period of time and then to be sent home because of lack of medical staff available to see the patient. We received reports of poor after with lack of staff to assist mothers caring for their baby and significant concerns about cleanliness.

Service planning and delivery to meet the needs of local people

- Facilities and services for parents facing pregnancy loss were not adequate. Staff had attempted to improve the room on the labour ward used as a bereavement room, but it remained a delivery room on the labour suite. There was no soundproofing, nowhere for the father to stay, although there was a sofa and normal delivery equipment was put away. A cold cot had been donated and the unit had a digital camera, but always tried to get medical photography to take photographs of the baby. They also had a supply of Moses baskets and small clothing to dress the baby in, if possible. This room was not reserved exclusively for the use of bereaved parents, but was used for normal deliveries when the unit was busy. We were unclear what facilities would be available if another woman was already labouring in the bereavement room.
- In an emergency, if a woman was over 14 weeks pregnant, women were advised to come to the labour ward and be assessed by a doctor. We were told that one-to-one care was always provided. A personalised care plan was created for women who were over 23+4 weeks, staff tried to get them a bed on a unit where a neonatal cot was available if possible. If a suitable transfer could not be found and the woman delivered her baby at the Conquest Hospital a paediatrician was called to talk to the parents.
- We were told that although a “very good” ultrasound scanning machine was available on the labour ward, this was only used out of hours when an experienced doctor was available. During the working week, women had to go from the maternity unit to the main ultrasound department on a different floor of the hospital for their scan. This was not in the best interests of the couple who were likely to lose their baby. There were no midwives employed with suitable training to provide ultrasound scans in these circumstances.
- Following the loss of their baby, women were offered a memory box that could be used to hold foot and handprints of the baby, photographs and other mementoes. It also contained a candle and a teddy bear along with a little angel and a CD. A leaflet about the support charity SANDS was included. Special boxes were available for very small babies and twins. Chaplaincy contact was offered and a minister was called to baptise or bless babies according to the parent’s religious preferences.
- No counselling was offered to parents by the trust, but we were told they were offered the telephone number of ‘Afterthoughts’ a children’s centre counselling service for parents who live in the Hastings and Rother or East Sussex Downs area and have children under the age of five years old. Funeral arrangements were discussed with the parents, but if they were not ready to consider this then the community midwives would follow this up as some parents chose to take their baby home.
- Subsequent to the inspection we were told that there was a well-established debrief service conducted by senior midwives and obstetricians which has continued to make an impact on women’s choices in subsequent pregnancies. Senior midwives and midwifery managers we spoke with were not aware of this service when we asked about provision.
- There was no provision for women who had difficult births or poor outcomes to return and talk through their experience to enable them to understand better how and why decisions were made about their care.
- Temporary closures of the midwifery-led units due to staffing shortages at Conquest Hospital were felt by staff and campaign groups to have a negative impact on the perception of local women about the birthing centre. Women who might be considering the Crowborough Birthing Centre did not want to take the risk that it would be closed; they said the preferred to know where they would have their baby and so chose to book elsewhere. We saw evidence that the number of women had been affected by the press and social media reports of unit closures. Senior midwives also told us that the number of women booking at Crowborough Birthing

Centre had declined since there had been several closures of the unit to move staff to Hastings. During August, 14 women had delivered their babies at Crowborough Birthing Centre with 11 of these being low-risk, first-time mothers. The team also supported one home birth.

- A complaint was made to the trust about closure of the Crowborough Birthing Centre in August 2014. The Trust recorded the following explanation on the complaints log: "We are not able to predict the peaks in activity or sudden staff shortages and, hence, we have to maintain services as best we can across the Trust; at times this will mean closure of some services." We saw that the staffing moves and impact of low staffing levels was not in relation to "peaks or sudden shortages", but a daily occurrence due to inadequate staffing.
- It was also felt that a lack of scanning service at Crowborough Birthing Centre reduced the likelihood of woman booking. The Friends of Crowborough birthing unit had bought a scanner, but there were no ultrasonography staff to use it. Anecdotally, woman wanted their antenatal, labour and postnatal care in the same place. They wanted to give birth in familiar surroundings. If they went to Tunbridge Wells for their early scans they were far more likely to book for delivery there too.
- No part of the service planning had addressed the issues of a lack of good transport links to the Conquest Hospital. We heard from community midwives that when they tell women they need to be reviewed in Hastings (for example, because there were concerns about reduced foetal movement) many said, "It's OK now, so I won't go," and didn't bother being checked because of the difficulty and cost of the journey.
- The maternity unit at Conquest Hospital appeared to be constantly busy. This affected the other midwifery-led units and community as staff were removed from these to try and meet the minimal staffing levels in Hastings. There was very limited flexibility of the service and staff had to cope with any additional workload. Women were already having inductions delayed; one-to-one care in labour was not being provided. The service had very little capacity to react to unforeseen circumstances.

Access and flow

- Discharge of patients sometimes caused delay and a backlog from one area of the maternity unit at Conquest Hospital to another. We spoke with women who were dressed and ready to go home, but who still awaited a final review. They told us they had been told they could go home after they were seen "hours ago".
- The problems related to staffing are compounded by postnatal women remaining on labour ward and requiring ongoing care from the labour ward team when they could be moved to the postnatal ward. When we spoke with staff we found that a lack of actual beds was partly to blame for the backlog. There was a space for women, but no bed to put in that space.
- Notes of a WRASH nursing and midwifery advisory group meeting dated July 2014, highlighted that staff had concerns about the number of times the door buzzer was answered on the postnatal ward. This was acknowledged as taking staff away from the women they were caring for. Currently, there were no administrative staff in post to answer the door or telephone on either the postnatal or labour ward.
- An incident form dated February 2014 showed a woman had been referred by her community midwife to the DAU as she had high blood pressure. After a five-hour wait, the midwife on duty offered the woman a bed for the night as she still had not been seen. The delay in obtaining a medical review was suggested as being due to emergencies on the labour ward. The woman was seen nine hours after arrival with a potentially serious condition. Concerns should have been escalated, but were not.
- Bed occupancy levels were reported as well below the national average. This was not what we observed; we saw and heard about women waiting for a space on the postnatal ward for prolonged periods. It was possible the figures given reflected the period of changeover at Eastbourne District General Hospital from a consultant-led unit to a midwifery-led unit when the numbers were low because of women's uncertainty about the unit. We were also unclear whether the low figures may have related to the times when the beds at the midwifery-led units were closed because of staffing problems.
- A telephone triage system was in place that allowed women to speak to a midwife for advice. This appeared to be an effective way of providing reassurance and an initial assessment to determine whether women should attend the day assessment unit or the labour ward. It allowed women from outside of Hastings to make

contact to determine how soon to make the journey and whether this should be by car or ambulance. The triage midwife provided a point of contact to women and was able to ask community midwives to call, suggest contact with a GP, or give advice over the phone. The only problem with the service was when staff were asked to cover other duties or where cover had not been arranged for leave periods.

Meeting people's individual needs

- In the 12 months preceding our inspection, 62 children gave birth at the Trust. The data we hold showed that there were more young mothers, less than 20 years of age, giving birth at the trust (5.4%) compared to the England average of 3.9%. We could not see that there was any provision made to meet the needs of children and very young mothers while they were pregnant or in hospital. No specialist teen midwife was employed. Staff spoken with were unaware of the need to provide provision for children who gave birth; they were unclear about the importance of child safeguarding referrals for very young mothers. We were told that the booking midwife would create an additional support form (ASF) and this would generate a maternity action plan (MAP), but there was no local policy about meeting the wider needs of very young mothers.
- The caseloads carried by community midwives were very high. A senior hospital nurse manager told us that they each had a caseload of approximately 100 women and babies. The midwives we spoke with showed us caseloads of up to 140 women and babies. Given the socio-economic deprivation of the population served by the trust and the number of woman with additional needs, there was evidence that the workload of community midwives resulted in some women's needs not being met.
- Low staffing levels on the labour ward also impacted on how responsive the service was to an individual's needs. One incident was reported by labour ward staff as, "Seven midwives on a day shift; unit extremely busy. Community midwives called in, manager called in, consultant made aware. Unable to proceed with inductions, unable to provide safe care to labouring women. Constant shortness of staff, shifts being left short until the last minute on a daily basis. Unable to provide safe care regularly." This demonstrated to us that contingency plans were effected that protected women by removing services to them and thus not meeting their needs. This incident was discussed at the daily risk review meeting and it was felt appropriate action had been taken to ensure patient safety. If failed to consider the impact on women having their planned induction cancelled.
- Another incident sheet showed us that there was a lack of midwifery cover for triage in the Day Assessment Centre at Hastings. A single midwife was required to provide care to the women presenting with antenatal concerns and care for women in labour. The manager they spoke with about their concerns insisted women in labour were assessed and managed on the day unit and then transferred to labour ward when the birth was imminent. No midwifery cover was provided for annual leave. This was contrary to guidance that suggests women's needs are best met and the delivery outcomes are optimised by providing one-to-one care in labour.
- An incident record dated October 2013 showed that the needs of a profoundly deaf couple had not been met. No ASF had been completed and appropriate discharge support was not planned. No paediatric plan was made for follow up of the baby despite congenital deafness in both parents and siblings.
- We also heard from a woman with significant physical disabilities who felt her needs were not met. She told us little assistance was given during the postnatal period when she found it very difficult to manage her baby without assistance.
- We spoke with a woman who was one day post emergency caesarean section and who had suffered a damaged bladder as a result of surgery. Her baby had been transferred to a neonatal unit in Brighton. She was being cared for in a bay where all the other mothers had their babies and found this upsetting. She said it had "been a difficult night". She told us she was happy with her care in labour and that she had been kept informed about what was happening. Her husband told us that the care on the postnatal ward had been less good. In fact he described it as, "Nothing – no dinner as it got forgotten, nobody answers the bell, they asked for help to express milk but nobody came."
- We were made aware of two planned homebirths who were asked to go to the midwifery-led centres as there not enough community midwives to provide care to them in their preferred place of delivery.
- Data provided which related to the midwifery-led units demonstrated that these units were better at meeting

individual needs and had better outcomes for low-risk women. The calmer atmosphere and one-to-one care allowed more women to give birth naturally, without recourse to medical intervention. Women also reported a better experience and higher quality postnatal care.

- The lack of dedicated facilities for low-risk women in Hastings resulted in less entirely midwife-led care for low risk women. Medical staff were more likely to attempt to become involved with the care of labouring women and, as a consequence, they were more likely to have some form of intervention (such as an epidural and an artificially-accelerated labour) when compared to the midwifery-led units. We asked for data on grade 1 and 2 perineal tears and episiotomies to compare outcomes between the units, but this was not available.
- While it is acknowledged that the transfer rates from the midwifery-led units were low, particularly for women who have given birth previously, we were concerned about the transfer arrangements. We heard from four women who had been transferred to Hastings for perineal suturing, after having given birth at the Eastbourne District General Hospital midwifery-led unit. They told us that they were not allowed to take their baby with them in the ambulance, but that their partner had to bring the newborn baby over to Hastings himself. We were also not clear what the arrangements were if the family didn't have access to a car.
- Limited written information was available to women interested in using the Eastbourne District General Hospital maternity unit. We were told this was because the reconfiguration had initially been a temporary arrangement, but that leaflets would be produced now that the arrangement was permanent.
- The supervisors of midwives told us that parental education was non-existent; there simply wasn't time. There were, however, homebirth workshops every other month, at each site
- An incident happened in November 2013. The hospital received a telephone call from the patient's mother. She reported that her daughter had had a miscarriage two months previously and had recovered well. On the day of the telephone call, her daughter had received an appointment for an antenatal visit from the health visiting service, which had caused distress and anxiety. The action from this incident was that the hospital phoned the grandmother and assured them they would put an incident form in. The review simply agreed that the forms were usually sent out and the case was closed.
- We saw an incident from June 2014 where telephone calls had been made to a mother to offer breastfeeding support, unaware that the woman's baby had been stillborn. The record shows that there was no information on maternity information system database that the baby had been stillborn. There was, apparently a problem with the documentation, which only stated that there was no feeding method identified. The report indicated that maternity information system team would be contacted to get the report changed so that it was clear in the future.
- The unacceptable situation of women who had suffered pregnancy loss being phoned by community midwives and health visitors to arrange antenatal appointments continued. An incident report from June 2014 said, "I phoned this mother to book an antenatal visit, she reported to me that she had miscarried in January." There appeared to be little learning from these incidents over time.

Learning from complaints and concerns

- The Maternity Incident News, dated 8 September, showed us the number of complaints and plaudits during the preceding quarter. In June 2014, there were two compliments received about care in the delivery suite balanced against four complaints. A similar ration of plaudits to complaints was shown for July and August 2014. The comment on the newsletter reassured staff that the level of formal complaints received was a small proportion of those who used services, rather than suggesting that the Trust learned by giving examples of where improvements had been made in response to complaints.
- A group of community midwives told us that they often received direct feedback from women who used services. They said this feedback was usually positive about support during labour, particularly from the maternity units, but that they heard lots of complaints about postnatal care being a poor experience with little support for feeding or care of their babies. They told us that the complaint level rose whenever the Conquest Hospital unit had been busy. The trust complaint log did not reflect these complaints and the information about the services provided to woman was not captured or

used for service improvement. The level of complaints related to maternity services provided by the trust was not an accurate reflection of the number of complaints staff received.

Are maternity and family planning services well-led?

Inadequate

Overall, the service was not well-led. There was a lack of vision for the service and a very resigned attitude with a 'wait and see what happens' stance on planning for the future. Staff at all levels were unable to articulate the maternity services vision or any goals or aspirations for the service.

There was no non-executive director lead for maternity services.

The lack of clear vision or a strategic plan following reconfiguration meant that the staff and patients were disadvantaged as the middle managers tried to stabilise a service that was in constant flux.

Data collection and analysis was insufficiently robust to properly inform service improvements. The information supplied to the board was not always entirely accurate, which provided false assurance and impacted upon their ability to make decisions and hold the executive team to account.

We were told frequently by staff of all grades about a bullying culture within the trust, but could not substantiate this; we were shown evidence that the some of executive team were dismissive of concerns and used quite intimidating approach. The Trust culture was devolved down to the frontline and while there were some good, kind leaders with an awareness of the impact of the changes on staff, others were described as "unapproachable". Lack of confidence in the leaders meant staff felt unable to raise concerns and when they did, they were often held responsible for the problem.

Vision and strategy for this service

- The trust executive team and maternity management team had limited vision for the service following the reconfiguration. When asked they talked of "letting the dust settle" rather than providing a clear sense of direction to staff.
- The maternity services management team were unable to clearly articulate where they wanted to be in five years' time neither could they tell us what they felt they did particularly well.
- It was noted that in the minutes of the annual general meeting of the East Sussex Healthcare NHS Trust held on 24 September 2014, that the assurance provided to the public and board by one of the two joint medical directors was that, "The quality of services has improved substantially as demonstrated by the review of services undertaken by the Care Quality Commission." The report of our visit was not available at the time this comment was made to the public. Our judgement of the service following our comprehensive inspection had not been finalised at this point. Previously, both Conquest Hospital and Eastbourne District General Hospital were inspected separately in August 2013. Five key outcomes were inspected and both sites were found to be compliant. It is difficult to see where the notion of "substantial improvement" had come from. This published comment provided false assurance and was inaccurate.

Governance, risk management and quality measurement

- There appeared to be a discrepancy in the threshold for incident reporting. We reviewed a number of incidents that demonstrated a failure of the service to escalate and learn from those incidents.
- We asked about the process and escalation for reporting Serious Incidents. We were told that there was a multistage process which we saw was too long. This chain of referral had many stages where the incident could be filtered and was likely to result in under-reporting of Serious Incidents.
- Trust board minutes dated 29 January 2014 stated, "A non-executive director asked if there had been any issues in relation to travel since the temporary single siting …." We saw there was a mismatch between the report to the board and the data we saw. Our concern was not that post-reconfiguration resulted in more

births en route, because the data did not support that view. We were more concerned that the trust board was not being given the complete information on which to make decisions and gain assurance about the service.

- We were told by one of the senior midwifery managers that the labour ward forum met monthly. During the period 25 January 2014 to 15 August 2014, there were 14 planned meetings. Five of the meetings were cancelled.
- The 'quality walks' report to board members dated 24 September 2014 showed that the board had agreed that service reconfiguration was one of the three key focal points to be reviewed during 'quality walks'. These walks were carried out by board members and members of the senior management team. They were intended to provide assurance to the board about the quality of care being delivered across the trust. The record of visits made show that the chief executive made visits to the two midwifery-led units and the postnatal ward during August. The director of strategic development and assurance made visits to the midwifery-led unit and the postnatal ward. There did not appear to be any visits to the labour ward nor the antenatal ward, community midwifery service or day assessment unit. There were no reports of the visits included in the 'quality walks' report to the board. The impact of the reconfiguration of the service could not have been considered without a visit to the labour ward.
- The Quality and Governance Performance Report dated May 2014 suggested there were two areas of recognised high risks on the Risk Register for maternity services. These related to midwifery staffing arrangements not meeting the European Working Time Directives and the state of the maternity records.
- Local leadership lacked the resources to manage the service effectively. The midwifery service manager had not got the time to manage effectively; they didn't even know what their equipment budget was, despite asking. There had been three managers covering the service until quite recently, but, since the restructuring, a lone midwifery service manager was struggling to cope with the management of an under-resourced (management and staffing capacity) service; they had responsibility for all women's health services at the Conquest Hospital, both midwifery-led centres and the community midwifery services. This resulted in a 'fire-fighting', reactive management, rather than a proactive and planned management. The service manager did not have the ability to support and manage all those below them, not because of a lack of competence, but a lack of capacity.

Leadership of service

- There were some pockets of good local leadership with individual managers providing much appreciated support to their team. However, the service, overall, lacked capacity to manage the service.
- We saw consultant led handovers where the consultant failed to manage the assembled team to ensure that there was a comprehensive and accurate handover of patient care. Junior medical staff were not paying attention; they were using their mobile phones and chatting in small groups.
- Most middle managers were simply trying to keep the service as safe as possible. Most band 7 staff had not been afforded the time to manage their teams effectively. Some were very new in post and had not had sufficient time to make an impact.
- The messages being given to the board by the senior managers within the service were very different to the messages we were given by frontline staff and patients.
- We met with the newly appointed head of midwifery, but as they had only been in post for two weeks it was too soon to determine whether their leadership would result in significant changes to how the service was led. They appeared to be confident, enthusiastic and had a grasp of some of the key issues that they needed to address.

Culture within the service

- A letter from a senior nursing and midwifery manager to all midwives at the trust, dated 22 July 2014, regarding staffing levels, showed poor communication with staff and was intimidating rather than supportive of staff.
- This letter corroborated what staff had told us about feeling pressurised to work excessive hours in unfamiliar surroundings. We were told that there was an expectation that they would miss breaks.
- The annual staff sickness levels within the women and children's clinical unit was shown as 5% on the Trust Performance Report June 2014. This compared unfavourably with the trust-wide level of 4.5% and was also above the national rates for qualified nursing and midwifery staff of 4.5%.

- The trust provides training placements for student midwives**;** this should be a good source of new staff, but we were told by the supervisors of midwives that none of the students who had been on placement within the trust had been retained because they had all chosen to work elsewhere. External funding had been obtained to employ a band 6 practice education facilitator to provide additional support to students and improve their experience, but they were not in post at the time of the inspection visit.

Public and staff engagement

- In a presentation to the inspection team, at the start of the inspection week, a trust representative told the inspection team that they were "responding to concerns of staff and local people about change and sustainability and learning from what they tell us about our services".
- The perception amongst the midwifery staff we spoke with was that of a total lack of support by their senior managers and the trust. They felt senior managers paid pay lip service to their concerns, but offered no real support.
- It was clear from trust board meeting minutes that the views of local people were not considered important where they disagreed with Trust decisions. Board minutes dated 30 July 2014 stated, "He also highlighted that there was a particular challenge at the Eastbourne end of the patch as the local media and some members of the public took every opportunity to view change as negative." This demonstrated a lack of effective engagement, collaborative working and empathy with the views of many people the Trust served.

Innovation, improvement and sustainability

- When we asked senior managers about examples of innovation and good practice they took a significant pause before mentioning the telephone triage system. When we asked how long this had been available, we were told over four years. No other examples of innovative or particularly good practice were given to us, despite us asking every manager that we spoke with.
- If the service remained as it was at the time of the inspection, there was very limited scope for improvement and it was unlikely to be sustainable. Senior managers were too comfortable with the performance, with a "these things happen" attitude that was likely to bring about real and sustainable improvements.
- The two midwifery-led units had a positive impact on the service overall and undoubtedly improved the trust performance overall.

Requires improvement

Services for children & young people

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

Information about the service

The children's service is managed as a single integrated service across the East Sussex Healthcare NHS Trust acute locations. Services for children and young people are provided at the Conquest Hospital and Eastbourne District General Hospital sites. Inpatient children's services, day surgery, short stay paediatric assessment unit (SSPAU), neonatal services and a level 1 special care baby unit (SCBU) are based at the Conquest Hospital. The SSPAU operates seven days a week from 9am to 9pm and is located adjacent to the children's inpatient ward.

On the 8 March 2013, the board agreed to take action to ensure the safety of obstetric and neonatal services. They did this through the temporary consolidation of a consultant-led obstetric service, neonatal (including the SCBU), inpatient paediatric and emergency gynaecology services at the Conquest Hospital. A stand-alone midwifery-led maternity unit, short-stay paediatric assessment unit and children's outpatients department are located at Eastbourne District General Hospital. The trust introduced these changes on the 7 May 2013. The trust identified that it had been monitoring the services since the reconfiguration. In the interim, the local clinical commissioning groups undertook a consultation on the proposed options for permanent changes to maternity and paediatric services. The consultation closed on the 8 April 2014.

The trust has kept the public informed of its 'Changes to children's services' through its website and in its frequently asked questions document. The trust identified that capacity planning for children's services had been undertaken based on current demand. This exercise identified a total capacity of 27 beds for Kipling Children's Unit would be sufficient for the children's inpatient ward at Conquest Hospital to manage the level of inpatient demand. Currently, Kipling Children's Unit is operating at a capacity of 21 beds.

On the 4 September, CQC received some information of concern relating to children's services at East Sussex Hospitals NHS Trust. We included these issues as part of the planning of the inspection.

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

During our inspection of Conquest Hospital, we visited Kipling Children's Unit, the children's outpatients' service and the special care baby unit (SCBU). We also looked at the children's facilities and services in the A&E department and the SSPAU. We spoke with 10 medical staff, 23 staff, two children, one carer and 13 parents at the Conquest Hospital children's service.

Requires improvement

Services for children & young people

Summary of findings

Services for children and young people at Conquest Hospital were effective, caring and responsive to patients and parent's needs; however, there are improvements needed for the service to be safe and improvements needed in the leadership.

Staff we talked with demonstrated awareness of how to report incidents through the trust's reporting mechanisms. A paediatric risk register is in place, which identifies current risks to the service.

The corporate records management policy identified that records must be kept securely. We saw that in some clinical areas records had been locked away. We found a total of approximately 5,600 pieces of patient records filing outstanding, for example: assessment reports, discharge letters, referral letters.

We found that incomplete records had been kept in five sets of notes reviewed on Kipling Children's Unit. The notes of daily living were incomplete and there was crossing out in the notes with no dates identified. It was also noted that care plans had not been completed.

The children's clinical areas were kept clean and had been regularly monitored for standards of cleanliness. However, we were told that no key person was responsible for checking and cleaning the toys in children's areas.

Pharmacy controls were in place; however, we found there was not a monitoring process identified for nurse prescribing.

We found shortfalls in staff attendance in mandatory training, which meant that staff skills and knowledge had not been regularly updated. We looked at what tools the trust had in place to recognise the sick child. We saw that the children's service used a national early warning score (NEWS) system developed regionally to detect a sick child or infant who may require urgent/ critical care.

We found a mixed picture regarding staffing within the clinical areas of the inpatient children's services. Staff told us that as the ward was currently quiet and that staffing levels had been "OK". We were told that when the ward was at full capacity, staff would struggle to take their two 30-minute breaks during the day shifts. They also told us that the staff on the SSPAU did not always take their breaks as there was only one trained nurse working on the SSPAU each shift.

Staffing of the children's outpatient department was not satisfactory, because there was not always a readily available registered children's nurse to oversee the clinics if the rostered outpatient nurse took annual leave. Staffing on some spans of duty within all children's clinical areas did not always meet national best practice guidance.

We found care was effective. Children, young people and parents told us they felt they received compassionate care with good emotional support. All, except one parent, felt they were fully informed and involved in decisions relating to their treatment and care.

The service did not currently have formal arrangements in place to respond to the transitional needs of all adolescents moving to adult services except for children with diabetes.

We found that children's services were well-led at ward level. There was a culture of openness and flexibility, which placed the child and family at the centre of decision-making processes. There were governance processes in place and risks were actively monitored.

We could not establish how cohesive the culture was within the leadership team, in part, as some clinicians continued to identify concerns relating to the reconfiguration. We found differences in opinion between paediatricians about the effectiveness of the reconfiguration.

The children's services strategy is in development. Managers told us that the commissioner's strategy was being used to develop and inform the children's services strategy.

We saw that some innovative practice had taken place, which had resulted in the development of a neonatal transitional care service within the special care baby unit (SCBU). We received positive feedback from one mother about this service.

Requires improvement

Services for children & young people

Are services for children & young people safe?

Requires improvement

Improvements are required.

Staff we talked with demonstrated awareness of how to report incidents when they occurred via the trust's reporting mechanisms. A paediatric risk register is in place, which identifies current risks to the service. Controls and action plans had been identified against each risk.

We did not see a consistent picture of how children's services assessed and responded to patient risk. We were told that patient acuity is measured through an audit tool that measures daily patient dependency levels. We found this tool had not been completed on Kipling Children's Unit, since February 2014.

The corporate records management policy identified that records must be kept securely. We saw that, in some clinical areas, records had been locked away in a lockable cupboard and/or cabinets. We found a total of 5,600 pieces of patient records filing outstanding, for example, assessment reports, discharge letters, referral letters.

We reviewed four sets of patient notes while on Kipling Children's Unit. We found that, generally, the notes were comprehensive and well documented. However, we found that one complex patient's notes had no risk assessments or comprehensive care plans identified, despite the child having complex needs. We did not see evidence that the child's care needs had been reviewed.

The SSPAU, children's outpatient clinic, SCBU and Kipling Children's Unit were clean and tidy. Infection prevention measures were in place and we observed members of medical, nursing and other staff regularly performing hand hygiene throughout the inspection on all clinical areas.

The SSPAU, children's outpatient clinic, SCBU and Kipling Children's Unit were well maintained. Clinical areas had equipment suitable for children and young people, which had been serviced, tested and/or repaired. However, we found an introducer in the resuscitation trolley on Kipling Children's Unit had passed its expiry date.

Pharmacy controls were in place and the trust adhered to NICE guidance. In acute children's services 43.2% of nursing staff had received training in medicine's management. Pharmacy audits had been completed and actions followed up by the ward matron.

Staff demonstrated an awareness of the laws surrounding children and young people's consent. Staff demonstrated an awareness of how to safeguard children.

Children's services training strategy had not been developed. Staff had received a range of mandatory training, although we noted shortfalls in staff attendance, for example, staff attendance at yearly paediatric intermediate life support training had not been achieved.

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

The trust told us they followed the Royal College of Nursing (RCN) 2013 core standards identified in services providing healthcare for child and young people. We found this guidance had not been fully implemented by the trust. This was because staffing skills mix and support on some spans of duty within the clinical areas were not always meeting national best practice guidance.

There were mixed views communicated from consultant paediatricians regarding the merger and whether it had improved care and support within children's services.

Incidents

- The trust has a comprehensive policy for the investigation of incidents, complaints and concerns (issued October 2013). We noted that the policy had clear guidance and associated procedures in place. The importance of following up action plans to ensure that lessons are learnt and changes in practice implemented was emphasised. We noted that this policy worked in combination with other trust policies, such as risk management and complaints, to ensure that all aspects of the incident had been covered. The trust also uses the National Patient Safety Agency (NPSA) risk matrix to identify risk severity.
- Staff we talked with demonstrated an awareness of how to report incidents through the trust's reporting mechanisms. Discussions with staff identified that incidents had been reported through Datix.

- The trust had captured information relating to incidents. We saw two examples of this information in statistic format and graph format.
- The trust demonstrated that it had identified incidents and that risks had been discussed through its monthly risk meetings and monthly quality governance meetings. In addition, meeting minutes of the nursing quality performance review group, patient safety and essential compliance group and the trust board confirmed discussions associated with incident and risk management.
- We saw a patient safety report dated 22 July 2014. The report contained information about Serious Incidents, root cause analysis and the risk register. The risk register identified 15 risks with identified actions, for example, a risk related to the lack of consultant presence on the Conquest Hospital SCBU. The actions taken were listed as the need for a daily consultant presence was agreed on the consultant away day on the 20 June 2014. This was reinforced at the consultant's meeting on the 18 July 2014 and the risk escalated to the medical director for response and action on the 25 July 2014. Discussions with four senior managers identified that the 'consultant of the week' completes a weekly SCBU teaching ward round. We were also told that there had been daily consultant presence on SCBU for four hours each day. We spoke with members of the SCBU team to ascertain whether daily consultant presence was in place. Some staff told us that they felt that they had to compete with the paediatric ward for consultant attention. We also saw that these concerns had been raised at the patient safety and essential compliance group on the 9 June 2014, and in the Nursing Quality Performance Review Group Report dated the 21 August 2014. We saw three consultant rotas for March, August and September 2014, which identified the consultant of the week for children's services. It was not clear from this rota how much time the consultant would spend on the SCBU.
- We noted that the current paediatric risk register identified nine risks relating to children's services. The register identified the controls in place and actions against each risk. Discussions with some staff confirmed their knowledge of what risks were identified on the risk register and what involvement they had had with this process.
- Serious Incidents (SI) are where the incident has resulted in death or permanent/serious harm. One SI had been reported for children's services in August 2014. The investigation relating to this incident is in progress. The staff we spoke with demonstrated the knowledge of how to report a SI. We saw that two serious incident completed root cause analysis documents had been shared with the Clinical Commissioning Group and that the trust was awaiting feedback from changes to their recommendations.
- We reviewed one SI report relating to an incident dated 25 November 2013. The report identified the incident, a chronology of events, actions taken, lessons learned and recommendations with an associated action plan for patients who may present with the same medical concerns. Information relating to how the parents were supported and involved was also identified. We saw that this report had been distributed to key people within the children's and midwifery service.
- Minutes from the Divisional Patient Safety and Clinical Improvement Group dated the 9 June 2014 and the Nursing Quality Performance Review Group dated 21 and 24 August 2014 confirmed that no new Serious Incidents had been identified.
- We saw discussions relating to morbidity and mortality had taken place at trust level. Information was seen in the minutes of the Patient Safety and Clinical Improvement Group dated the 9 June 2014. The information presented did not identify that it related to children. Minutes of the joint obstetric and perinatal morbidity and mortality meeting dated the 27 June 2014 identified there had been 10 paediatric alerts. We also saw unexpected child death guidance in place for staff. The guidance was in protocol and flow chart formats. Detailed guidance could also be accessed through a joint agency protocol for unexpected child deaths (2014). The link to this guidance was included in the child death protocol. This meant that staff had clear guidance to follow in the event of a child death.
- Staff confirmed that the trust does not have a paediatric Safety Thermometer. We were told that one was in development. We saw that each clinical area had a 'quality and safety board' displayed. Staff told us that the information displayed on this board was updated as required. The type of information displayed related to staffing levels, the last C. difficile infection and the last MRSA blood stream infection diagnosed on the ward.
- Safety alerts – staff told us that safety alerts were received at ward level and had been actioned as appropriate.

- There had been no Never Events in children's services at this trust.
- The trust had previously invited two external bodies to review paediatric, maternity and gynaecology provision at the trust. These bodies were the National Clinical Advisory Team (NCAT) and the Royal College of Paediatrics and Child Health (RCPCH). The outcome of these reviews resulted in recommendations. We have noted that some of the paediatric recommendations have been implemented from both reviews. Action plans are in place for the RCPCH recommendations. The progress and completion column identifies progress made to date against the recommendations. We noted that the last update had taken place in April 2014. This updated action plan identified actions specific to recommendations, which required final sign off, for example the paediatric operational policy. We saw a copy of the paediatric operational policy and noted that it had been signed off in September 2014.

Cleanliness, infection control and hygiene

- We received information from a listening event on the 4 September 2014, which identified concerns relating to when infection control measures being used, for example, barrier nursing. Additional concerns were raised regarding the training of non-medically trained staff in infection prevention and control. Concerns were also raised at a staff focus group on the 9 September 2014. These concerns related to doctors not washing and/or using hand sanitising gel on their hands.
- We found the SSPAU, children's outpatient clinic, SCBU and Kipling Children's Unit to be clean and tidy. We did note, however, that work was being undertaken on the drug treatment room on Kipling Children's Unit. This area had been screened off and the surrounding area remained clean. We saw infection prevention measures in place, such as wall mounted hand sanitising gels outside bays and cubicles. Containers containing aprons and gloves were also wall mounted throughout the clinical areas and hand sinks were available. Hand washing guidance was also seen to be displayed throughout the clinical areas.
- We observed members of medical, nursing and other staff regularly performing hand hygiene throughout the inspection on all clinical areas.
- Nursing staff told us that hand hygiene audits had taken place in the clinical areas. We saw performance documented on the quality and safety boards in clinical areas. For example, on Kipling Children's Unit the national cleaning standards audit for ward cleanliness had been identified as 98% in August 2014. We saw audit documentation confirming that 100% compliance had been achieved in the hand hygiene audit for September 2014.
- The trust has a designated infection prevention and control management team. A director of infection prevention and control (DIPC) lead the team. The team also included infection control nurses, practitioners and intravenous nurses and practitioners. One staff member told us that the infection control nurse had visited Kipling Children's Unit daily to check on infectious patients. They told us that the infection control nurse had asked questions about how staff had managed any infectious episodes and gave advice where required. The ward matron told us that the ward had an infection control link nurse who had received additional training through the infection prevention and control team, to enable them to perform within their role. We were told that this person had attended monthly infection control meetings.
- The trust provided us with infection control training statistics for 2013 and 2014. The statistics for 2014 showed that 78% of inpatient paediatric staff and 90% of neonatal staff had completed infection control training. Two of the staff we spoke with on Kipling Children's Unit confirmed attendance at infection control trainings within the last year.
- We saw information relating to the diagnosis of the last C. difficile infection and MRSA blood stream infection displayed on the quality and safety board in each clinical area. The Kipling Children's Unit statistics for these infections was recorded as January 2014 for the last C. difficile infection and September 2009 for the last MRSA bloodstream infection.
- We asked who was responsible for checking and cleaning the toys in children's areas. We were told that there was no designated responsibility and that a toy-cleaning regime did not exist. Therefore, children could be put at risk if adequate checks and cleaning are not carried out on children's toys. We were told that a children's toy policy or risk assessment had not been developed.

Requires improvement

Services for children & young people

Environment and equipment

- We found the SSPAU, children's outpatient clinic, SCBU and Kipling Children's Unit well maintained. We did notice, however, that some equipment had been stored in corridors. We saw that the ward comprised of a mix of shared bay areas and cubicles.
- We saw that space within the SCBU was limited, especially so in the designated high-dependency bay, which accommodated four cots. The ward matron told us that the SCBU could accommodate up to 12 level 1 special care cots and four transitional care cots.
- Facilities for children, young people and their families and/or carers were available. For example, on Kipling Children's Unit there was a large, spacious play area, parents could also make drinks in the kitchens, there were two parent rooms on SCBU and a designated parents sitting room.
- We saw that all clinical areas had equipment suitable for children and young people. The trust provided equipment and maintenance logs, which confirmed that equipment had been serviced, tested and/or repaired. We checked the paediatric resuscitation equipment on Kipling Children's Unit and saw that the equipment had been checked at weekly intervals. However, we undertook a check against random equipment on the resuscitation trolley and found that an introducer had passed its expiry date which was August 2009. The ward matron was made aware of this so that the introducer could be replaced. The inspection team also checked the paediatric resuscitation equipment in the Conquest Hospital A&E and identified that appropriate paediatric equipment was available. We also under took random checks on some equipment, for example, two fire extinguishers on Kipling Children's Unit and noted that they had been serviced in 2014.

Medicines

- The trust has identified medicine management policies and procedures in place. For example, we saw children's guidance in the 'Procedures for patient self-administration of medicines' dated November 2013. The guidance related to self-administration of medication by children. This guidance identified that consent from the parent or guardian is desirable and the child's competence would be assessed using the Gillick competencies and Fraser guidelines for deciding whether a child is mature enough to make decisions and give consent . We did not see any specific guidance relating to administration of the child's medication by parents. We saw that the trust had identified an equality and human rights statement in relation to patient self-administration.
- We were told that the trust adhered to NICE guidance in relation to medication management.
- Staff told us that clinical staff had received a one hour medicines management training on induction in relation to writing prescriptions and medication doses. The management team confirmed that a "safe handling of medicines course" had been attended by staff at the trust induction. Three yearly medical devices update courses, which related to the administration of medicines were also offered. We saw competency documentation that confirmed that medicines management training included administration of oral medication, administration of subcutaneous/ intramuscular and intravenous medications. This formed part of the nurses' mandatory core clinical competencies to ensure clinical competence. Staff training statistics confirmed that 43% (35 out of 81) of the current acute nursing staff had undertaken medicines training.
- We observed two nurses preparing antibiotics. This observation confirmed that medication checking procedures had been followed. We spoke with a nurse prescriber who identified they had attended bi-annual general nurse prescriber update training.
- We observed that all the necessary pharmacy controls were in place. For example, on Kipling Children's Unit we saw that all the drug store cupboards were locked, records of controlled drugs had been completed and stock checked daily. Evidence detailing the controlled drug checks were seen. We were told there had been no incidents involving controlled drugs identified at the biannual pharmacy review. Daily checks of the drug fridge had taken place; records of checks were seen confirming this.
- We reviewed five drug charts and saw that they had been signed, dated and reviewed by the doctor where necessary.
- We were told that one drug chart had been mislaid and that this had been discussed with the ward matron. This incident had not been raised as a risk, instead the chart was just rewritten.

- The outcome of a drug error has resulted in additional pharmacy controls being put in place. These controls include the pharmacist checking patient drug charts to ensure that intravenous regimes are correctly prescribed.
- The paediatric pharmacist confirmed that a pharmacist would visit the paediatric wards daily and the SCBU three times a week. The pharmacist and nurse prescriber identified that they had not been at any of the medication audits that had taken place. They also said a monitoring process was not in place for nurse prescribing. Meeting minutes of the Nursing Quality Performance Review Group Report for Kipling Children's Unit and SCBU confirmed that a pharmacy audit had taken place in May 2014 on Kipling Children's Unit. Partial compliance had been achieved and the ward matron was taking forward the actions with pharmacy.

Records

- The trust has corporate and health records management policies in place. Both policies had been issued in 2014. Compliance against these policies was monitored through the trust information governance steering group.
- The trust has both paper and electronic patient records. The corporate records management policy identified that records must be kept securely. We saw that, in some clinical areas, records had been locked away in a lockable cupboard and/or cabinets.
- We found a total of 5,600 pieces of patient records filing outstanding, for example, assessment reports, discharge letters and referral letters. 2,600 pieces of filing were outstanding in office 1, the paediatric administration office, while 3,000 pieces of filing were located in the community office. This could potentially put the patient at risk if full and accurate records are not available.
- We also observed that patient notes were kept in an unlocked trolley within the administration area on Kipling Children's Unit.
- The trust's policy identified that, when patient information is shared with other agencies, the patient would be asked to consent to this before information was released. Evidence of this consent would be documented in the person's records. Staff said that babies and children's information is shared with members of the multidisciplinary team, such as health visitors and the child's GP prior to discharge.
- We reviewed three sets of patient notes while on Kipling Children's Unit. All contained good documentation of the admission process, nursing care, assessments and ward round decisions. The paediatric early warning score (PEWS) charts were age appropriate. We noted the child's clinical observations were documented on the charts. Feed and fluid charts had been completed were necessary. For the complex patient we saw evidence of good documentation of multidisciplinary discharge planning.
- We reviewed another five sets of notes while on Kipling Children's Unit and found that the notes of daily living were incomplete and there was crossing out in the notes, with no dates identified.
- We also looked at one more patients' notes and saw that no separate nursing risk assessments had been identified for that child, despite the child having complex needs. We raised this with the ward matron who said that risk assessments were not required.
- The matron told us that the "at a glance summary of child's need" section, page 12 of the paediatric integrated patient documentation, was where care planning information was identified for the child. We looked at this child's care plans and noted that they were not in a typical care plan format and there was minimal space on the document to make changes, should the child's care needs change. The matron said that in the event of care plan changes a new care plan document would be completed. We did not see evidence that the child's care plans had been reviewed.
- We were told that monthly records audits had been completed and the results of these audits were communicated to staff by the ward matron or clinical service manager. The outcome of these audits were also discussed at the paediatric quality meeting. We were told that tri-monthly documentation audits had also been completed and the last audit on SSPAU at Eastbourne District General Hospital had taken place approximately three weeks ago. Meeting minutes of the 'Nursing Quality Performance Review Group Report' for Kipling Children's Unit and SCBU confirmed that Meridian records audits had been completed. The SCBU audit compliance score for August 2014 was 95%. The Kipling Children's Unit August feedback identified concerns relating to non-completion of sections, for example, consent to care and property. It was also noted that care plans had not been completed.

- Training statistics identified that, to date, 71.7% of inpatient paediatric staff and 100% of neonatal staff had attended information governance training in 2014. One nurse asked confirmed they had completed the online information governance module.
- We also saw health and safety and moving and handling training statistics for inpatient paediatric and neonatal staff for 2014/2015. We noted a shortfall in health and safety staff training attendance for both areas, at 51% and 36.7% respectively. Staff attendance at moving and handling training for the same time period was 65% for inpatient paediatrics and 90% for neonatal staff.
- We asked what staff recruitment checks had been undertaken and were told that references had been collected and criminal record bureau checks undertaken prior to staff starting in post. We saw documentation for one employee confirming that a criminal record bureau check had been undertaken.

Consent

- Staff we talked with showed that they understood the Fraser guidelines and Gillick competence laws surrounding consent for children. Staff explained that the consent process was completed by surgeons for children requiring surgery. One staff nurse said they would answer parents'/carers' questions to ensure that the child and parent/carer understood what the surgeon had told them prior to obtaining consent. The trust also had consent guidance in place for staff to access. Discussions with a parent confirmed they had signed a consent form prior to their child's surgery.
- We asked what would happen should a child or young person request that information is not shared with their parent/carer. We were told that this wish would be respected, although it would depend on the information.
- We saw staff training statistics for 2014/15, which identified that, to date, inpatient paediatric staff had completed Mental Capacity Act 2005 (71.8%) and Deprivation of Liberty Safeguards (71.4%) trainings. Training statistics for neonatal staff confirmed completion of Mental Capacity Act 2005 (100%) and Deprivation of Liberty Safeguards (79%) trainings.

Safeguarding

- The trust has child protection systems and support in place. The trust's safeguarding child protection policies and systems last review was March 2014. A whistleblowing policy and a new policy 'Allegations relating to staff involved in child abuse' (issued February 2014) also provided guidance to staff.
- The director of nursing is the trust executive lead for safeguarding children and young people. The acute hospital currently does not have a lead consultant for safeguarding. The trust's named nurse for children identified that medical support for children's safeguarding issues was provided by two community paediatricians. A specialist nurse supervisor and two specialist nurses had also been appointed into the children's safeguarding team. These nurses are senior nurses. We were told that the specialist nurse supervisor was responsible for updating protocols and provided supervision to staff across the trust site. We did not see any completed staff supervision records or supervision schedules to confirm what had taken place to date. The specialist nurses' role included reviewing the notes of children from the A&E, minor injury department and paediatric department.
- The trust's named nurse for child protection/ safeguarding children said that new safeguarding pathways were being introduced, which related to bruising and also to an intoxicated child. We were told that no guidance or pathway existed for the child who was admitted to the trust to undergo a termination of pregnancy.
- The trust's named nurse for children said that an electronic alert system had been introduced onto the EDs electronic alert board. The senior nurse practitioner in the ED confirmed that they had a safeguarding information folder for staff to access in the reception area. They confirmed that staff had completed children's safeguarding training at either level 2 or level 3. We were told that information about children or young people on the child protection register or 'looked after' children could be accessed by telephone.
- The trust had strategy and discharge-planning meetings prior to a neonates discharge from SCBU. For children and young people, a strategy meeting took place prior to their discharge. We were told that a child's discharge would always take place after the weekend.
- The trust meets the statutory requirements in relation to the Disclosure and Barring Service (DBS) checks. All staff employed at the trust underwent a DBS check prior to employment and those working with children underwent an enhanced level of assessment.

- NICE safeguarding guidance recommends that permanent staff be trained to a level 3 standard. We were told that staff who worked with children had been trained to level 3. The trust's training statistics for 2014/2015 identified that 82.8% of inpatient paediatric staff and 96% of neonatal staff had received safeguarding children level 3 training.
- Additional trust training statistics also confirmed some staff had completed safeguarding children, level 2 training, 72.5% of inpatient paediatric staff and 100% of neonatal staff. Four of the staff we spoke with confirmed attendance at safeguarding training in 2014. These staff showed an awareness of safeguarding and what to do should an incident be identified. Staff were also aware of the trust's children's safeguarding policy and supporting procedures.
- The trust's named nurse for child protection/safeguarding children said that domestic violence had been incorporated into staff training. We were told that domestic violence champions work in the ED.
- We saw the training information provided for every junior doctors' induction. We spoke with two junior doctors who said they had received plenty of input and support from the named nurse for child protection. We were told that the named nurse had also attended handovers and they had received additional support from the consultants. They told us they had received child safeguarding training at induction. We observed that there was uncertainty about who was the lead consultant for safeguarding.
- The trust's named nurse for child protection/safeguarding children said that yearly formal supervision had recently been implemented for nursing staff. We were told that it was the responsibility of the paediatric specialist nurse supervisor to ensure that yearly supervision was completed by nursing staff. Medical staff received supervision from the community paediatrician. We were told that informal supervision was in place for doctors and that locum doctors did not receive supervision.

Mandatory training

- Members of staff of all grades we talked with confirmed they had received a range of mandatory training and training specific to their roles.
- We saw the trust's mandatory training rates for 2013 and 2014, which confirmed the percentage of paediatric staff attendance at identified mandatory training sessions. We noted from the 2014/2015 training rates that compliance was generally better for neonatal staff than for inpatient paediatric staff. We noted that neonatal staff had scored 100% attendance at information governance, Mental Capacity Act 2005 and safeguarding children level 2 training. The highest attendance rates for inpatient paediatric staff related to safeguarding children level 3 – 82.76%, fire safety – 79.35% and blood transfusion – 78%.
- We were told that staff should attend yearly resuscitation training. One senior member of staff identified that staff attendance at yearly paediatric intermediate life support training had not been achieved. Training statistics for the inpatient paediatric staff confirmed this, as staff attendance rates for 2013/14 had been 70.3% and for 2014/15 (to date) attendance rates had been 71.5%. We saw that neonatal staff attendance at resuscitation training was higher, 2013/2014 attendance identified as 92.6%. In 2014/2015 (to date) attendance rates had been 90%.
- This meant that the trust did not meet the Royal College of Nursing (RCN) core standards identified in services providing healthcare for children and young people. The third core standard identifies "At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS, depending on service need."
- The trust has an induction programme for new staff. One nurse and two junior doctors confirmed attendance at the staff induction programme. The nurse said that they had not received a paediatric unit induction as the paediatric ward had been very busy when they started in post. The nurse said they had a preceptor identified to support them, but they had not had the time to sit down and discuss things. This nurse said they had been given a competency book to complete. As yet, this book has not been fully completed. We were also told that no teaching was in place for newly qualified staff.
- Staff from the SCBU unit told us that new staff have a mentor and their first three months was spent shadowing on the unit. Staff had been given competencies to complete, which are monitored.

Assessing and responding to patient risk

- We received information from a listening event on the 4 September 2014, which identified concerns relating to the safe transfer of children. Concerns relating to staff

competencies in caring for the deteriorating child and protocols relating to the management of children in "cardiac distress" not being followed or adequately developed were also identified.

- The trust has a paediatric risk register. The register identified nine risks in total. One risk had been attributed to children's service on the Conquest Hospital site. This risk was identified as a lack of consultant presence on the SCBU. We have some conflicting evidence on how well the trust was managing this risk. This is because the initial staff feedback identified limited, if any, consultant presence on the SCBU. Staff told us that consultant presence had improved recently as the consultant of the week now does a daily ward round. We reviewed consultant rotas, which showed consultant presence across the paediatric unit, although, it did not specify when consultant staff would be present on the SCBU.
- Six of the risks were attributed to all hospital sites, while two risks were attributed to the Eastbourne District General Hospital site. One of these risks related to delays in the transfer of patients from Eastbourne District General Hospital SSPAU to Conquest Hospital's Kipling Children's Unit. We saw that the risk register identified specific controls to ensure timely transfers took place in the future. Discussions with staff identified that transfer delays were still a problem. We were given two examples of when the paediatric nurse had to remain with the child until the next day.
- The trust has an operational policy for children's and neonatal services, which identified the arrangements for the transfer of sick babies or children requiring specialist support out of hours. Staff told us that children would be transferred with the assistance of South East Coast Ambulance (SECAMB) service. For sick babies and children requiring airway support and ventilation we were told they would be collected by the retrieval team who arrived with the appropriate equipment to take the baby/child to the most appropriate hospital. Babies who are sick, but not ventilated were transferred in baby pods.
- The trust also had the following policy guidance in place, the 'Patient Admissions, Transfer, Clinical Handover of Care and Discharge Policy'. This policy guidance had been issued in August 2014. We saw that the guidance was clear and identified accountabilities and responsibilities to individual staff, to ensure effective deployment of processes. However, we did note that the policy appeared to be more adult focused and there were no dedicated sections relating to children's and young people or neonatal transfer.
- The trust had a dedicated 'Transfer to Special Care Baby Unit' policy in place, which was issued in January 2013. We also saw a copy of the neonatal transfer service specification for neonatal critical care retrieval and the SECAMB neonatal service operational procedure, issued 2 May 2012. These documents identified that neonates and children could be transferred safely through the contracted service provider.
- We looked at what training and support the staff had received in recognising and caring for the deteriorating child. One senior member of staff identified that the nursing staff had not been able to complete advanced paediatric life support (APLS) training. We were told that, currently, two nursing staff had completed this training. However, we were told that both staff required an update in their resuscitation skills. The lack of staff training in this area meant that the trust did not meet the Royal College of Nursing (RCN) core standards identified in services providing healthcare for children and young people. The third core standard identifies "at least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS, depending on service need".
- We asked the ward matron whether paediatric nursing staff at Conquest Hospital had any paediatric high-dependency training. We were told that no staff had completed training in this area.
- We looked at what tools the trust had in place to recognise a sick child. We saw that the children's service used an early warning system developed regionally to detect a sick child or infant who required urgent/critical care. The system was known as the paediatric early warning score (PEWS). It allows the paediatrician and children's nursing team to identify when a child's clinical observations could be lying outside the normal range. The colour codes on the charts assist the decision-making processes regarding the stabilisation and transfer of critically-ill children to a regional paediatric intensive care unit (PICU). We reviewed a sample of PEWS observation charts and found these were completed in detail by members of the nursing team.
- The children's service managed local environmental risks appropriately. For example, local health and safety

risk assessments were in place for Kipling Children's Unit. These risk assessments had controls identified and in place and a level of risk identified. They had been reviewed on the 6 June 2014.

Nursing staffing

- We received information from a listening event on the 4 September 2014, which identified concerns relating to the skills mix of nursing staff on Kipling Children's Unit per shift.
- Children's service managers told us that they had adopted the Royal College of Nursing (RCN) guidance identified in 'Services providing healthcare for child and young people' (2013). The management team were unable to provide a written staffing strategy relating to children's services. The ward matron told us that the agreed staffing levels for Kipling Children's Unit operating on 25 beds were: six registered nurses – from morning to evening and four registered nurses for night duty. Unregistered staffing levels for Kipling Children's Unit per shift were: morning – two staff, afternoon and night duty – one unqualified staff member.
- We looked to see what skills mix and staff cover were identified on the Kipling Children's Unit duty rota. We looked at two dates initially and found shortfalls in experienced staff (band 6 nurses and above). The RCN guidance for 2013 identifies that, in addition, to a band 7 sister or charge nurse, a competent, experienced band 6 nurse is required throughout the 24-hour period, to provide the necessary support to the nursing team.
- On the 10 September 2014 eight children were being cared for on the ward. The staffing compliment identified was: four qualified staff in the morning and afternoon and one unqualified staff member in the evening. This included the ward matron and one band 6 nurse. Three qualified staff and one unqualified staff member were booked for the night duty. We noted that there was not a band 6 sister allocated to work the night duty.
- On Friday 22 August 2014 the Kipling Children's Unit duty rota identified no sisters at band 6 or band 7 had been allocated to work. We looked to see what staff were allocated to work on Friston Ward Children's Unit at the Eastbourne District General Hospital site, which is at least 45 minutes' drive away on a clear run. The Friston Ward Children's Unit duty rota confirmed that the Friston Ward Children's Unit matron and one registered nurse were allocated to work on the ward.
- We looked in total at three duty rotas for both Kipling Children's Unit and Friston Ward Children's Unit and found shortfalls in band 6 qualified nurse presence on Kipling Children's Unit. The majority of band 6 nursing provision shortfall was on duty night shifts. This meant that children's care could be compromised should the nursing staff on duty not have the skills or experience to provide appropriate care and recognise the deteriorating child. We saw that senior paediatric nursing support could be provided by ringing the ward matron on Friston Ward Children's Unit. The head of nursing also confirmed that staff could contact the Friston Ward Children's Unit matron with any queries as well as the Conquest Hospital site manager.
- We spoke to some staff and the ward matron about the staffing levels and skills mix on Kipling Children's Unit. Staff told us that the ward had occasionally been short-staffed, due to staff sickness and this had impacted on the quality of care staff given to children. One nurse told us that the last time this had happened was two months ago. They said that staffing issues had also impacted on the time they should have spent with their preceptor.
- Another nurse we spoke with corroborated the first nurse's concerns about staffing levels and also identified there had been high levels of staff sickness. We were told that, as the ward was currently quiet, staffing levels had been "OK". They described how the managers had been "playing with staffing numbers each day and night shift". This was to see what worked. We were told that when the ward was at full capacity staff would struggle to take their two 30-minute breaks during the day shifts. They also told us that the staff on the SSPAU did not always take their breaks as there was only one trained nurse working on the SSPAU. We asked a nurse on the SSPAU whether they had been able to take their breaks, we were told that there had been times when breaks could not be taken. They also told us that staff sometimes chose not to take breaks. The ward matron told us that SCBU had also be asked for help with paediatric staffing shortfalls.
- The Kipling Children's Unit matron told us that the ward had sufficient staff although there had been occasions, (usually once a week), when a band 5 registered nurse was left in charge of the ward. We were told that three newly qualified nursing staff had been appointed and that now the ward staffing was at full staffing establishment.

- The ward matron told us that, since the reconfiguration, ward staffing budgets had been reviewed and that following this review band 6 nursing staff budgets had been reduced. We saw copies of the March and June 2014 staff budgets which confirmed a reduction in band 6 nursing provision had been made. We were told that the increase to the minimum establishment to cover annual leave, sickness and study leave had also been reduced to 18.5%. The RCN guidance for 2013, core standard 5, identifies a 25% increase to the minimum establishment.
- We asked whether a senior paediatric nurse was on call over the 24-hour period. We were told there was no senior paediatric nurse on the on-call rota. Staff who required senior advice would contact the hospital site manager. There had been occasions when there had been difficulties accessing assistance through the site manager for staffing-related issues. This was in conflict with RCN 2013 guidance.
- We spoke with the senior management team about paediatric staffing levels and the support paediatric staff received. We were told that paediatric staffing had been reviewed at trust bed management meetings four times a day. We did not see the minutes from these meetings to confirm these discussions.
- Senior management told us that that patient acuity was measured through an audit tool that measured daily patient dependency levels. We asked staff whether these acuity tools were completed and were told that they had been completed up to the week commencing 10 February 2014. After this date this tool had not been used. The tool was supposed to be reintroduced a month ago, but, to date it had not been reintroduced or completed on Kipling Children's Unit, due to time pressures.
- Staff within the SCBU said they had been well supported. We were told by the ward matron that 76% of neonatal staff had been trained on the neonatal pathway. We saw that staffing was in line with national guidance.

Medical staffing

- The trust has 11 paediatric consultants providing acute cover for children's and newborn services; five at Hastings and six at Eastbourne District General Hospital. A new medical clinical lead had been appointed for children's services. We spoke with the existing consultant lead for paediatrics and a second paediatric consultant. We were told that there was one vacant consultant post and one locum paediatric consultant employed at the trust at the time of the inspection.
- The March 2013 trust board report identified that poor working relationships existed between the consultant bodies and, as such, working practices, policies and procedures had not been harmonised across the trust. At this inspection, we found that concerns continued to be raised by consultants, for example, the provision of consultant cover for paediatric services at the Eastbourne District General Hospital in situations such as sudden infant deaths and abuse cases.
- We were told by senior managers and the ward matron that there had been some joint paediatrician team working in paediatric polices development. For example, in the development of the paediatric operational policy.
- We spoke with one consultant anaesthetist who told us that paediatric anaesthetic cover at Conquest Hospital was adequate. Four of the consultant anaesthetists have a paediatric interest and do regular children's lists. They are happy to anaesthetise babies and children from the age of six months. We were told that the remaining consultant anaesthetists were competent and would anaesthetise children in an emergency situation. We were told that there could be some gaps in service provision as some anaesthetists were reluctant to anaesthetise children under five years of age; therefore out-of-hours these children could be transferred to Brighton.
- Anaesthetists would always attend urgent paediatric cases, resuscitations and PICU transfers. Out of hours there could be delays in anaesthetic consultant attendance. This was because they were travelling into the hospital. In these instances a middle grade anaesthetist would stabilise the child.
- We asked whether anaesthetic medical staff were able to maintain their paediatric skills, considering the low throughput of elective and emergency paediatric cases. We were told that, at that time, skill maintenance had not proved a problem.
- We saw a selection of paediatric consultant rotas for March, August and September 2014. These rotas identified the consultant of the week, consultant daytime and evening cover up to 9pm. Consultant cover from 9pm until 9am the next morning was not identified

on these rotas. It was, therefore, difficult to determine whether there had been sufficient consultant cover over night. Consultant cover for sites not providing paediatric inpatient services was from 9am to 9pm.

- There had been some concerns about consultant cover in SCBU. This was because the consultants had not always been present for sick babies, or for routine ward rounds. We saw that this had also been documented on the paediatric risk register. Staff told us that consultant presence had improved recently as the consultant of the week did a daily ward round.
- The trust's paediatric middle-grade doctors consisted of a combination of non-training grade doctors (specialty doctors) and trainees (specialty registrars). We were told that the trust had been unable to recruit to establishment levels for middle-grade paediatric doctors. There were two middle-grade doctor vacancies until recently. One new middle-grade doctor was due to start work at the trust. Senior managers told us that interviews were due to take place for the second middle-grade doctor. Once these posts had been appointed, the trust management said they would have a full complement of middle-grade doctors.
- We saw that locum doctors had been employed to replace shortfalls in medical staff. Locum statistics provided by the trust confirmed a monthly use of between 4.70 to 12.80 locum doctors over a 12-month period.
- We were told that formal supervision arrangements of locums by consultants was not in place.
- We found that the Royal College of Paediatrics and Child Health (RCPCH) 'Facing the future' standards had been fulfilled.

Major incident awareness and training

- There was a trust major incident plan, business continuity plan and paediatric ward closure procedure in place. These documents set out the actions to be taken for major incidents and other events such as insufficient nursing, medical staff or beds/cubicles.
- One staff member told us there were aware of the trust major incident plan and that additional guidance was in place relating to an increase in paediatric admissions, due to hot or cold weather conditions. We were told by the ward matron that extra beds would be opened on the short stay assessment unit, which was located next to Kipling Children's Unit to accommodate an increased admission rate. We were told that a maximum of 25 paediatric beds would be opened in these situations.
- We did not review any training records which showed there had been any specific training in the use of the major incident plan.

Are services for children & young people effective?

(for example, treatment is effective)

Good

We received information from a listening event on the 4 September 2014, which identified concerns relating to children's medical care. At inspection, we did not find any evidence to confirm these concerns from the information we looked at and the conversations we had with parents and staff.

Children's services made improvements to care and treatment where these had been identified by audit findings or in response to national guidelines. Children were provided with pain relief when they needed it. The majority of staff had received their annual appraisal for 2014. The majority of staff we spoke with said they had received good levels of support and personal development. There was clear evidence of multidisciplinary working across various disciplines and specialities.

Evidence-based care and treatment

- Clinically-endorsed guidance from authorities such as the Royal College of Paediatrics and Child Health (RCPCH) and the National Institute for Health and Care Excellence (NICE) was used to inform children's care.
- The trust had systems and processes in place to review, implement and audit clinical guidance and evidenced-based best practice guidance. We saw the minutes of meetings relating to the auditing of clinical practice. The audit and paediatric mortality meeting notes dated the 9 July 2014 identified recent clinical audits. Learning points and actions had been identified following the audits. For example, the learning points

from the 2011 to 2012 National Paediatric Diabetes Audit (NPDA) stated that every child over 12 needs extra monitoring annually; compliance at the trust was below the national average.

- We saw a brief update on some of the learning from serious case reviews in the East Sussex Healthcare NHS Trust had been shared at a trust audit meeting on the 14 May 2014.
- We were told that the trust used the Brighton & Sussex University Hospital guidance for children's services, which had not as yet been ratified by the trust. We saw that paediatric policy development had been identified as a risk on the paediatric risk register as current paediatric and neonatal policies were out of date. The risk register identified that the policies had been sent to the consultants to review.
- We reviewed 10 paediatric policies and saw that all had been ratified and dates of review identified. We noticed that a number of policies had been ratified in 2014.
- We were told that a dietician vacancy existed to cover paediatric diabetes. This shortfall in dietician expertise has been identified as a risk on the paediatric risk register. In the interim, another dietician was providing a limited service. We spoke with a recently appointed band 6 diabetes nurse who also worked on Kipling Children's Unit. This member of staff felt that care was good, with patient contact in homes and schools. Good consultant availability and supervision were also in place.
- Regarding do not attempt cardio-pulmonary resuscitation (DNACPR) decisions – the trust had a DNACPR policy that staff could refer to. Staff told us that documentation relating to DNACPR decisions was kept in the child's notes and a copy was given to the child's parents/carers. We saw that the question relating to resuscitation status had been included on page three of the paediatric integrated patient document used by children's services.
- The neonatal unit had repeated the Bliss Baby Charter Audit and were finalising their action plan.
- We were told how initiatives had been introduced into the SCBU as examples of "best practice" as identified through Bliss. These initiatives were a post-discharge courtesy telephone call to parents to see how they are getting on and colouring packs with stickers were given to siblings of the babies to help them to feel welcome.
- We were told that strong links existed with a neonatologist at Brighton & Sussex University Hospital and a result of these links is that staff could attend teaching sessions run by Brighton & Sussex University Hospital. Biannual training for nursery nurses from the SCBU unit was accessed through Brighton & Sussex University Hospital.
- During the inspection, we saw that parents and/or carers remained with their child. We were told that a parent could accompany their child to theatre and diagnostic areas, such as radiology.
- We saw children and young people being cared for in child-friendly surroundings. We were told that adolescents would be given a choice as to where they wanted to be cared for in the ward, where possible. For example, they were asked if they were happy to share a bay with younger children, or if they would prefer to be with older children.
- Separate children's outpatients areas existed. We were told that a mixture of clinics were run from this area, although, occasionally, some children could also be seen in adult outpatient clinics, for example, the ear, nose and throat clinic. Staff told us that, occasionally, consultants from other hospital groups could see children at the Conquest Hospital children's outpatient clinic.
- The trust had just appointed a band 6 research nurse in paediatrics. This person worked three days a week. The research they were involved in included diabetes, cystic fibrosis, dermatology and childhood obesity.

Pain relief

- Children and young people had access to a range of pain relief if it was required, including topical, oral analgesia's and intravenous analgesics.
- The trust had a dedicated pain management team who were based at Eastbourne District General Hospital. We were told by staff that the team would provide support when necessary.
- The service used an evidence-based pain scoring tool to assess the impact of pain. The tool had been adapted so that it could be used to measure pain in younger, as well as older, children. We saw guidance on the back of the chart relating to assessing ongoing pain requirements.
- We spoke with one older child and his mother about their experiences in relation to pain management. We were told that he had received adequate pain relief and,

when requested, the medication had been given quickly. No concerns were raised about the management of his pain since admission to Kipling Children's Unit.

- Staff told us that parents are involved in ongoing discussions surrounding effective pain management for their child. We were told that, initially, CALPOL® and Brufen would be prescribed. The medication would be reviewed with the parent and child by nursing and medical staff for stronger pain-relieving medication, should the child require it.

Nutrition and hydration

- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment of the child's activities of daily living. Children were able to choose their food from the daily menu, with the support of the housekeeper or parent. We were told there was a children's menu, which had been reviewed every three to four months by the catering department. We were told that it was a nursing responsibility to ensure that children's food and fluid needs were met.
- The information relating to children who had special dietary needs or a specific dietary status identified, for example, nil by mouth, halal, diabetic diets was displayed on the main board by the Kipling Children's Unit reception. This was so housekeeping, as well as medical and nursing staff were kept informed of the child's needs.
- There had been some negative feedback in the August 2014 comments made by parents on Kipling Children's Unit about the food offered to children, for example, lack of healthy options. Negative feedback had also been given about the selection of food in the hospital café.
- The SCBU had a dedicated milk kitchen and facilities available so that parents could make up their own baby milk within their babies' preferred bottles. We also saw there was pre-prepared milk available for parents to use should they prefer to bottle feed their baby.
- We were told that breastfeeding was promoted on both neonatal and paediatric ward areas. The ward matron from Kipling Children's Unit told us that breastfeeding mums were offered food and/or vouchers to use in the hospital canteen.
- We were told that parents could make drinks on the ward and could help themselves to foods, such as toast and cereal from the ward kitchen. Parents who had children in hospital for longer periods of time, three days or more, were also offered vouchers to buy food from the hospital canteen or have the remaining food from the kitchen trolleys at meal times.
- We saw an information booklet that was given to parents called 'Your child's general anaesthesia'. This book contained fasting (nil by mouth) guidance for parents to follow prior to surgery. Information about the latest times the child should eat or drink was also given.

Patient outcomes

- We reviewed information, which demonstrated children's services participated in national audit that monitored patient outcomes where this was applicable to the service. For example, we reviewed information relating to the National Neonatal Audit programme (NNAP) and the National Paediatric Diabetes Audit (NPDA).
- We discussed the poor outcomes identified from the 2013 NNAP audit with the ward matron. We were told that this audit had been completed at the time of the merger and that some of the outcomes related to very small numbers. We were told that they were confident that the 2014 results would improve. Actions had been implemented, such as training and the introduction of a family support group to try to encourage new mums to breastfeed their babies.
- We reviewed a selection of audits that had been completed by the trust in 2014. The Child and Adolescent Mental Health Services (CAMHS) pathway audit, Palivizumab re-audit and audits of 2,765 ED attendances by children and young people aged under 17 as a result of alcohol intoxication. All of these audits identified learning points, recommendations or action plans.
- The trust's audit dashboard identified a list of the audits that had been completed and the progress they had made against them. From the 16 audits submitted the trust identified that 14 of the audits recommendations had been effectively implemented. The remaining two audits, NICE: Managing Allergic Reactions was to be re-audited in one year and NICE: Head Injury, the action plan, was identified as progressing. We saw that a decision was requested as to a possible re-audit.
- Children's services did not participate in the NHS Friends and Family Test. An alternative system had been introduced which asked parents and children to provide

feedback about the service. We saw some feedback from parents from Kipling Children's Unit and the SSPAU, which had been given throughout August 2014. Generally, we found the comments to be very positive about the care received. We were not given any information as to how this information would be audited and whether any progress had been made against the areas identified for improvement.

- We were told that children's services did not use the Safety Thermometer to measure composite harm in children. The management team told us they were developing a paediatric Safety Thermometer, which would be introduced to the paediatric service in November 2014. We saw a copy of the proposed paediatric Safety Thermometer. We were told that staff would receive training in the use of the Safety Thermometer prior to its launch.
- Data for this trust identified that the rate of multiple emergency admissions was worse than the national average for epilepsy and diabetes.
- Minutes from the 'Nursing Quality Performance Review Group' showed that clinical effectiveness issues had been discussed weekly and improvements noted. We also saw that quality, safety and performance were standing agenda items on the trust board report.

Competent staff

- There were formal processes in place to ensure staff had received training and an annual appraisal.
- Records showed 71.4% of staff had an appraisal in 2013/2014; while, to date, for 2014/2015 records showed a slight increase, as 77.3% of staff have had an appraisal. We asked some staff if they had had an appraisal. We were given a mixture of responses. These responses included that staff had had appraisals in 2013 and their next appraisal was due. Staff had had their 2014 appraisal. Staff told us that their future development, such as attendance at specific courses had been identified within their appraisal process. We spoke with two junior doctors who confirmed they had an educational supervisor and received regular appraisals.
- Our discussions with two paediatricians confirmed that all middle-grade doctors have appraisals and supervision. We were told there was good provision for teaching and that the advanced paediatric life support course was held yearly. The trust also hosted the Membership Examination for the Royal College of Paediatrics and Child Health (MRCPCH) clinical exam regularly, which was good experience for the middle-grade doctors taking it. Two junior doctors we spoke with confirmed that regular teaching activities took place at Conquest Hospital, for example, perinatal meetings, radiology meetings, audit meetings, weekly teaching sessions and a journal club.
- We were told that SCBU staff had received training through the neonatal pathway and staff had been encouraged to undertake extra training and courses, for example, leadership courses run by the NHS Leadership Academy, study days at the Trevor Mann Baby Unit in Brighton, documentation modules and simulation training.
- NICE safeguarding guidance recommends that permanent staff be trained to a level 3 standard. We were told that staff who worked with children had been trained to level 3. The trust's training statistics for 2014/2015 identified that 82.8% of inpatient paediatric staff and 96% of neonatal staff had received safeguarding children level 3 training.
- Trust training statistics also confirmed that some staff had completed safeguarding children level 2 training: 72.5% of inpatient paediatric staff and 100% of neonatal staff. Four of the staff we spoke with confirmed attendance at safeguarding training in 2014. These staff showed an awareness of safeguarding and what to do should an incident be identified. Staff were also aware of the trust's children's safeguarding policy and supporting procedures.
- The trust's named nurse for child protection/safeguarding children said that yearly formal supervision had recently been implemented for nursing staff. We were told that it was the responsibility of the paediatric specialist nurse supervisor to ensure that yearly supervision was completed by nursing staff. Medical staff received supervision from the community paediatrician. We were told that informal supervision was in place for doctors and that locum doctors did not receive supervision. One member of the nursing staff told us they had attended safeguarding supervision.
- We did not see evidence of any other planned formal supervision sessions for nursing staff. However, we spoke with a member of staff from the SCBU, who told us that they had received supervision recently.
- We spoke with a range of staff from healthcare assistants to matron. The staff told us that they felt supported by their ward matron and the director of nursing. We also spoke with two junior doctors and

asked them about consultant support. They expressed no concerns and told us that the consultants were always prepared to attend out of hours, if required, and would come in for preterm deliveries. They said they felt well supported.
- We were told that all new nursing staff had completed competency assessments. One nurse we spoke with confirmed they had been given competency assessments to complete on starting work in children's services.
- We were informed that paediatric competencies for CCU (ITU) nurses were taught through the Sussex Care Network and simulation training for staff was provided by the Brighton paediatric team. Local paediatricians also provided training days for CCU (ITU) staff.

Multidisciplinary working

- Staff told us how they worked in partnership with other healthcare professionals, such as dieticians, physiotherapists and health visitors to ensure children and their families received the care and treatment they required. Nursing staff gave positive examples of multidisciplinary working. We were told that paediatricians and nursing teams worked closely with each other to ensure positive outcomes for children and their families.
- There had been some concerns about consultant cover in the SCBU. This was because the consultants had not always been present for sick babies, or for routine ward rounds. We saw that this had also been documented on the paediatric risk register. Staff told us that consultant presence had improved recently as the consultant of the week had started a daily ward round.
- We observed a ward round remotely on Kipling Children's Unit and SCBU, which was led by a locum consultant, attended by a nurse, junior and middle-grade doctors. The ward round appeared unhurried with there was sufficient time for each patient. The parents appeared satisfied afterwards.
- The consultant paediatricians told us what multidisciplinary working existed between the hospital and other providers. They said they had been able to access specialist advice from tertiary centres. Links were in place with a number of tertiary centres for different sub-specialities: Brighton and Sussex University Hospitals, The Royal Marsden Hospital, Kings College Hospital and Evelina London Children's Unit at St Thomas' Hospital for paediatric intensive care.
- Rheumatology was shared care with an adult rheumatologist.
- Tertiary paediatric specialists undertook visiting clinics at one or other site for all major sub-specialities.
- Staff told us that they had access to a paediatrician who specialised in oncology and palliative care. Children's care was shared with The Royal Marsden Hospital. Shared care with Great Ormond Street Hospital was in place for children under the age of two years.
- We were told by the CCU (ITU) that they had received good support from the local paediatricians. They said there had been between 40 and 50 cases yearly of children being admitted to CCU (ITU). In the last 12 months one child had been transferred by the CCU (ITU) team. Registered sick children's nurse support had been provided from Kipling Children's Unit. The CCU (ITU) staff identified concerns about children in CCU (ITU), as they did not frequently use paediatric equipment and they were concerned that their paediatric skills were not sufficient.
- The children's services management team told us that the service had no formal written agreement with the Sussex Partnership NHS Foundation Trust for Child and Adolescent Mental Health Services (CAMHS). They said that a care pathway (v12) had been developed with the trust. They said that should a child or adolescent be admitted with mental health problems a mental health nurse would be brought in to help care for the child. We were told that acute CAMHS training had been given to staff on Kipling Children's Unit. We saw no training statistics to confirm this training had been given to Kipling Children's Unit staff. The paediatric diabetic team said they could access psychology support from Child and Adolescent Mental Health Services (CAMHS).

Seven-day services

- We spoke with two junior doctors and asked them about consultant support. They expressed no concerns and told us that the consultants were always prepared to attend out of hours, if required, and would come in for preterm deliveries. They said they felt well supported.
- We were told that there were no problems accessing out-of-hours investigations, for example, urgent lab tests would be completed quickly and computerised tomography (CT) scans would be done. One area where difficulties had been experienced was getting ultrasounds done.

- We were told that pharmacy support and advice was available. The service had two paediatric pharmacists who job shared.

Are services for children & young people caring?

Good

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

Compassionate care

- Throughout our inspection, we observed members of medical and nursing staff. We saw that they provided compassionate and sensitive care, which met the needs of the child, young person, parents and/or carer.
- We observed that members of staff had a positive and friendly approach towards the child and parent. Staff explained what they were doing, for example, when completing their clinical observations.
- The environment was warm and welcoming in the children's and neonatal areas. There were facilities available to assist staff in ensuring the child and family's privacy and dignity had been met.
- We spoke with two children, one carer and 13 parents within the children's service. They told us that they had been happy with the nursing care received. Where children had required pain management, their parents told us that their child's pain had been effectively managed. One parent described the Kipling Children's Unit staff as being "very responsive" and that they felt like "one of the family".
- One mother told us the care and support provided on SCBU was excellent.
- One young person told us that he felt happy with the way he was treated, and felt that the consultant talked to him directly and not just to his mum.
- The parents and carers we spoke with identified satisfaction with the medical care provided as part of their child's treatment.
- Children's services did not participate in the NHS Friends and Family Test. An alternative system had been introduced, which asked parents and children to provide feedback about the service. We saw some feedback from parents from Kipling Children's Unit and the SSPAU, which had been given throughout August 2014. Generally, we found the comments to be very positive about the care received. We were not given any information as to how this information would be audited and whether any progress had been made against the areas identified for improvement.

Patient understanding and involvement

- There was a range of information leaflets available about various treatments and other care available within the hospital. Leaflets available at this trust were written in English. Staff explained they could get leaflets interpreted should this be required and that leaflets in different languages could also be obtained through the Lullaby Trust. We were also told that a translator could be arranged through the PALS service, should this be required.
- We also saw examples of information leaflets given to parents and children involved in clinical research. The children's information was age appropriate in that children of different ages received information leaflets written to their age and understanding, for example, information leaflets for diabetes were available for children of ages five years, six to ten years, 11 to 15 years and 16 years and above.
- Information folders for parents on the SCBU told them about the unit.
- We observed that spiritual and cultural information could be collected within the child's integrated documentation. The ward matron told us that children's cultural needs were accommodated in areas such as diet, for example halal and kosher meals could be obtained for children.
- We saw information boards throughout the children's service and photo boards of staff to say who was who.
- We observed members of staff who talked with children and young people at an appropriate age-related level of understanding. One young person told us that he felt happy with the way he was treated, and felt that the consultant talked to him directly and not just to his mum. He said he felt happy with the explanations which had been given.
- We spoke with another parent who said they had been happy with the nursing care and pain control their child had received. This mother told us she had signed her child's consent form as he was too heavily sedated at the time of consent. However, this mother identified

some concerns. These were that: they had been told the operation would take 1.5 hours, but the child was in theatre for six hours. No explanation was given. Conflicting information was given by medical and nursing staff about the plan of treatment. There was confusion about whether the child had or had not had blood tests done.

- We spoke to another mother about her experiences and were told that she had been happy with the care they had received on Kipling Children's Unit and their treatment plan had been explained by the medical staff. However, she was deeply unhappy about being transferred from Eastbourne District General Hospital, because she had to leave other children behind and had access and child care problems.
- We spoke with another three parents and one carer about their experiences. They told us the medical and nursing care received had been satisfactory.
- Staff told us that the special needs nursing team and WellChild Nurse would assist with discharge planning. We were told that these people were a brilliant resource and that with their involvement children have been discharged home faster. For example, a child requiring occupational therapy assistance would have this support arranged through the WellChild Nurse. One parent told us that they had been involved in the discharge planning process and they were happy with the plans that had been agreed to accommodate and support their child's complex needs.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions – the trust had a DNACPR policy, which staff could refer to. Staff told us that documentation relating to DNACPR decisions was kept in the child's notes and a copy was given to the child's parents/carers. We saw that the question relating to resuscitation status had been included on page three of the paediatric integrated patient document used by children's services.

Emotional support

- Parents and children told us they had been generally been well supported during their visits to the children's areas.
- The children's service did not employ play specialists. We were told this was because a choice had to be made between employing a play specialist or another qualified nurse.
- Paediatric specialist nurses, such as diabetic and child protection nurses were available for parents and staff to access for support and explanations, should they be required.
- The paediatric diabetic team said they could access psychology support from Child and Adolescent Mental Health Services (CAMHS).
- The neonatal service told us that they held a bi-monthly parent support group at a local children's centre to provide a medium for families to meet in a relaxed atmosphere. A health visitor was invited and, occasionally, a resuscitation officer came to give teaching and advice.
- One parent we spoke with made very favourable comments about the housekeeping staff. These comments were, "They were helpful and friendly."

Are services for children & young people responsive to people's needs?

(for example, to feedback?)

Good

During the inspection, we spoke to parents who expressed concerns about the reconfiguration of the children's service. The main areas of concern were expressed by parents from Eastbourne District General Hospital and related to the distance they would have to travel to access inpatient children's services. The cost and time taken to reach Hastings was also identified as an area of concern.

The children's service provided good access and flow to its services and met children's and parent's individual needs. However, we were made aware of problems experienced with flow from the ED to Kipling Children's Unit. The trust had good support from tertiary centres, such as Brighton and Sussex University Hospitals, Great Ormond Street Hospital and the Evelina London Children's Unit at St Thomas' Hospital.

The children's service had no formal written agreement with the Sussex Partnership Trust for Child and Adolescent Mental Health Services (CAMHS). However, we found that the CAMHS pathway guidance was in place for staff to refer to.

Services for children & young people

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

Service planning and delivery to meet the needs of local people

- The trust clinical strategy 'Shaping our Future' was developed to ensure that it could deliver clinically and financially sustainable services in the future. The strategy was approved by the trust board in March 2012. The strategy identified eight primary access points to the trust's services, for example, maternity and paediatrics. Future models of care and delivery options for these services had also been identified.
- On the 8 March 2013 the board took action to ensure the safety of obstetric and neonatal services. They did this through the temporary consolidation of a consultant-led obstetric service, neonatal (including the SCBU), inpatient paediatric and emergency gynaecology services at the Conquest Hospital. A stand-alone midwifery-led maternity unit, SSPAU and children's outpatient department are located at Eastbourne District General Hospital. The trust introduced these changes on the 7 May 2013. The trust identified that it had been monitoring the services since the reconfiguration. In the interim, the local clinical commissioning groups undertook a consultation on the proposed options for permanent changes to maternity and paediatric services. The consultation closed on the 8 April 2014. The outcome of the consultation was that option six was chosen.
- Option six resulted in the following configuration of paediatric services: SSPAUs at Eastbourne District General Hospital and Hastings. Inpatient paediatrics and the SCBU at Conquest Hospital, Hastings. Children's outpatient clinics are also based at Eastbourne District General Hospital and Hastings.
- The trust kept the public informed of its "changes to children's services" in its 'frequently asked questions' document, which could be accessed through its website.
- The trust identified that capacity planning for children's services had been undertaken based on current demand. This exercise identified a total capacity of 27 beds for Kipling Children's Unit would be sufficient for the children's inpatient ward at Conquest Hospital to manage the level of inpatient demand. At the time of the inspection, Kipling Children's Unit was operating at a capacity of 21 beds. We were told that when the children's service was busy an additional six beds could be opened on Kipling Children's Unit.
- Managers told us that the paediatric consultants had attended an away day on the 20 June 2014 to discuss acute operational issues. We saw the agenda and minutes of the away day. Issues, such as neonatal support, review of the second on-call rotas, reducing length of stay, streamlining patient management, outpatients and processes, such as getting notes from one site to another were discussed. The afternoon session involved both the acute and community paediatricians and discussed joint operational issues. For example, updates on pathways for surgical children, operational policy, child protection responsibilities and consultant's responsibilities around the child death strategy.
- We saw clear signage in place identifying the clinical areas within children's services. We observed that access to the clinical areas was by a swipe card. Parents and visitors had to ring the access bell to inform staff of their arrival.
- Free car parking was available for parents of children with long-term conditions and oncology patients. Other parents could get a discounted three-day parking ticket if their child was going to be staying for this length of time. Vouchers were also available for some parents to help them with food. Drinks and toast/breakfast could be accessed directly from the ward.
- We were told that the service had close links with health professionals in the community, such as health visitors, GPs, paediatric community nurses and paediatricians. Prior to discharge, letters were written by the acute paediatricians and referrals made to community professionals as needed, for example, health visitors.

Access and flow

- Throughout the inspection, we spoke with staff and parents who expressed concerns about the reconfiguration of the children's service. The main areas of concern expressed by parents from the Eastbourne areas related to the distance they would have to travel to access inpatient children's services. The cost and time taken to reach Hastings was also identified as an area of concern.

- Parents told of two occasions when there had been problems experienced with flow from the ED to Kipling Children's Unit. One three year old had a very long wait overnight. Another was sent there when they should have gone to the ward.
- The children's service at Conquest Hospital provided good access and flow to its services. The 13-bed SSPAU was located adjacent to the inpatient paediatric ward – Kipling Children's Unit. The SSPAU accepted referrals from the ED and from general practitioners. Following assessment, the child was either discharged or admitted to Kipling Children's Unit. Kipling Children's Unit provided 21 inpatient beds. These beds were comprised of a mixture of bays and cubicles.
- The children's service utilised an early warning score system developed regionally to detect a sick child or infant who may require urgent or critical care. This system was known as the Paediatric Early Warning Score (PEWS). It allowed the paediatrician and children's nursing team to identify when a child's clinical observations lay outside the normal range. The colour codes on the charts assisted the decision-making processes regarding the stabilisation and transfer of critically-ill children to a regional paediatric intensive care unit (PICU).
- The children's service operational policy identified the arrangements for the transfer of sick babies or children requiring specialist support out of hours. Staff told us that children would be transferred with the assistance of South East Coast Ambulance (SECAMB). For sick babies and children requiring airway support and ventilation we were told they would be collected by the retrieval team who arrived with the appropriate equipment to take the baby/child to the most appropriate hospital. Babies who were sick, but not ventilated were transferred in baby pods.

Meeting people's individual needs

- Staff told us that children's and family's needs could be accommodated by accessing the necessary support, for example, interpreters could be accessed through the Patient Advice and Liaison Service and information was provided in different languages. The service could also access a special needs nursing team and WellChild Nurse to ensure that children's individual needs had been met.
- The children's services management team told us that the service had no formal written agreement with the Sussex Partnership Trust for Child and Adolescent Mental Health Services (CAMHS). They said that a care pathway (v12) had been developed with the trust. They said that, should a child or adolescent be admitted with mental health problems, a mental health nurse would be brought in to help care for the child. We saw a copy of the CAMHS pathway and saw clear guidance and telephone contact numbers identified on the pathway.
- The trust had provided staff with training to assist their understanding of people's needs. We saw that staff had attended training sessions in equality and diversity, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- We saw that facilities to meet children and young people's needs were sometimes limited in areas that saw mostly adults. For example, in the x-ray department and adult outpatient areas.
- We found there were good transitional arrangements for adolescents with diabetes. However, the service did not have effective transition arrangements for adolescents moving across to other tertiary adult services, such as cardiology or cystic fibrosis.

Learning from complaints and concerns

- The trust had guidance in place in a form of booklet 'Let us know your views'. This booklet informed people on how to give compliments, make a comment or suggestion and how to make a complaint. Information about the Patient Advice and Liaison Service (PALS) was incorporated into this booklet, as well as being available separately. A leaflet called: 'How have you found today's hospital experience?' was also available for people to leave feedback on.
- Prior to the inspection, the trust submitted complaints data, which identified 32 complaints in total for all of children's services. We saw that there were 15 complaints relating to children at the Conquest Hospital location. We saw that the 15 complaints had been investigated by the trust and closed. We noted that two of the closed complaints for children's services at the Conquest Hospital site had been re-opened. We discussed both of these complaints with the service general manager who identified that one complaint had since been closed. The learning from this complaint was to be discussed at the surgical audit meeting. From our discussions with the general manager, we were assured that the parents' concerns had been listened to and that learning had been identified for both communications.

Services for children & young people

- Staff told us that any learning from complaints had been communicated back to them. For example, we were told that, following one complaint, where a child had sustained an extravasation, staff had been advised to undertake hourly intravenous site checks on children with an intravenous infusion.
- We saw documentation showing that complaints had been discussed at trust board level and reviewed in clinical unit governance meetings with learning shared across the organisation. The trust board meeting agenda dated 30 July 2014 confirmed that the trust complaints report for quarter one (April to June 2014) had been discussed.

Are services for children & young people well-led?

Requires improvement

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

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

The trust children's services strategy was in development. Managers told us that the commissioner's strategy was being used to develop and inform the children's services strategy. They said that both acute and community paediatricians were involved in developing this strategy. We were told that the new strategy would be included in the 2014/2015 trust business plan.

We could not establish how cohesive the culture was within the leadership team, in part, as some clinicians continued to identify concerns relating to the reconfiguration. We found differences in opinion between paediatricians about the effectiveness of the reconfiguration. One paediatrician felt that the merger had improved care; the other paediatrician was less positive and was concerned about having to cover Eastbourne District General Hospital remotely for sudden infant deaths and abuse cases.

Governance processes were in place and identified clinical risks were actively monitored. Children's, young people's and parent's views were sought. There was a culture of openness and flexibility at ward level, which placed the child and family at the centre of the decision-making process.

There was a leadership structure in place within the women's and children's division. The children's services were well-led at ward level.

We saw that some innovative practice had taken place, which had resulted in the development of a neonatal transitional care service within the special care baby unit (SCBU). We received positive feedback from one mother about this service.

Vision and strategy for this service

- The trust clinical strategy 'Shaping our Future' was developed to ensure that it could deliver clinically and financially sustainable services in the future. The strategy was approved by the trust board in March 2012. The strategy identified eight primary access points to the trust's services, for example maternity and paediatrics. Future models of care and delivery options for these services had also been identified.
- On the 8 March 2013 the board took action to ensure the safety of obstetric and neonatal services. They did this through the temporary consolidation of a consultant-led obstetric service, neonatal (including the SCBU), inpatient paediatric and emergency gynaecology services at the Conquest Hospital. A stand-alone midwifery-led maternity unit, short stay paediatric assessment unit (SSPAU) and children's outpatient department were located at Eastbourne District General Hospital. The trust introduced these changes on the 7 May 2013. The trust identified that it had been monitoring the services since the reconfiguration. In the interim, the local clinical commissioning groups undertook a consultation on the proposed options for permanent changes to maternity and paediatric services. The consultation closed on the 8 April 2014. The outcome of the consultation was that option six was chosen.
- Option six resulted in the following configuration of paediatric services: SSPAUs at Eastbourne District General Hospital and Hastings, inpatient paediatrics and the SCBU at Conquest Hospital, Hastings. Children's outpatient clinics are also based at Eastbourne District General Hospital and Hastings.

- We asked the children's services management team whether a local trust children's strategy had been developed. Managers told us that the commissioner's strategy was being used to develop the children's services strategy, which was in development. They said that both acute and community paediatricians were involved in developing this strategy. We were told that the new strategy would be included in the 2014/2015 trust business plan. We were not shown the new strategy, despite asking to see a copy of it.

Governance, risk management and quality measurement

- Children's services sat within the integrated care division's women's and children's services governance committee. The governance lead told us that a reconfiguration of the governance team was taking place and that governance responsibilities were going to be devolved to clinical managers. They also said that children's and neonatal services had a designated clinical governance lead.
- Combined meetings took place within the women's and children's clinical unit relating to governance, risk management and quality measurement. These included monthly business management meetings for quality and governance, monthly risk and budget meetings, quarterly health and safety meetings, a nursing quality performance review group and five weekly ward matron meetings. Bimonthly community children's nursing meetings, accountability review meetings and consultant meetings.
- We saw meeting minutes from the monthly trust board meetings, which confirmed that children's issues had been discussed. For example, minutes from the board meeting dated the 3 June 2014 provided an update on the action plans that related to the external reviews of maternity and paediatric services. One part of the update identified that the majority of actions from the joint review by the Royal College of Obstetrics and Gynaecology and the Royal College of Paediatrics and Child Health had been implemented. The risk rating was green. The trust said that the remaining actions could not be implemented until the outcome of the Better Beginnings consultation was known. We saw that the board had noted the action plans and agreed that they would be monitored by exception through the Quality and Standards Committee.
- We saw feedback provided from a 'quality walk', which had been undertaken by a non-executive director. The non-executive director had met with the child protection team at Conquest Hospital. We saw that advice had been given for the issues identified. For example, staff were advised to engage with the Sussex Partnership Trust because of the lack of service provision for children and adolescents with mental health problems. The details of this walk had also been presented at the trust board on the 30 July 2014.
- Staff on Kipling Children's Unit told us that quality walks had been undertaken by the chief executive officer on the 27 August 2014, the director of nursing had visited twice in August 2014 and the chairman visited regularly. Staff described the director of nursing as supportive.
- Minutes seen from the nursing quality performance review group confirmed that staff had been kept informed of issues and updates relating to patient safety, patient experience, clinical effectiveness, health and safety, cleanliness and infection control, workforce and area specific quality issues. Staff members we talked with confirmed information had been regularly shared with them.
- The trust has a paediatric risk register. The register identified nine risks in total. We saw that the risk register identified controls.

Leadership of service

- There was a clear leadership structure within the various children's wards, short stay paediatric assessment unit (SSPAU), special care baby unit (SCBU) and children's outpatient departments. For example, on Kipling Children's Unit the band 7 ward matron was supported by 10 band 6 sisters. The ward matron and sisters had processes in place that ensured staff were supported and received training and personal development. Staff we talked with on all children's clinical areas told us they had felt supported by their immediate line manager. We directly observed a good standard of leadership at ward/unit level regarding the day-to-day management and organisation of the clinical area.
- The children's outpatient department was managed by a band 6 sister. A band 7 ward matron for the SCBU had day-to-day management responsibility for the unit. One ward matron told us that band 7 sisters undertook 50% clinical work and 50% management work.
- Each band 7 ward matron reported to a senior leadership team. The leadership team was a combined

children and family services team for acute and community services. The leadership team for acute services included a general manager who was also a paediatric nurse, a head of nursing who was not a paediatric nurse by background, a clinical unit lead and a consultant paediatrician who was the operational lead.

- The women's and children's management team reported to the assistant director of operations and the chief executive officer. We were told that the director of nursing could be approached for nursing issues.
- Children did not have adequate representation at trust board level. During our interviews of the management team and consultant staff, we did not establish that children had a formal board level non-executive director to promote children's rights and views as required by the National Service Framework for Children Standard for Hospital Services.
- The trust did not have a dedicated acute services paediatrician identified to lead children's safeguarding in the trust. Currently advice and support was received through two community paediatricians and the director of nursing was the designated executive lead for children's safeguarding.
- We were told by staff that they had been encouraged to undertake extra training and courses, for example, leadership courses run by the NHS Leadership Academy. One ward matron told us they had received training in leading empowered organisations, a postgraduate certificate in health and social care, first-line manager's programme and appraisal. This person told us they felt supported to access additional training as needed.
- We saw meeting minutes from the paediatricians' away day on the 20 June 2014 and from a consultants meeting, which confirmed consultant job plans had been discussed. We did not see or receive any information confirming what the outcomes of these discussions had been.
- Staff told us that they had been kept informed by the chief executive update and the director of nursing's weekly messages to staff.

Culture within the service

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

Public and staff engagement

- The trust had guidance in place in the form of booklet 'Let us know your views'. This booklet informed people on how to give compliments, make a comment or suggestions and how to make a complaint. Information about the Patient Advice and Liaison Service was incorporated into this booklet, as well as being available separately. A leaflet 'How have you found today's hospital experience?' was also available for people to leave feedback on.
- The trust has a Patient Advice and Liaison Service, which offers help, support, information and advice to patients and their relatives, friends and carers. Feedback to the

Patient Advice and Liaison Service can be by completing the online feedback form, by phone, post, fax or email or by visiting the Patient Advice and Liaison Service in person.

- Staff on Kipling Children's Unit told us that quality walks had been undertaken by the director of nursing. Where issues had been identified, we were told that the director of nursing had been supportive.
- The trust has captured comments, concerns and complaints from patients and their family and friends on the Meridian system. We saw a copy of the questionnaire that patients and/or their families could complete. We also saw some feedback that had been collected on the Kipling Children's Unit from parents. We were not given details of how the service had responded to any concerns raised through this route.
- We asked some of the staff whether whistleblowing procedures were in place. We were told that this procedure had been used by staff to raise concerns.

Innovation, improvement and sustainability

- The trust and a ward matron told us that four 'transitional care cots' had been developed in the SCBU. We saw the criteria for babies to be admitted to transitional care. We were told that the transitional care unit had provided care for babies who need more than ordinary postnatal care, but not as much as SCBU-level care. We were told that this facility had proved popular with families. One mother told us that they had been very happy with the support and observation by the SCBU staff in the transitional care area.

Requires improvement

End of life care

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

Information about the service

East Sussex Healthcare Trust provides End of life Care Services across the Trust. End of life care was not seen as the sole responsibility of the Specialist Palliative Care Team (SPC).There were 2,749 deaths across the Trust from January to December 2013.

The Specialist Palliative Care (SPC) teams consist of two multidisciplinary teams (MDTs); a Conquest based team and an Eastbourne based team. These teams are also associated with their respective Community Palliative Care teams and work in partnership with local voluntary sector hospice providers.

The Conquest Hospital's, SPC team consists of one part time Consultant in Palliative Medicine, 2 full time Macmillan Clinical Nurse Specialist's and a patient pathway co- coordinator. In addition a chaplaincy team provided multi-faith support.

The SPC team were available 5 days per week, Monday to Friday 9-5 pm. Outside these hours the SPC service was covered by telephone support from St Michael's Hospice.

During the inspection we visited a variety of wards across the trust including Baird, Newington, Mac Donald and Gardner wards, Acute Admissions Unit Ward (AAU), mortuary, bereavement office and the chaplaincy to assess how end of life care was delivered. We spoke with palliative care leads, ward staff, patients, and relatives. We looked at patients' notes and reviewed documents relating to the end of life service provided at the trust.

We reviewed the medical records of 4 patients at the end of life and observed the care provided by medical and nursing staff on the wards, and spoke with family members of a patient receiving end of life care. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

Requires improvement

End of life care

Summary of findings

The specialist palliative care team were available five days a week, with the hospice providing out-of-hours and weekend cover. Medicines were provided in line with guidelines for end of life care. Do not attempt cardio respiratory resuscitation (DNACPR) forms were not consistently completed in accordance with policy and there were no standardised processes for completing mental capacity assessments.

Training relating to end of life care was provided at study days. End of life champions were being introduced across the Trust wards however uptake into these positions was patchy. Leadership of the specialist palliative care team was good and quality and patient experience was seen as a priority.

All patients requiring end of life care could access the specialist palliative care team. There was a multidisciplinary team (MDT) approach to facilitate the rapid discharge of patients to their preferred place of care.

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

Are end of life care services safe?

Requires improvement

End of Life Care services at the Conquest Hospital requires improvements.

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

A true picture of end of life care incidents across the Trust was not available and learnings from these incidents did not inform improvements in the quality of care delivered to end of life patients.

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

The Trust had 2 types of syringe drivers in use across the hospital. This introduced a level of risk as staff did not feel confident in using both syringe drivers and therefore required support from the SPC team when using the McKinley T34 syringe driver.

In the most recent DNACPR audit, 99% of forms were dated, however only 31% orders were completed thoroughly according to Trust guidelines. This meant that 69% orders were not completed appropriately which put patients safety at risk. We saw that there were variations in the completeness of the forms across the hospital.

Incidents

- Incidents related to end of life care were reviewed by the Lead Cancer Nurse who ensured that actions were taken to address any issues identified. There is no recognised coding system so identification is made by highlighting words such as: bereavement, end of life, dying, Liverpool Care Pathway (LCP), and Key Elements within text. Data from April 2014 – 10th June 2014 (sourced 11th June 2014) showed 21 incidents. On the Trust's analysis 5 showed a reduced standard of care for end of life care patients. This information was shared at the multiagency Verification of Expected Death Group and the multiagency Pressure Ulcer Prevention Group.

However we found no evidence of systems in place to discuss and review end of life incidents at the 'End of Life Steering Group' were actions and learnings could be disseminated across the Trust.

- The SPC team had been inputting drug related incidents/near misses into an electronic reporting tool but no end of life care report had ever been raised. This had been highlighted at the end of life Steering Group. A true picture of end of life care incidents across the Trust was not available and learnings from these incidents did not inform improvements the quality of care delivered to end of life patients.
- In all the areas we visited we found that staff were encouraged to report incidents. Mortuary and portering staff told us that there had been one incident reported in the last year that involved a deceased patient. This was confirmed in the electronic recording tool's data submitted. We saw incidents were managed appropriately and actions taken to prevented a similar incident happening in the future.
- There were no Never events relating to end of life care services.

Cleanliness, Infection control and hygiene

- We saw that the wards and mortuary viewing area we visited were clean, bright and well maintained. In all the patient areas the surfaces and floors were covered in easy to clean materials which allowed high levels of hygiene to be maintained throughout the working day.
- We saw that ward and departmental staff wore clean uniforms with arms bare below the elbow and that personal protective equipment (PPE) was available for use by staff in all clinical areas. In the mortuary we observed adequate supplies of PPE for use by undertakers, porters and the police when visiting the mortuary.
- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or caring for people after death. We saw, for example, that adequate numbers of body bags were available to support deceased patients. Porters and ward staff showed good knowledge of when body bags should be used. However on our un- announced inspection we were told by the sister on Newington Ward that the wrong type of body bag had been issued in the previous week. The sister told us the actions taken and how the proper body bag was allocated.

Environment and equipment

- The Mortuary was secured to prevent inadvertent or inappropriate admission to the area. CCTV was evident in all areas in the mortuary with 24/7 records of activity. Fridges were lockable to reduce the risk of unauthorised access and the potential for cross infection.
- Service records were available for equipment in the mortuary. Servicing took place by outside contractors and the hospital estates department. We were told by staff that estates check alarms monthly. On the day of the inspection all equipment was working correctly and there were no issues around getting equipment repaired or replaced in a timely manner.
- All the people we visited on the wards, who were receiving end of life care were being cared for on alternating air pressure relieving mattresses that were correctly set.
- Syringe drivers were available across the Trust to support end of life patients with complex symptoms to deliver consistent infusions of medication. We observed that the T34 McKinley syringe drivers were being attached to mobile patients and patients being discharged. The majority of patients on the wards we visited had the Graseby Alvaris syringe drivers attached. This introduced a level of risk as 2 different types of syringe drivers are in use with different methods of delivering the medication. Staff were unfamiliar with the McKinley T34 syringes and required the SPC CNS to attach the pumps.
- In 2010 the National Patient Safety Agency released a rapid response report (NPSA/2010/RRR019) relating to ambulatory syringe drivers and the reporting of fatal errors. In this alert NHS providers have an expected date of compliance of December 2015.We saw evidence on the wards of the mentioned syringe drivers being used across the wards even although the Trust had purchased an adequate supply of the recommended T34 McKinley syringe drivers. We saw no action plan around the removal of the mentioned ambulatory syringe drivers to become compliant with the alert. The Trust was running a dual system leading to the risk of delivery errors and therefore a risk to patient's safety.

Medicines

- Medication Guidance had been agreed and implemented for 'symptom control and prescribing for adults' which clearly set out the medication necessary to support the management of dying patients. These

covered the 5 recommended areas including pain, agitation, and nausea and vomiting. The guidance was available in the 'end of life information boxes' in all ward areas we visited and the hospital intranet site.

- The guidance included 'supportive information' which signposted staff to the SPC team or pharmacists where complex medical conditions existed such as renal and liver failure, to ensure patient safety was paramount and specialised skills supported the prescribing process.
- We were told by staff on Newington Ward that medication for end of life care was available on the ward and was easily accessible. The ward manager was confident in the ability of the nursing staff to care well for end of life patients with syringe drivers with support from the SPC Team.
- A recent follow up audit (completed April 2014) looked at prescriptions for end-of-life medications for patients being discharged to enable a quick discharge. Some of these medications were 'Just in Case' prescriptions which can be dispensed and ready for administration at the end of life by trained community nurses. A previous audit (Dec 13) had shown that discharge prescriptions had an error rate of 89%.To address this; a new standardised Drug dispensing chart was piloted. This chart was evident during the inspection, we were told errors have reduced and turnaround time through the pharmacy department had improved. This highlights those actively performing audits across the service can improve the quality of the service provided.
- The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. Consultants from the Specialist Palliative Care Team worked across the community and at the local hospice which improved safety and continuity of care for patients.
- Through direct observation we found the new prescription booklets difficult to navigate. We found no separate section for syringe driver's prescription; therefore the prescriptions had to be written in the regular portion.

Records

- Across the wards we visited we found evidence that paper medical records were in use which documented the patient's personalised care and treatment.
- The SPC team enter reviews into the patients' medical records and input their findings onto the 'Somerset Cancer Register database.' This enabled SPC team to record activity and keep accurate care and treatment records of each patients using the SPC service for discussion at the multi-disciplinary team meetings.
- The SPC team told us end of life patients reviewed would have an initial holistic assessment which would identify the patients individual needs such as previous medical history, physical, psychological, social and family concerns. We reviewed one end of life patient's medical records on McDonald ward. The holistic assessment was clearly documented, signed and dated. This showed that accurate personalised records are kept and maintained on all the occasions the SPC CNS reviewed the patient.
- On reviewing one set of end of life patients' medical notes on Gardiner Ward we observed that information such as clinical information and conversations undertaken with the family were recorded in detail however we did note that recommendations made by the SPC CNS were not correctly followed.
- We saw the Trust had a Resuscitation Policy that set out the use of 'Do Not Attempt Cardio – Pulmonary Resuscitation' (DNA CPR) orders which was available to all staff.
- On visiting the ward areas, we randomly checked nine medical records containing DNA CPR orders. We saw that all decisions were recorded on a standard form with a red border at the front of the notes, allowing easy access in an emergency. In the most recent audit (February 2014) it was recommended that all ward staff needed to be made aware on the importance of the DNA CPR order being kept at the front of the notes so it is easily found when needed. In the nine medical records we reviewed we found the DNACPR forms in the front of medical records as per Trust policy.
- To monitor compliance to the 'Resuscitation Policy' weekly audits along with a 'Resuscitation Committee,' annual audit is led by the Palliative Care Consultant. In the most recent audit, 99% of forms were dated, however only 31% of forms were completed thoroughly according to Trust guidelines. An action plan has been developed and is waiting for sign off by the Palliative Care Consultant which highlights a continuing need to educate all doctors on the need to complete all boxes of DNACPR orders to ensure they are valid and to avoid any confusion in the event of cardio-pulmonary arrest.
- We saw that there were variations in the completeness of the forms across the hospital: Only six out of nine

orders were signed by a consultant. Our findings showed that DNACPR orders did not always provide evidence that Trust policy had been followed; this indicated that more work was required in this area. Completing the DNACPR forms ensured that appropriate decisions were made about the care of these patients.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We were told by ward staff that Mental Capacity Act (MCA) assessments were carried out by the doctors who would write a summary in the patients' medical records. On admission an 'assessment' would be completed by the admitting doctor and a best interest's decision would be made. We saw no evidence of this process during the inspection.
- Where DNACPR orders were in place we saw that patients with capacity were involved in discussions. Where the patient lacked capacity we saw no evidence of assessments being undertaken or documentation of the assessment. Where people lacked capacity we observed that family members were involved in the discussions about the ceiling of care to be provided
- We observed that with patients that lacked capacity the nurses would complete a 'Nursing care plan for Adults lacking capacity to make specific decisions'.
- Safeguarding adults training was provided to key groups of staff who were not clinical but who had contact with patients. We spoke to the porters who confirmed they had received Safeguarding adults training. We were told that the training consisted of written information. No practical class room lessons were given. The porters were asked to sign the training form to confirm the training had been undertaken. We saw records that confirmed porters had received safeguarding training.
- Staff we spoke with all had a sound understanding of their responsibility in relation to safeguarding adults. The Trust had a dedicated Adult Safeguarding lead nurse.

Training

- The End of life facilitator and the SPC team were actively involved in the training of staff around end of life care. A training needs analysis was performed in February 2014. A five year training programme was developed to ensure that all staff would be trained in the seven core competencies of good end of life care.
- We saw training records which confirmed that since March 2014,419 staff had received end of life training, of these 240 were from the nursing staff group and 58 were medical staff. On Wellington ward we were told that four end of life study days had been arranged and at the end of the study days all staff will be trained in end of life care.
- We saw data that confirmed that four staff members had attended the 'Sage and Thyme' communication train the trainer course. This included SPC Nurses and a Dementia Champion. We were told that work will now beginning on rolling out this training. St Michael's and St Wilfred's Hospices were delivering a Symptom Management programme which is open to ESHT staff.
- Currently monthly workshops covering the guidance set out in the 'Key Elements of care of the dying person' are available to all clinical staff across the Trust. Staff have access to 150 e-learning modules.
- Advanced Care Planning (ACP) workshops are running to train staff in supporting patients in completing their future care wishes and preferences. We were told by the end of life facilitator that Advance Care Planning Training (ACP) included communication skills and the use and completion of Advanced Care Plans. We did not find any completed ACP on the wards we visited.
- Across the Trust end of life care nursing champions are being introduced onto the wards. 84 champions have been identified across the Trust. Training includes any issues and what is new around end of life care. This provides staff on the wards with regular updates around end of life care to keep their knowledge up to date. We were told by the sister on Newington ward that the end of life care link nurses share knowledge learn through updates at team meetings, monthly newsletters and emailing out any literature.
- We observed that staff recruitment into these roles is patchy however on the Baird and Newington ward, two end of life care champions have been identified to perform this role however many areas had no nurses identified to take on this role. Several wards had identified end of life champions but we found no training had been delivered.
- We were told by the SPC team that their role included training core teams of staff on the principles of end of life care. The Palliative Care Consultant provides training to junior doctors including at induction. The SPC CNS provides training to junior doctors on 'Just in case medication'.

End of life care

- The SPC team told us that Continuing Professional Development (CPD) takes place within the team. We saw records that confirmed that the CNS's had completed their mandatory training.
- The porters told us that they had received training to support the movement of deceased patients to the mortuary .The training is not structured and the mortuary staff do not undertake the training. The 'on the job training' included the use of the mortuary out of hours to ensure that mortuary procedure are maintained. The porters we spoke to were able to describe the process in a knowledgeable manner and were able to demonstrate how they treated deceased patients with dignity and respect. The Matron on Wellington ward told us that the porters were always respectful when collecting deceased patients.
- The porter we spoke with had recently received infection control training. The porters we spoke to were able to describe the processes that are in place to protect themselves and other patients from harm when dealing with deceased patients.

Management of deteriorating patients

- The hospital used the 'VitalPAC' system to identify patients who were at risk of sudden deterioration in their condition. The tool monitors the patient's heart rate, blood pressure, temperature and urine output to name a few. The VitalPAC is remotely monitored by the critical care outreach team. We were told that when patients had an elevated score the nursing staff contacted the medical staff to review the patient.
- For other patients, where the progression of their illness was more clear the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible, at all times. We were told by the matron on Wellington ward as part of the ongoing discussion with patients and their relatives the ceiling of care was discussed and documented.
- Patients that are recognised as deteriorating or dying would be commenced on an end of life care plan using guidance set out in the 'Key elements of care of the dying patient'. We were told by staff that this would be commenced after discussion with the Consultant and multi professional team including the SPC team, patient and relatives.
- Following referral to the SPC Team, patients are reviewed by the team on a regular basis depending on the needs of the patient. Patient contacts range from 15-120 minutes depending on the need of the patient and their families, with many end of life care patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases and speak to medical teams and carers.

Nurse Staffing

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

Medical staffing

- SPC medical consultant advice and support was available five days a week. Out of hours support was via a specialist palliative care nurse led telephone advice service provided by St Michaels's Hospice.

Requires improvement

End of life care

- The Palliative Care Team MDT consists of one part time Palliative Medical Consultant who works at the local hospice as well as at the Trust. This allows improved continuity and management of patients across the different service providers.
- The Palliative Medical Consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.

Major incident awareness and training

- The mortuary had systems in place to ensure that if a sudden surge in demand for refrigerated mortuary space (such as following a major incident or utility failure) The Trust had access to extra refrigerated space. At the Conquest hospital we saw that '12' extra storage spaces were available.
- We spoke with the lead cancer nurse to establish whether Business Continuity and Escalation plan supported end of life care patients should a major incident occur. During the inspection we were unable to establish if the plans referred to end of life care patients.

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

Requires improvement

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

The SPC Team provided evidence based advice to other professionals as required. ESHT formulated a document highlighting the 'Key Elements of Good Care in the Last Hours to Days of Life' that would support the removal of the LCP after the 14th July 2014. Staff were asked to follow these steps and complete this document for all patients approaching the end of their life. The SPC consultant told us that the 'key elements' form has only been evident in the last 2 weeks and is not embedded.

The Trust was actively engaged in the NHS Improving Quality Transform Programme (Phase 2).This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care

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

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

The SPC team were inputting all end of life care information into the Somerset Cancer Register.This allows the real time collection of information about a patient. This method of collecting data supports the national and clinical audit requirements. The SPC team have this data available during their MDT's; ensuring accurate information supports management decisions.

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

The SPC Team had a weekly Multi DisiplinaryTeam (MDT) meeting (thursday am) to discuss treatment plans for new and current patients. Due to capacity issues attendance of the SPCteam at site specific MDT's such as the Lung and Gastrointestinal cancer was not possible.

Evidence-based care and treatment

- East Sussex Healthcare Trust had implemented National Institute of Health and Care Excellence's (NICE) quality standards for Improving supportive and palliative care for adults with the introduction of a specialist palliative care (SPC) team that demonstrated a high level of specialist knowledge and provided wards and departments across the trust with up-to-date holistic symptom control advice for patients in their last year of life.
- East Sussex healthcare Trust had responded to the National Recommendations of the Liverpool Care Pathway (LCP) review by targeted work being undertaken following the national review of the LCP. ESHT formulated a document highlighting the 'Key Elements of Good Care in the Last Hours to Days of Life'.
- Whilst we were told that the LCP was still being applied (up until 14th July 2014), staff were asked to follow the guidance set out in the 'Key Elements of Good Care in the Last Hours to Days of Life' and complete this

document for all patients approaching the end of their life. In the minutes of the End of Life Care –Last Days Meeting, May 2014, it 'was felt the Key Elements were not sufficient and that a personalised care plan should be instigated.'

- Ward staff, we spoke to confirmed that the trust was not continuing to use the LCP. Staff received guidance from the Medical Director around the continuing use of the LCP until July 14th 2014. This showed that the trust had responded to concerns regarding the LCP and informed staff of conditions to ensure a safe approach to care for patients.
- The Assistant Nurse Director told us that the use of LCP documentation dropped considerably after publication of the LCP review in July 2013. The "Key Elements Document" listed a number of core principles which were felt to be crucial to good care in the last few days of life. The format of this document was a simple checklist, which aimed to support healthcare workers as an aide memoire.
- The 'key elements 'document was introduced to the workforce in the acute sector through an email to senior staff members, who were to cascade the information downwards. The SPC Nurse told us that the 'key elements were introduced with not much training', which is in contrast to the LCP where the training was good. On Gardiner's ward the SPC CNS told us about a patient last week where the 'Key Elements 'documentation would be appropriate but was not in place. Nursing staff have to be told when to start the patients on the 'Key Elements'.
- The SPC consultant told us that the 'key elements' form has only been evident in the last two weeks and is not embedded. On the forms audited approximately 70% of the principles were recorded but this was felt to be retained memory from the LCP.'
- An audit undertaken in July 2014 at The Conquest hospital showed a good level of end of life care awareness and practice within a clinical setting. Since the initiation of "Key Elements of Good Care in the Last Hours to Days of Life" policy in 1st February 2014, there has been limited uptake and application of this document. We were told by the SPC CNS that Wellington and Macdonald ward had received training on the guidance. This was confirmed by the sister told us they were using the 'principles of care and key elements document' and were 'very proud' of the end of care delivered.
- Staff we spoke to told us the SPC team; medical teams would seek verbal consent from patients and / or families before moving a patient onto the 'Key elements'. The SPC CNS told us that they were reviewing more patients since the removal of the LCP 'to reassure nurses' as the new guidance had left staff floundering.
- The Leadership Alliance for the Care of Dying People published One Chance to Get it Right(July 2014), the response to the recommendations set out in More Care, Less Pathway, the independent review of the Liverpool Care Pathway. With this in mind, In August 2014, an updated version of the Key Elements of the Care of the Dying was introduced (version 2), in line with national recommendations set out by the Leadership Alliance.
- We were told that patients at end of life would be assessed by the medical and nursing teams to develop individualised care plans to meet their individual needs. However on the wards we visited we did not see any individualised care plans for end of life patients. Building up a picture of the care required was by reading through the entries by the various healthcare professionals.
- The SPC team aim to review urgent patients within 24 hours however this time maybe extended at busy times such as when one CNS is away. Referrals can be made by the patient, their relatives and staff within the Trust. Urgent advice is available from the Clinical Nurse Specialist (CNS) who can give telephone advice prior to reviewing the patient. We saw data that confirmed the SPC team see the majority of the referral on the same day. The staff we spoke to across the wards we visited reiterated to us the availability and effectiveness of the SPC team.
- A telephone and bleep system is in place for referrals to the SPC team which ensures patients are seen and assessed in a timely way. We were told by the SPC CNS that previous paper referral systems had been removed as telephone referrals were found to be more effective. One junior doctor we spoke to on Newington ward told us the SPC team were 'amazing' in the support they provided for both patients and staff.
- Integrated workings of the SPC team and End of life facilitator demonstrated a high level of specialist knowledge which provided wards and departments across the trust with up-to-date symptom control advice for patients in their last year of life basing the care they provided on the NICE Quality Standard 13 – End of Life Care for Adults .

Requires improvement

End of life care

- We reviewed the medical records of 4 end of life care patients, these demonstrated the SPC team had supported and provided evidence-based advice for example, on complex symptom control and psychological support for the patients and families. This specialist input by the SPC team ensures that a high level of expertise is used to ensure the best possible care is delivered to end of life care patients and people have a positive experience of (health) care.
- NICE Quality standard for end of life care for adults, Quality statement 6: Holistic support – spiritual and religious support. The chaplaincy service was particularly good at meeting the needs of people receiving end of life care but the chaplain told us that 'they had been unable to resolve issues about knowing which patients had given permission or requested contact with the chaplaincy which made it difficult to focus effectively. 'This supports the findings of the recent audit (ELCQuA results) where it was found that spiritual and religious support is available however; documented evidence that spiritual and religious needs were explored was available in only 10 sets of notes (10/51). The 'Key elements' guidance directs staff to ask such a question.
- On Wellington Ward the matron ran through the ward procedure after a patient has passed away. The matron confirmed that most patients leave the ward within 2 hours. This was confirmed in the ELCQuA audit where timely verification of death occurred within two hours in the majority of care records 41/51.As part of the end of life care action plan (2104/15) the ELCQuA results are an areas to be improved but how actions will be delivered has not been decided. (End of life Steering Group minutes July 14.)
- The Trust had introduced a National Dementia Strategy. The Dementia Strategy supported staff to provide good care to people with dementia including good care at end of life. There was a dementia lead nurse and link nurses on wards to support frontline staff to have the appropriate training, development and support to deliver good care.
- A policy was ratified in July 14 giving 'Guidance for Staff Responsible for care after Death.' The policy takes into consideration multi faiths and ensures that peoples faiths are checked and signposts staff to 'A Guide to Religious, Belief and Lifestyle Traditions', on the Chaplaincy website to ensure deceased patients are managed in line with their culture/faith. Systems were in place that 'Medical Certificate Cause of Death' (MCCD) was processed immediately for some cultures in order for burials to happen within one day.
- The Trust had not contributed to the National Care of the dying Audit or a local Bereavement Survey. This meant that the opinions of bereaved relatives are not being collected and no service improvement programme can be initiated to improve the quality of care that is being provided however the bereavement officer told us about the 'Plaudits'. This is feedback that is collected from relatives when the death certificates are collected.

Pain relief

- Effective Pain control was an integral part of the delivery of effective end of life care and this was supported by the SPC Team. On reviewing an end of life care patients medical records on Newington ward we saw that the SPC CNS and Palliative Care Consultant were actively involved in daily reviews of the patient's pain management.
- Care of the dying guidelines included guidance on prescription of anticipatory pain relief for patients at the end of life. Staff were able to locate the guidance placed in the end of life boxes on the ward and on the hospital end of life care intranet page.
- The SPC team were involved in the prescribing of patients medication. We were told by staff on the wards we visited that all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly. The amount of analgesia and sedation did increase as death approached, but made it clear that this increase was always a response to symptoms increasing.
- A junior doctor we spoke to told us they had received training from the pharmacist as well as shadowing the SPC CNS's on medication at end of life. The doctor felt confident to prescribe end of life medication but would use the SPC team expertise if required.
- We were told by a junior doctor that a system has been introduced to protect the safety of patients having medication delivered through a syringe driver .A data base records all patients with complex symptoms including plans for treatment over the weekend. This

data is backed up by handing over patients to the 2nd on-call doctor and hospital at night. This data base supports the delivery of safe effective care at all times day and night.

Nutrition and hydration

- Trust wide to ensure nutrition and hydration needs are met, on admission a risk assessment was completed by a qualified nurse. The sister on Newington ward told us that a Malnutrition Universal Screening Tool (MUST) assessment is carried out which identifies patients at risk of poor nutrition, dehydration and swallowing difficulties. It included actions to be taken following the nutrition assessment scoring and weight recording.
- Patients who were identified as high risk were directly referred to the dietician and Speech and language Therapist (SALT). We were told by the sister on Newington ward that coloured (red) tray and cup scheme were used to indicate those patients who needed additional help at meal times but on the day of the inspection no red trays were available. We did observe above the beds a sign specifying if the patient had any special dietary needs. Meal times were protected which meant staff ensured people could eat uninterrupted except for urgent clinical care.
- The new 'key elements' guidance included prompts to ensure patient and family views and preferences around nutrition and hydration at the end of life were explored and addressed. We were told that separate menus were available such as soft and pureed food.
- On Newington ward we reviewed a set of medical notes .This contained fluid balance chart but we did not see a MUST assessment had been carried out on this patient.

Patient outcomes

- The Trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring high quality care for patients who wished to die at the hospital. We reviewed the data of two audits that had been performed and saw that in 2012/13 that 74% of end of life patients received their preferred place of care/death. (PPC/PPD)This had improved from the previous year which was 60%.
- The improvement in End of Life Care for Adults in East Sussex in 2013/14 was via a locally agreed CQUIN (Commissioning for quality and innovation) between East Sussex Healthcare Trust (ESHT) and the Clinical Commissioning Groups (CCGs). The first indicator was for a CQUIN for ESHT to complete a base line audit of End of Life Care using the End of Life Care Quality Assessment Tool (ELCQuA).
- The audit commenced in July 2013 with 51 sets of notes being reviewed. The limited information gathered did offer some insight into the practices at that time and areas that would benefit from improvement strategies as well as aspects of care they were are delivering well. Co-ordinated personalised care planning was limited 24/51. On reviewing medical records of four end of life patients across the wards we visited, we did not find individualised care plans. We saw evidence that care was delivered and recorded but we did not see any information on how they intended to deliver individualised care
- The Trust did not contributed to the National Care of the Dying Survey so it was difficult to judge how the Trust was performing in the areas such as access to information relating to death, compliance to dying medication protocols and protocols promoting patient privacy. We were told by the Trust that they were unable to support the National Care of the dying Audit due to a high workload in the previous year.
- We were told the Trust was actively engaged in the NHS Improving Quality Transform Programme (Phase 2).This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care by supporting the implementation of five key enablers: advance care planning (ACP), AMBER care bundle, co-ordinated care with community and GP's services (electronic system), priorities of care for the dying person and Rapid Discharge Home to Die Pathway.
- We found evidence that the Trust was in the process of implementing 3 of the 5 priorities but no evidence was found around the use of the AMBER (Assessment, Management, Best Practice, Engagement, Recovery Uncertain) Care Bundles (ACB) which are used to support patients that are assessed as acutely unwell, deteriorating, with limited reversibility and where recovery is uncertain nor any evidence of the introduction of an electronic palliative care co coordinating system which will be led by the local NHS Commissioning Group.

Requires improvement

End of life care

Competent staff

- The Clinical Nurse Specialists from the SPC team had built up experience in palliative care over several years. The CNS's and the Palliative Care Consultant provided support to all grades of staff across the hospital to ensure that ward staff felt confident to deliver end of life care.
- Direct management responsibilities have changed during the year and the SPC CNS team are now line managed by the Macmillan Lead Cancer Nurse. Appraisals had not been performed in recent years but the aim was to complete appraisals for all staff by the end of October 2014.This will ensure that staff are adequately supported to develop their skills and deliver high quality care.
- Guidance was available on wards, in the chapel and multi faith room and on the intranet to support staff in providing care in accordance with peoples religious and cultural preferences. Staff had access to specialist advice from the chaplaincy were clarification was needed.
- Syringe driver pumps to deliver analgesia continuously were available to all end of life care patients. The use of two types of syringe drivers within the hospital had allowed in- sufficient staff to become competent and confident in both types of syringe drivers. We were told by ward staff that the SPC team needed to attach the T34 McKinley syringe drivers as there was a lack of staff with the necessary skills on the wards.

Multidisciplinary team working

- The Somerset Cancer Register database enabled the SPC team to record activity and link with the cancer site specific MDT outcomes. The Somerset Cancer Register collects all the information necessary to make sure that a patient is seen, diagnosed and treated as quickly as possible. The electronic register allows real time collection of information about a patient. This method of collecting data supports the national and clinical audit requirements. The SPC team have this data available during their MDT's; ensuring accurate information supports management decisions.
- The SPC team were visible to staff across the hospital. Nursing staff in all the departments and wards that we visited were aware of how to contact the SPC team and could cite examples of their involvement with specific patients.
- The SPC Team had a weekly MDT meeting (Thursday am) to discuss treatment plans for new and current patients. The Palliative Care consultant runs a clinic on Wednesday to support patients with complex symptoms.
- The SPC CNS works closely with the cancer site specific CNS's to support with complex symptom management at end of life .The SPC CNS told us that close working with the Oxygen nurse and the heart failure nurse takes place in complex cases to ensure specialist skills maximise the care received by end of life patients.
- The SPC team told us that working alongside other specialities including the acute oncology team, community teams and the Medical consultants working sessions at the local hospice and in the community helps to provide streamline care across care providers and provide a more standardised model of care across the local healthcare economy.
- The Trust is not part of an Electronic Palliative Care Co-ordinating System (EPaaCS) This system would support better care and prevent inappropriate admissions to hospital. However we were told that 'System 1 'is being introduced in the community and this will allow care records to be shared

Facilities

- The Conquest Hospital mortuary had a viewing suite where families can come and view their relatives. We visited the area and saw that the viewing suite was divided into a reception and viewing room. The suite was neutral with no religious symbols which allow the suite to accommodate all religions. We were told families were supported during the viewing and relatives know what to expect and are safe.
- On our visit to the mortuary we were shown where deceased patients leave the hospital with the undertaker or with family. The area outside the mortuary was poorly maintained and backed on to a through road that schoolchildren used often.
- The hospital had both Christian chapel and a multi-faith prayer room located centrally and available to all staff, patients and visitors. In the chapel, prayer leaflets were available for prayers to be written and placed in the chapel.

Seven-day services

- No seven day face to face specialist care is available from the SPC team however systems were in place to

provide timely SPC advice at any time of day or night for people approaching the end of life .The specialist palliative care team based at the Conquest hospital offer services Monday to Friday 9am – 5pm.

- Out of hours St Michael's hospice gave telephone advice and support. This is a nurse led service however if the specialist nurses are unable to help the 1st doctor on call will be contacted. This meant that end of life patients had access to specialist skills to support their needs. Staff on the wards told us that they felt confident in the support mechanisms in place for end of life patients.
- Chaplaincy cover is provided 24 hours per day, outside the hours of 9 a.m. and 6 p.m. it is for emergencies only. The Chaplaincy Centre is open 24 hours a day for prayers. The information booklet "the chaplaincy Team" lists the services that are performed within Hospital throughout the week.

Are end of life care services caring?

Good

Staff at the Conquest Hospital provided compassionate end of life care to patients.

We observed the SPC CNS visit an end of life patient and observed the CNS was very professional and also very sensitive and empathetic towards the patient.

Hospital staff we spoke to demonstrated a strong commitment to empathy and enhancing the environment for dying patients.

We saw that families were encouraged to participate in care if they wish such as mouth and personal care.

Compassionate Care

- Hospital staff we spoke to demonstrated a strong commitment to empathy and enhancing the environment for dying patients. We saw that families were encouraged to participate in care if they wish such as mouth hygiene and personal care.
- We observed the SPC CNS visit an end of life patient. The SPC CNS was very professional, sensitive and empathetic towards the patient.
- We spoke to seven family members who were visiting Gardiners Ward to have a conversation with the doctors caring for their relative. The family told us they were happy with the care that was being provided on the ward but were unhappy with the care their relative had received during their time in Accident and Emergency. The family were happy with the response of the matron.
- The matron on wellington ward told us that a named nurse is allocated per shift. The matron tries to accommodate the same RN but this is not always possible. The matron is the point of contact for all patients and relatives. We were told that at handover end of life patients will receive 1:1's to ensure information is correctly relayed to the next nurse managing the patient.
- We spoke with the porters about the arrangements for transporting patients to the mortuary. We were told that porters had received training to ensure that they were able to carry out the necessary procedures in the mortuary at weekends and overnight. The porters we spoke to could tell us about the protocol they followed.
- The Mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger type book that contained the required information. We observed that the book was completed appropriately and neatly and was completed in a respectful way. Confidentiality was maintained at all times.
- The porters told us that transporting adults and babies to the mortuary was performed ensuring at all times deceased patients were treated with the utmost dignity and respect. Suitable concealment trolleys were available to support the movement to the mortuary as per Trust policy.
- The bereavement officer carried out the administration of a deceased patient's documents and belongings, providing practical advice and signposting relatives to support services such as counselling services and funeral directors, future contact with the team is welcome but probably only 1% make contact. The bereavement officers make up a bereavement pack for the families around individual needs.

Patient understanding and involvement

- We were told by the Palliative Care Consultant that doctors were good at communicating with patients and family about patient's condition, in particular the young consultants are 'much better at recognising dying and talking to families.'

Requires improvement

End of life care

- We saw evidence that the SPC CNS was actively involved with both the patient and the relatives, providing support and keeping families involved in management of the patient with patient consent.
- The matron on Wellington Ward told us how important it was to get families involved in the care; staff encourages relatives to get involved in mouth and personal care. Relatives can be asked to support relatives at meal times.
- After the death of a patient the matron on Wellington Ward told us that some families wish to be involved in after death care. The matron was able to give us an example of when a family got involved in the aftercare.

Emotional support

- All Clinical Nurse Specialists have completed the training necessary to enable them to practice at level 2 psychological support for patients and carers. The SPC CNS's provided ongoing support and advice to patients and their families. They were able to signpost people to additional sources of support such as those provided by the St Michaels hospice.
- The Chaplain is available to provide spiritual and religious support. In A&E there is a 'Chaplaincy policy 'and within this the chaplaincy is the point of contact with the Bereavement Counselling Service offered by the Voluntary service.
- Volunteers are available from the chaplaincy to provide emotional and spiritual support when asked by the patient/families and medical and nursing staff. One volunteer told us that they visit the wards daily and collect prayer leaflets to place in the chapel and talk to patients.
- During our visit to the Accident and Emergency (A&E) we were told by staff that there were links with the SPC team to provide emotional and practical support for relatives and staff that experience a sudden death. The chaplaincy had a policy in place to guide staff in order that the appropriate support was available to relatives at this time.
- The bereavement officer is able to refer relatives to St Michaels Hospice. At present there are no bereavement support groups in the hospital.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

All patients requiring end of life care could access the SPC team. An increase in referrals was believed to be due to uncertainty felt by general ward staff about the best way to support end of life patients after the removal of the LCP.

We were told that patients on end of life care would be offered a side room if this was available and was not being used to nurse infection control patients. The lead Cancer Nurse told us that there was shortages of single rooms across the Trust therefore end of life patients were rarely nursed in a single room.

We found little evidence of family rooms on the wards however the wards have access to a room in the accommodations block for families who wish to stay overnight. Breaking bad news or if relatives are distressed can take place in the quiet room or in the staff room on the wards we visited. We found that relative facilities on the wards we visited were poor.

The Trust maintains a 'Mortality Data base' where information about the management of the patient is collected. This data is reviewed at monthly Mortality meetings were medical consultants review all the deaths across the Trust. We found no evidence that mortality data is used at a high level in the Trust. The Lead Cancer Nurse told us that no End of Life leads attend the meeting.

The SPC team support complex and fast track discharge process in order patients achieved their Preferred Place of Care (PPC). The Trust undertook an Audit in July 14 around the fast track discharge process. The conclusion from the audit was that 'there is a limited awareness and knowledge about the Rapid Discharge pathway which meant patients rarely got discharged within the 72 hour window.

In 2012/13 the number of patients that were achieving there PPC/PPD was 74%. This showed that patients who were referred to the SPC Team were asked about their PPC/PPD and this was achieved in a high percentage of patients.

The Trust was piloting a Proactive Elderly person's Advisory CarE (PEACE) planning tool. This has been developed to support the discharge of elderly patients to their preferred Place of Care (PPC) providing advice for community and GP's on the ongoing management of patients approaching the end of life.

Requires improvement

End of life care

We found no evidence that end of life complaints were discussed at the end of life steering group. Learnings from complaints were not being cascaded through the Trust which meant staff were not learning from the parts of the service people were not happy about.

There was no End of Life care alert system in place that informed the SPC team of any emergency admissions to the emergency department of palliative care patients previously known to the team.

Service planning and delivery to meet the needs of local people

- The SPC Team was widely embedded in all clinical areas of the hospital we visited and we were told by staff on the wards they would referral a high percentage of their patients commencing end of life care. This increase is believed to be due to uncertainty felt by general ward staff about the best way to support these patient's after the removal of the LCP.
- Staff we spoke to told us that patients on end of life care would be offered a side room if this was available and was not being used to nurse infection control patients. The Matron on Wellington Ward told us they had 8 single rooms but infection control patients are a priority. End of life care patients would be nursed at the edge of a six bedded bay. Privacy is maintained by keeping the curtains drawn if requested by the patient and family. The lead Cancer Nurse told us that there was shortages of single rooms across the Trust therefore end of life patients were rarely nursed in a single room.
- We found little evidence of family rooms on the wards however on Wellington Ward the Matron told us that they had a put up beds and recently two family members were able to stay with their relative overnight for one week. The wards have access to a room in the accommodations block for families who wish to stay overnight. Breaking bad news or if relatives are distressed can take place in the quiet room or in the staff room. We found that relative facilities in the wards we visited were poor.
- The Trust maintains a 'Mortality Data base' where information about the management of the patient is collected. This data is reviewed at monthly Mortality meetings were medical consultants review all the deaths across the Trust. We found no evidence that mortality data is used at a high level in the Trust. The Lead Cancer Nurse told us that no End of Life leads attend the meeting.
- However the end of life facilitator told us that information from the data base identifies the wards that have the most deaths. The end of life facilitator will visit the wards 'and see if staff need any teaching' to support the delivery of good quality end of life care.
- We observed that over the previous weeks 3 patients had died in the Acute Admissions Unit (AAU).We visited the unit which was noisy, busy and was like an extension of the A&E department. One single room was available. We found this area did not provide the environment or the atmosphere to nurse patients at end of life.
- In the nine DNACPR orders we reviewed we found that only 4/9 orders had been discussed with the patient and we found 6/9 had been discussed with the relatives. We saw that there were variations in the completeness of the forms across the hospital.

Access and flow

- The SPC CNS supports the fast track discharge process in order patients achieve their Preferred Place of Care (PPC) or Preferred Place of Death. (PPD) The SPC nurse explained that a multi professional approach is in place, which includes an Occupational Therapist and discharge sister, to secure rapid discharges to the preferred place of care. We saw no evidence of plans to increase the SPC Teams capacity to meet the increasing demands being placed on the service.
- The SPC nurse coordinates and liaises with the discharge team to provide advice relating to care packages including care home placement, assessment for future community palliative care support, assessment for hospice admission and assistance with utilising the Rapid Discharge Pathway for end of life care for patients who wish to die at home or in a care home.
- In Accident and Emergency the RN told us that over the weekend a physiotherapist and social services are available to support the discharge process. We were told that there were no issues around discharging patient's home at the weekend.
- The Trust undertook an Audit in July 14 around the fast track discharge process and found that 56% of patients were discharged from hospital within 72 hours once discharge had been discussed with the patient and/or those close to them. For some patients it was felt that 72 hours was too long to wait for discharge and improvement of the rapid discharge pathway and processes was needed

Requires improvement

End of life care

- The conclusion from the audit was that 'there is a limited awareness and knowledge about the Rapid Discharge pathway'. We were told by the SPC nurse that securing packages of care are difficult and can delay discharge. In 2012/13 the audit around PPC /PPD, 17% of patients did not receive their PPC due to the time taken to secure continuing healthcare.
- In 2011/12 and 2012/13 the Trust undertook an audit around the number of patients that were achieving their Preferred Priories of Care (PPC) and Preferred Place of Death (PPD).In 2012/13 the number of patients that were achieving there PPC/PPD was 74%. This showed that patients who were referred to the SPC Team were asked about their PPC/PPD and this was achieved in a high percentage of patients.
- The Trust was piloting a Proactive Elderly person's Advisory CarE (PEACE) planning tool. This has been developed to support the discharge of elderly patients to their preferred Place of Care (PPC) providing advice for community and GP's on the ongoing management of patients approaching the end of life. On Seaford 2 ward, the matron told us they were implementing the PEACE project. This tool will support streamline care across care agencies by including a summary of medical problems, anticipatory medications, advisory/ suggested action plan and mental capacity information.
- There was no End of Life care alert system in place that informed the SPC team of any emergency admissions to the emergency department of palliative care patients previously known to the team. This would support the early assessment and management of patient care and sometimes prevented the need for admission.
- Patients discharged from the acute setting who do not have specialist palliative care needs are initially followed up by District Nurses who will act as their Keyworker. The option is available to refer to the Community Palliative Care team at any time.

Meeting people's individual needs

- We visited the mortuary viewing suite where families can come and spend time with their relatives. Appointments can be organised through the bereavement office or mortuary, Monday to Friday. The viewing times are allocated in the afternoon due to the other work the mortuary performs.
- Information leaflets for families whose relatives are receiving end of life care are available and are given out by ward staff. The information leaflets include 'Coping with Dying ', 'an explanation of the plan of care in the last hours or days of life' and 'Guidance following bereavement'. Ward staff we spoke to told us they would give relatives these leaflets and a brief overview of the information making themselves available for any questions relatives may wish to ask.
- Across the Trust we found considerable respect for the cultural, religious and spiritual preferences of patients. We saw information leaflets were available one being 'organ donation and religious beliefs.'
- Christian services are available in the chapel on a Sunday but these have been stopped at present since the full time chaplain retired .The Chaplains are on call for all faiths and the point of contact for other faith leaders. The multifaith room supports other religions. We were told that on each Friday the Imam attends the hospital to perform prayers.
- The chaplaincy volunteer told us that they receive a list of all the new admissions to the hospital; they will visit the wards and say 'hello' and leave a calling card if the patient was asleep. They also receive calls from the wards to come and visit patients.
- The Bereavement office was open, Monday to Friday, 9 a.m. to 5 p.m.
- As part of the Dementia initiative 'My care' documents are used across the Trust. The booklet has been used to provide individualised patient care for dementia patients who are unable to express their needs and expressions so that the nursing staff can develop individualised nursing plans. One relative we spoke to told us that they had only noticed the document on the ward corridor and had wished the principles had been applied to her mother's care'. We were unable to establish during the inspection how widely this documentation was used.

Learning from complaints and concerns

- We were shown a number of complaints relating to end of life care. The lead Cancer nurse told us that complaints received would be investigated with the staff involved and letters of explanation would be sent to the complainants. We found no evidence that end of life complaints were discussed at the end of life steering group. Learnings from complaints were not being cascaded through the Trust which meant staff were not learning from the complaints made.
- The Lead Cancer Nurse told us that there had been a reduction in the number of complaints received by the

Requires improvement

End of life care

Trust which related to end of life care. There were 5 complaints made in Q1. Primary subject groups were communication x 2, attitude x 1, and infection control x 1, standard of care x 1. Trends in primary subject and location will now be recorded on a quarterly basis.

- The Bereavement Office is now collecting quantitative data. The Bereavement Officer told us that there is a noticeable difference over the last year in the positive feedback offered when relatives and carers come to collect the death certificate. She estimated that at least 85% relatives voluntarily offered positive comments on the good care their relatives had received on the acute wards. This is fed back to the Ward Matrons.

Are end of life care services well-led?

Requires improvement

We found no evidence of an End of Life Strategic Plan however we did see an action plan had been developed which set out the key areas the Trust would like to develop around end of life care in 2014/15. A single action group will implement the Trust End of Life Care Action Plan.

We found little evidence of what happens above the SPC team around the Trusts strategy around EoL care. We were told by the SPC team that general management support has never been there and there is no infrastructure to support the development and expansion of end of life care services.

At the time of the inspection the End of life Steering Group had been disbanded and was being re-launched with engagement with a wider attendance of clinicians across the Trust including an elderly care and A&E consultant to ensure that end of life care was the responsibility of all staff members across the Trust.

The Trusts Medical Director was the lead for EoLC at board level. We were told by the Medical Director that end of life care was not a regular agenda topic at the monthly board meetings However all frontline staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.

Vision and strategy for this service

- We found no evidence of an End of Life Strategic Plan. This showed us that the Trust did not have a clear direction of travel around end of life care.
- We did see an action plan had been developed which set out the key areas the Trust would like to develop around end of life care in 2014/15. These include an electronic alert system that highlights patients that are recognised as dying in the next few days or hours, the introduction of questionnaire to collect the opinions of patients and carers, introduction of 7 day working and the introduction of an electronic system to share summary care records across the care providers. These key developments would be discussed at the End of life Steering Group.
- The Trust had developed an End of Life Policy (adults) in August 2014.Staff we spoke to delivering care knew about the policy but were unable to tell us what was set out in the policy or what the Trusts vision was around end of life care. The involvement of a wider participation of clinicians including an elderly care and A&E consultant on the End of life Steering Group is hoped to raise the profile of End of life care across the Trust and removed responsibility for good end of life care from the SPC Team alone and made it the business of all staff.

Governance, risk management and quality measurement

- Governance systems were in place around EOL care. The End of Life Care Steering Group discussed aspects of EOL care .Any actions and reports will be taken to the Trust Nursing and Midwifery and Allied Healthcare Professionals Group and the Clinical Quality and Review Group. Involvement with other stake holders was through the End of Life Care Programme Board
- End of Life Care Steering Group reports into the external End of Life Care Programme Board chaired by the CCGs and Adult Social Care provides trust-wide leadership and overview to end of life care improvements and developments. The aim of the group is to develop and operationally manage the set of actions which are required to embed a culture of change, improvement, education, learning and standards of consistently high levels of clinical performance.
- The End of Life Care Steering Group review any risks associated with end of life care across the Trust. The Steering Group membership includes key clinical leads in end of life, palliative care and specialist palliative care

in addition to senior representatives from elderly care and Accident and Emergency. At the time of the inspection the End of life Steering Group had been disbanded and was being re-launched. With a wider attendance the Trust conveyed it was serious that End of life care was everyone's business and not just the responsibility of the SPC team.

- A single action group will implement the Trust End of Life Care Action Plan. This group will feed into the end of life Steering Group which reports directly to the Quality and Standards Committee which scrutinised its work, highlighted issues and challenged their processes.
- The Medical Director was the lead for End of life care at board level. We were told by the Medical Director that end of life care is not a regular agenda topic at the monthly board meetings.

Leadership of service

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

Culture within the service

- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.
- We spoke to staff about how supported they felt in their roles. They all described how they felt supported and told us how approachable there managers were.
- We asked the mortuary staff whether the staff working in their department felt a sense of belonging to the wider hospital team. They told us that they had lots of contact with non-mortuary staff and had input into the End of life policy (adults).There were frequent visitors such as the chaplains, porters and undertakers who they got to know quite well. They were able to see where their work fitted into the provision of end of life services.
- All the staff we spoke to spoke positively about the service they provided for patients. Quality and patient experience is seen as a priority and everyone's responsibility and this was very evident in the SPC team in their patient centred approach to care.
- We found that staff had a 'can do attitude'. Which mean that the staff were very patient centred and wanted to deliver good care through good training and support.
- Across the wards we visited we saw that the SPC team worked well together with nursing and medical staff and there was obvious respect between not only the specialities but across disciplines.

Public and staff engagement

- The Trust did not receive feedback on end of life care. No bereavement surveys are undertaken across the Trust.
- During Dying Matters Week (12th May – 16th May) the End of Life Care Facilitators from East Sussex Healthcare NHS Trust held public events in the Arndale and Langley Shopping Centre to provide information and answer any questions around dying, death and bereavement.
- We observed that 2 listening into Action events have been arranged in May 2014 to increase staff engagement. Additional "on the ward" training has been undertaken by the End of Life Care Facilitators to promote the "Key Elements" guidelines.

Innovation, learning and improvement

- The SPC team gave examples of practice that the team were proud which included providing a holistic approach to patients receiving end of life care, non-medical prescribers and facilitate Preferred Priorities of care (PPC) and Preferred Place of death (PPD).
- Networking with other providers, community and GP's for better care closer to home.

Inadequate

Outpatients

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

Information about the service

East Sussex Healthcare NHS Trust had 706,534 outpatient (OPD) appointments annually (figures taken from trust data from June 2013 to June 2014). The majority of outpatient activity took place at either the Conquest Hospital site, which had 326,363 attendances per annum (figures taken from trust data from June 2013 to June 2014) or Eastbourne District General Hospital, which had 280,171 attendances per annum (figures taken from trust data from June 2013 to June 2014). There was also significant activity that took place in the trust's community sites, which was covered in the community part of our report.

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

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

The OPD had recently undergone a service redesign, which was still being embedded at the time of our inspection. The trust was centralising OPD booking services, which was now located at the Eastbourne District General Hospital site and managed bookings across the whole service. The trust had also restructured its administration staff across both sites.

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

Inadequate

Outpatients

Summary of findings

The outpatient services provided at the Conquest Hospital overall are inadequate. Although outpatient services were caring they were inadequate for safety, being responsive and being well-led. The service was inspected for effectiveness, but not rated.

The central booking service was not always able to give patients appointments within the NHS England and clinical commissioning groups (CCGs) regulations 2012 18-week targets. We were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the trust improved their waiting times and met with these targets.

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

The OPD had not ensured that when medicines were prescribed and dispensed, the prescription and dispensing complied with relevant legislation. The OPD were unable to provide assurance that this medication had been stored at the correct temperature.

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

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

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

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

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

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

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

Inadequate

Outpatients

Are outpatients services safe?

Inadequate

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

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

The OPD had not ensured that when medicines were prescribed and dispensed that the prescription and dispensing complied with relevant legislation. The OPD staff were unable to provide assurance that this medication had been stored at the correct temperature.

Patient's health records were disorganised and in a poor state of repair. This made it difficult for clinicians to locate important information that could put patients at risk of inappropriate or unsafe treatment.

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

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

Incidents

- At the time of our inspection visit there had been three recent serious incidents (SIs) in the outpatients department (OPD). One of which was a patient fall, one an unexpected patient death, and one a failure to act on test results.
- At the time of the inspection, there had not been any Never Events relating to the OPD.
- Trust policy stated that incidents should be reported through an electronic software system that enabled incident reports to be submitted from wards and departments. We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns.
- We were told by managers and staff that the recording of incidents with health records management was inconsistent across the OPD. Staff told us that this was because issues with health records were so frequent that they did not have time to report all of these incidents through the electronic system.
- We noted that, in different areas of the OPD, staff were using different systems to record issues with health records. For example, the matron in the main OPD told us that they only tended to electronically record health record incidents that had a direct impact on patients (for example, where appointments had been cancelled as a result of notes not being available).
- In August 2014, 16 incidents relating to patient health records were recorded through the electronic incident reporting system. On top of this recording, the matron held a separate record on which staff recorded where health records were missing or in poor condition. On the record we were shown, there were 37 issues with notes for the month of August 2014 that had been documented, but not recorded electronically. We were told that this list was not complete either and was likely to be "the tip of the iceberg".
- We also found several incidents which had been recorded on the trust essential care system around the documentation of incidents in the OPD, which were not recorded electronically as per trust policy. These mostly involved patients being sent to the wrong areas of OPD and no staff being available to redirect them. A patient who was hard of hearing and had not heard their name called who had been recorded by staff as not having attended their appointment. Staff realised their mistake when the ambulance transport arrived to take them home.
- An administration manager told us that missing notes was under-reported due to the large numbers of incidents of this nature. We were told that, despite this, they had 200 incidents of missing notes across both hospital sites on their system, which they were expected to investigate. They told us that they were already working long hours, as well as overtime at weekends, and had had their annual leave cancelled – and they did not have time to analyse incidents due to the workload they were expected to complete.
- The matron for the main OPD told us that they had never received feedback from incidents that had been

reported electronically. The department had not had a clinical unit meeting for over 18 months. This had been identified as an issue by the trust and meetings for senior staff were due to start in September 2014.

- The matron did attend quality review meetings with other senior staff across the trust every five weeks. They told us that they used these meetings to discuss incidents.
- We reviewed the minutes from the past three OPD staff meetings and found that incident reporting and feedback had not been recorded as discussed at these meetings.
- The matron of OPD gave us two examples of where patient care and experience had altered due to learning from incidents. One example was a manual handling incident. Following the incident, staff had received further training.

Cleanliness, infection control and hygiene

- There were hand hygiene 'bare below the elbow' audits undertaken, which demonstrated staff were compliant with best practice guidance. These were done for each clinical area, and documented in the annual clinical governance report.
- Staff working in the OPD had a good understanding of responsibilities in relation to cleaning, infection prevention and control.
- Clinical areas were monitored for cleanliness by the infection control team and results were displayed on noticeboards in the department. Housekeeping staff could be called between scheduled times to carry out additional cleaning, where staff felt it was necessary. We noted that, although the cleaning audit scores met with expected cleaning standards, we found ingrained grime around door stops and in the corners of the floor in some areas.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place and they were completed, providing assurance that this was done.
- The equipment that we saw was in good repair, but we also noted that the green labels the trust used to indicate that equipment had been cleaned were not always used and this risked leaving staff uncertain as to which equipment was cleaned and ready for use. We saw that some clinical storage trolleys were not clean.
- We found some inappropriate equipment stored in a dirty utility area, such as clean curtains, trolley rolls and a mobility aid. Staff acknowledged that this risked clean equipment becoming contaminated.
- The overwhelming majority of staff we observed in the OPD were complying with the trust policies and guidance on the use of personal protective equipment (PPE) and were 'bare below the elbows'. We did, however, see one consultant in a clinic room with patients who was wearing a suit jacket and was not 'bare below the elbows'.
- We observed staff in the main OPD washing their hands in accordance with the guidance published in the 'Five Moments for Hand Hygiene' guidelines published by the World Health Organization (WHO, 2014).

Environment and equipment

- All mobile electrical equipment that we looked at had current portable appliance testing (PAT) certification.
- All equipment in the OPD had a process for updating and maintaining contracts with external providers for specialist equipment. A register was kept of the contract arrangements.
- We saw that the resuscitation trolley was checked and maintained ready for use in an emergency.
- From observation in the OPD, we saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment and that replacements were provided, when necessary.
- The environment was reasonably well maintained and there were no obvious hazards, such as worn flooring.

Medicines

- The ways that medicines were administered in the ophthalmology OPD on the Conquest Hospital site was looked at during our unannounced inspection of the trust.
- The service were not able to provide assurance that medicines had been appropriately obtained or stored. Medical samples, which had been received by consultants from medical sales representatives, were being administered to patients. These medications had no dispensing labels and no assurance of supply chain, as well as no record of source or temperature. Therefore, the trust had not ensured that when medicines were dispensed that dispensing and dispensed product complied with the relevant legislation and best practice.

- Medicines were being dispensed without adequate labelling when doctors dispensed eye drops in the clinic; details of the consultation medication were recorded in patient health records. We looked at three patient records and found that in all three records there was insufficient information recorded for these to act as a prescription. We also found no record in patient health records regarding the dispensing of medications. The trust should ensure that when medicines are prescribed and dispensed, that the prescription and dispensing complied with relevant legislation.
- Temperature checks were not being completed by staff in line with trust policies. Temperature records that we looked at were incomplete and did not contain minimum and maximum temperatures to alert staff when they had not been within the required range. Therefore, the service was not able to assure us that medicines that required refrigeration were stored within the recommended temperature range.
- The service were also not able to assure us that the freezer equipment was capable of reaching the required temperature range. No records for freezer temperatures were being kept. One medication in the freezer needed to be stored at under -20°C . The OPD were unable to provide assurance that this medication had been stored at the correct temperature.
- Medical gases without an expiry date were available for use in the department. This was because the expiry date was unreadable. This meant that medical gases that had passed their expiry date could be used, which meant that patients could receive unsafe treatment.

Records

- During our inspection of the OPD, we noted that, in one corridor that was a used by members of the public, there were two unlocked filing cabinets containing patient medical records. It had been left unattended. We raised this with staff members, but found that the cabinets had not been locked later in the day. Therefore, we raised the issue for a second time with the sister in charge of the department. When we returned to the department two days later, the same cabinets were still accessible and unlocked. We raised this with staff for a third time.
- We observed that in the ear, nose and throat (ENT) clinic in the public space, health records were stored in an open trolley, without staff being present. We stood and went through the notes for several minutes and were not challenged by staff at any point. Only those individuals who need access to personally identifiable information should have had access to it. Therefore, the department had failed, on this occasion, to protect patients' confidential data, as they were required to do by law (Data Protection Act, 1998).
- All of the staff that we spoke with, including administrators, clerks, secretaries, nurses, and clinicians told us that the trust had an issue with the availability and condition of patient health records. We found that incidents around health records were not being recorded in a consistent manner by any staff groups in the hospital. Therefore, we were unable to clarify the exact extent of this issue.
- We were told that health records were in a poor state of repair and that some records were so large that staff were unable to handle them safely. We saw multiple examples during our inspection of records that were in a poor state of repair, with documents and test results loose. One set of notes we looked at was large in volume and falling apart. As a result of this, they had been bound around several times with masking tape making them unusable. Clinicians told us that the poor state of patient health records made their job difficult and risked them missing important information in muddled records.
- The poor condition of health records had been on the trust risk register for OPD since August 2005. The trust had not been able to resolve this issue since this date.
- The matron in the main OPD told us that if health records were not available and the consultant felt it would be unsafe to see the patients as a result of this, their appointment would be cancelled. We were told of incidents when patients had arrived at clinic to be turned away when their records were not available.
- The unavailability of patient records was also on the OPD risk register. Staff told us that, due to staff shortages and the location of medical records, clinics frequently ran with several patients having temporary sets of notes. This meant that clinicians would not have access to a complete picture with regards to the patients past medical history, which could result in unsafe or inappropriate treatment. We are unable to

give exact numbers on how often this happened as medical records staff, and staff responsible for preparing the notes for clinics on both sites all told us that they did not report this through the electronic reporting system.

- Staff told us that notes were sometimes unavailable because staff were unable to locate them. Trusts have a responsibility to track all patients' health records (Records Management: NHS Code of Practice, Part 2, January 2009). Due to a recent review of administration in the trust, the task of tracking patients' health records back to medical records had not been allocated to a staff group or job role. This meant that, at the time of our inspection, health records leaving OPD departments across both sites were not being tracked. Although administration staff, medical records staff and management were aware of this issue, there were no plans in place to rectify this issue. This issue was not on the risk register and had not been reported via the electronic incident reporting system.
- Staff told us that, where records needed to be bought from the trust's offsite storage for medical records, this caused delays. Staff said that the reason for this was that, at times, so many records were being requested from offsite that staff were unable to meet the demand.
- We were told that another reason that health records were delayed from this site was that, although the delivery van ran notes from the offsite storage facility four times a day to both sites, they sometimes had to leave records behind because they did not have space in the van for the notes required. We did not see documented evidence that this had occurred, but many members of administration staff raised this as an issue.
- We spoke with the manager and staff responsible for preparing notes for clinics. We were told that they did not have enough staff in this department to ensure that health records for clinic were prepared in a timely manner. Because of this, staff were working over their hours, and were doing extra shifts over the weekends. We were told that, because staff were coming to work on a Saturday to prepare clinics, this put a great deal of pressure on medical records staff on a Monday to find the notes that had been requested over the weekend.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff had completed training, appropriate to their role and grade, in the Mental Capacity Act 2005 and the impact of this on their work. They had also completed training in Deprivation of Liberty Safeguards.
- Staff we spoke with demonstrated a good understanding of the legislation and their role in this legislation.
- We viewed three consent forms during our inspection, which had been completed correctly by staff.

Safeguarding

- OPD staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the trust safeguarding lead was and how to contact them.
- Staff working in the OPD had completed the mandatory safeguarding training. Staff were able to talk to us about the insight and knowledge they had gained from this training. They were also able to show us the trust safeguarding policies on the intranet.
- Staff were able to give us examples of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- The trust had a chaperone policy that was followed by the OPD staff.
- The trust had a whistleblowing policy that was known to staff that we spoke with working in the OPD.

Mandatory training

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

Assessing and responding to patient risk

- Staff working in the OPD had completed basic life support training.

Nursing staffing

- The department used regular bank (overtime) staff to fill spaces in staffing, but the management team was reluctant to use agency staff that had not worked in the OPD before, as they were not trained in the specific competencies required to work within the department.

Inadequate

Outpatients

- OPD sisters told us that staff were very accommodating about swapping shifts and working extra hours to ensure that clinics were covered by staff with the correct skills.
- The rheumatology nurse specialist, who had worked across sites, had stopped working for the trust two years previously and had not been replaced. We were told that this service suffered particularly long waiting lists, due to lack of staff running clinics in this specialty.
- The trust had stopped ad hoc clinics when the turnaround team had come in to reduce spending. This had impacted on waiting lists and staff were now being asked to run extra clinics to clear the backlog. However, they were unable to staff these clinics with substantive staff as staff were already stretched to the limit. Therefore, extra clinics were mostly being nurse staffed by bank nurses.
- The matron told us that, although activity had increased over the years in OPD, the staff establishment had not been reviewed to reflect these changes. They said, "We are running clinics on fresh air."

Medical staffing

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

Non-clinical staffing

- We spoke with 72 members of administration, clerical, medical records and secretarial staff across the trust, during our inspection.
- Administration staff had recently undergone a review of their roles and responsibilities and some staff had changed job roles and locations as part of the review.
- The trust had changed processes and job roles in order to centralise the administration teams, and to create a new operating system for OPD. This was to improve the quality and safety of the services they provided.
- At the time of our inspection, the new ways of working were still being embedded and staff were telling us that they were under a great deal of pressure.
- Staff told us that they felt that their life at work had become stressful and unhappy. They said that changes had been made without consulting staff on the ground, and that, as a result, processes were failing and patients were suffering.
- Staff across all grades working in administration, clerical, reception, medical records and secretarial support described feeling undervalued, not listened too, deskilled and demoralised.

Major incident awareness and training

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

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

Not sufficient evidence to rate

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

Inadequate

Outpatients

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

We saw examples of multidisciplinary working.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance for smoking cessation had been met within the department. The OPD assessed each patient who accessed the service to establish whether they would benefit from a referral to the smoking cessation service. Staff would refer patients to the service where a need was established.
- The OPD was able to demonstrate that it was planning care based on National Institute for Health and Care Excellence (NICE) guidelines for macular degeneration. However, a backlog of ophthalmic first and follow-up appointments meant that appointments and treatment pathways were not always completed within the required timeframe to meet with NICE guidelines for macular degeneration.
- The ophthalmology department planned that patients referred into the service had been given an optical coherence tomography (OCT) and had seen the consultant and started on a five-week treatment plan, where needed, within two weeks of referral. However, administration staff did raise concerns relating to the rebooking of patients for OCT. They had discovered that, because the department had removed administration staff from their specialty clinics, administration staff were misinterpreting doctors writing 'OCT' on a referral for an urgent scan thinking it meant 'October'. Staff had, therefore, been booking patients in for follow-up appointments in October, rather than for an OCT scan. To mitigate this risk, the staff members with the knowledge required were managing ophthalmology follow ups for the time being. They told us that, because of a high pressure workload, they did not currently have the time to retrain other members of staff.

Patient outcomes

- The OPD ran a continuous patient experience survey, which patients were encouraged to complete following their visit to the department.
- Results of these surveys were shared with staff and patients on display boards within the departments.
- The OPD used these boards to display a 'You said, we did' section – these told patients about things that they had said and what the department was doing to improve the service as a result.

Competent staff

- Along with mandatory training, staff in the OPD were expected to demonstrate competencies in the areas that they worked in. For example, we were shown competency assessments for cervical pathology and colposcopy, hysteroscopy, sigmoidoscopy, and proctoscopy.
- Staff attended a trust induction on starting work at the service. The OPD management team also ensured that staff completed a local induction programme, which related to OPD.
- Records demonstrated that staff with the exception of those on long-term sick leave had a 100% record for appraisals.
- The sister in ophthalmology was being sponsored by the trust to attain a degree. They told us that they felt happy with the way their developmental needs were being met by the trust.
- We spoke with a matron who worked across both hospital sites. They told us that they were sent on a leadership course and had a buddy who supported them through the programme. They described the course as "inspirational".
- We spoke with staff nurses, who told us that they valued their annual appraisal and felt that their developmental needs had been recognised and supported through learning.

Multidisciplinary working

- We saw, and were told, about a number of other examples of where joint clinics were provided. These included the nasal polyp clinic, breast clinic, urology clinic and orthopaedic clinic, which had physiotherapists involved in clinics, the diabetic service having have podiatrists and dieticians working in clinics alongside the consultants and diabetes nurse specialists.

Inadequate

Outpatients

- We were told that the trust OPD staff worked collaboratively with community services to the benefit of patients. There was evidence of liaison over individual wound care and copies of letters relating to patients were faxed to the community nurses.

Seven-day services

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

Are outpatients services caring?

Good

The outpatients department staff were caring.

We saw very caring and compassionate care delivered by all grades and disciplines of staff working at the Conquest Hospital.

Staff offered assistance without waiting to be asked.

Staff worked hard to ensure patients understood what their appointment and treatment involved.

Compassionate care

- One of the strengths of the service in the OPD was the quality of interaction between staff and patients.
- We watched staff assisting people around the different OPD areas. Staff approached people rather than waiting for requests for assistance, asking people if they needed assistance and pointing people in the right direction.
- We saw staff spending time with people, explaining care pathways and treatment plans. We noticed that staff squatted or sat so that they were at the same level as the person they were speaking to in the reception area and maintained eye contact when conversing.
- Staff were trained and expected to keep patients informed of waiting times and the reasons for delays. We observed this happening in all areas of the OPD, during our inspection.
- All of the patients we spoke with were complimentary about the way the staff had treated them. A patient said, “The staff are lovely.” Another patient said, “They are so kind, they helped me undress and they were very patient with me”.
- Patients also told us that they had been treated with dignity in the department. One patient told us, “They have always treated me well, they are very respectful.”
- Most staff knocked on doors and waited for a response before entering. Although we did see one staff member not do so on two occasions.

Patient understanding and involvement

- We spent time in the department observing interactions between staff and patients. We saw one healthcare assistant (HCA) meeting and greeting patients as they came to her clinic area. We saw that she introduced herself, explained which doctor was in clinic, explained what would happen next, and described where the patient was in the queue and whether the clinic was running on time. We observed the HCA following this routine with nine patients during the time we were observing.
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account. One patient, however, said that the doctor had talked to the computer screen rather than their face.
- There were patient leaflets in each waiting area, which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We saw patients reading this information. When asked, they all said that the information was in a format that they understood.
- Patients received a copy of the letter that was sent to their GP. This outlined what had been discussed at their appointment and any treatment options.
- We also observed the doctors behaving in a friendly and respectful manner towards the patients in their care.
- The service provided chaperones, where required, for patients. We were told that staff were always available for this.

Inadequate

Outpatients

Emotional support

- We saw one person who was a diabetic and had become unwell. The patient was cared for by an HCA who showed them compassion and understanding while dealing efficiently with their deteriorating condition. They talked to the patient, reassuring them and telling them what they were doing at each stage. It was evident that the patient felt safe and reassured due to the nurse's actions.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Inadequate

The outpatients services at the Conquest Hospital were not responsive to the needs of patients.

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

The trust had consistently not met with the operating standard for the NHS National Statistics on NHS consultant-led referral to treatment times (RTT) over the past year. Some specialties performed worse. For example, rheumatology, where patients were left waiting 48 to 49 weeks for an appointment.

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

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

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

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

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

Service planning and delivery to meet the needs of local people

- Due to the reconfiguration of some clinics to specific sites, booking staff were having problems booking patients for appointments as patients were refusing to travel the distance from Eastbourne District General Hospital to Hastings to attend their appointments at the Conquest Hospital site. Staff were not aware of any strategy to assist patients when this happened. Staff told us that they had received verbal abuse from patients who felt that they should have outpatient appointments offered to them closer to their home.
- The booking-in system had been centralised in a recent review of services. We were told by most of the staff and members of the public with whom we spoke that this had not been implemented well by the trust and that patients had suffered as a consequence. The new system had caused confusion and long queues for patients. Staff said that the changes had been made too fast with no consultation with the staff that worked in the department. As a consequence, staff felt that the current system was not fit for purpose.
- The new design of the booking system meant that, regardless of specialty, all patients entering OPD were booked at a central desk in the entrance lobby. Patients were then entered into the system as having arrived and sent to the area that their clinic was in.
- The electronic system did not allow staff in the OPD areas to be informed about which patients had arrived in clinic. We were told of many examples where patients were being sent in error to the wrong place or clinic because staff were not aware that patients had arrived at the hospital. When they didn't arrive in their clinics, staff made the assumption that the patient had not arrived for their appointment.
- We were told many stories of the impact this had on patients. We saw documented evidence of a frail patient

bought in by hospital transport that staff were not aware of until the transport arrived to take them home. On the day of our inspection, one patient had been waiting anxiously for a biopsy in the wrong area. Although staff did locate the patient after half an hour, this meant the patient had been subjected to an unnecessary wait.

- The issues with this system had also affected staff, who were struggling with their workloads as they routinely had to walk down to the main reception of the hospital to see whether patients that were not in clinics had arrived in the hospital. Staff told us they spent most of their time redirecting patients who were in the wrong place. One manager told us, "I agree with the centralisation of appointment booking, but it has happened too fast, with not enough thought."
- As the trust had not removed the appointment desks in the different areas of OPD, we also saw many patients standing by unmanned desks waiting for staff attention. This was confusing for patients as they assumed that these desks were manned.
- We were told by staff that the new appointment desk in main reception was so busy that the queue there had, on many occasions, been so long that it had stretched outside of the hospital entrance. Staff pointed out that many of the patients who were being expected to queue that length of time were frail or had issues with their mobility. We were told that queues had become so long that patients had missed their appointment times, which had caused them a great deal of stress.
- Although we did not witness queues of this length staff told us that the appointment lists for OPD had been reduced due to our inspection. We asked the trust for data on the number of patients attending OPD and found that on the two weeks prior to our inspection across both sites OPD had booked 12,207 and 12,142 patients for appointments in total. On the week of our inspection, they had booked 9,489 patients, and the week following our inspection they had booked 12,310. Therefore, we had not seen the department running at its usual capacity, during our inspection.
- Some patients complained to us that they were unable to contact the OPD via the telephone. Some said that the numbers they had no longer worked, others said that the line was either constantly engaged or rung without being answered. Staff acknowledged that this was a problem, as, due to the reconfiguration of services, telephone numbers had changed. Appointment clerks told us that they often had patients who were frustrated with them, as they had been unable to get through. They said that they always answered the phone as soon as they were able to, but were struggling under a heavy workload.

Access and flow

- The 'two-week wait' national standard for patients with urgent conditions, such as cancer and heart disease, was implemented to ensure patients with potentially urgent conditions are able to see a specialist more quickly. Patients have a right to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals, where cancer is suspected (The Handbook of the NHS Constitution, Department of Health, 2013).
- The trust fell below the national average (performed worse), with the percentage of people seen by specialist within two weeks, of an urgent GP referral for a suspected cancer. The number of patients seen by a specialist within two weeks for the first quarter of 2014 was 93.1%, where the average for England was 95%. For the second quarter of 2014, the trust saw 90.3% of patients within two weeks, where the England average was 93.5%. The trust consistently fell below the national average over the past year.
- The monthly national statistics on NHS consultant-led referral to treatment (RTT) waiting times were released on 10 July 2014, according to the arrangements approved by the UK Statistics Authority. During May 2014, 84.1% of admitted patients (the NHS operating standard was 90%) and 94.1% of non-admitted patients (the NHS operating standard is 95%) started treatment within 18 weeks. This meant that the trust was not meeting with the operating standard for the NHS. From April 2013, the trust had failed to meet with the NHS operating standard for ten months over that period. In the first three months of 2014, the trust had fallen below 75%.
- We received complaints, during the inspection, regarding the wait that patients experienced to receive their appointments at the trust. The majority of these complaints related to rheumatology. Patients complained that they had to wait for around a year to be seen by the rheumatology department.

Inadequate

Outpatients

- The monthly National Statistics on NHS consultant-led referral to treatment (RTT) waiting times showed that, in rheumatology, the proportion of patients seen in the outpatient department who did not require admitted treatment to hospital was 48.1%. The national operating standard is 95%. Data provided by the trust showed that, at the time of our inspection, 783 patients were waiting to have their first appointment with the rheumatology department. With 107 of these patients having already waited over 18 weeks for their appointment, 37 of these patients had been waiting over 39 weeks for their appointment. Trust staff told us that they were currently booking rheumatology patients in for appointments between 48 and 49 weeks after their referral.
- Staff raised concerns about the amount of time that patients were waiting for an ophthalmology follow up and first appointments. Staff showed us folders full of referral letters that they told us they were not able to book within the timeframes required for follow-up appointments. Staff had raised this issue with their managers and provided us with evidence of this. Staff also told us that, by the time they were able to offer patients their first appointment, they had often already gone elsewhere to have their treatment. During May 2014, 84.4% of admitted patients (the NHS operating standard is 90%) and 98% of non-admitted patients (the NHS operating standard is 95%) started treatment within 18 weeks. However, it is worth noting that these figures only reflect the number of patients who had completed their pathways and not patients who were still waiting for an appointment.
- Other specialties that were consistently falling below the expected waiting time targets between April 2013 and June 2014 were trauma and orthopaedics, general surgery, oral surgery, and gynaecology.
- Prior to the inspection staff informed CQC about a number of practices which the trust used to monitor and manage the flow of patients though the outpatients department. Staff reported that these mechanisms were not fair but apart from one example in relation to an individual patient, we did not find evidence that such practices were in general operation across the outpatients department.
- We found an example in the central booking office where a patient had been recorded incorrectly as having rung to cancel their appointment. A member of staff showed us one patient who was recorded as having rung to say they couldn't attend their appointment, due to work commitments (which were very specific). When we asked how the member of staff knew this to be incorrect, they told us that the appointment was for someone they knew personally who did not work in the area specified and had not rung to cancel their appointment.
- Since the service redesign, we found that essential documentation of patient pathways through OPD had not been recorded. Once a patient was seen in clinic, they were given a sheet of paper to hand in at reception, which detailed the decisions that had been made during their consultation. Since the service redesign, this documentation had not been collected and recorded by reception staff consistently. This may have been due to patients not wishing to queue up again at main reception, or misunderstanding the need to return the documentation to staff. Without this paperwork, the trust could not accurately record patient waiting times for the 18 and two-week pathway data.
- The manager responsible for investigating these incidents across both sites told us that before the redesign of the service they found that, on average, around ten patients a month did not have this documentation completed and that they were easily able to track the patient's journey through the department and rectify the problem. However, since the redesign of the service, the manager had received 874 cases of incomplete documentation. They told us that, due to the numbers involved, and the difficulty they would have tracking the patients journey through the service, that it would be, "virtually impossible", for them to collect the missing documentation. This meant that, at the time of our inspection, the trust was unable to report accurate data for their 18 week and two-week waiting times. Additionally, patients may not be getting to their next appointment for care in a timely or appropriate way.
- The trust had no alert system in place to inform staff when patients' follow-up appointment dates were required, or overdue. This meant that staff could miss dates, because they were not alerted to them. Staff responsible for booking these appointments across

both sites told us, "We are usually made aware because the patient will ring and tell us that they are overdue on their appointment, we are unaware of this because nothing on our system tells us."

- Staff responsible for booking follow-up appointments across both sites told us that clinic spaces for follow-up appointments did not meet with demand. They also told us that they were given mixed messages from managers regarding booking patients for follow-up appointments. Many staff members told us that they were repeatedly being asked to cancel patients' follow-up appointments. They said that they were booking patients far beyond the dates that had been requested by the consultant.
- We sampled four random patient booking records in the central booking office. We found that all four patients had not received follow up appointments within the time that they should have. All four had also had appointments cancelled at least once. For example, one patient who should have had a six month follow up appointment had had two appointments cancelled and was currently booked 18 months after the initial consultation.
- Clinic delays were recorded on essential care round documentation, which was completed for each clinic. Staff were told to announce delayed clinics once they got to a one hour delay. We were shown essential care round documentation that had been completed by staff.
- Although staff told us that some clinics ran consistently late, they identified some clinics as worse than others, with ophthalmology regularly having a two to three hour waiting time. We asked the matron if they audited the time that patients waited for their appointments. They told us that they did not.
- The trust's policy required GP letters to be sent following clinic appointments within five days. Medical secretaries we spoke with across both sites told us that this policy was not being adhered to consistently. They said that the reason for this was that dictated letters were sent abroad for typing. They said that the typing of these letters was not always correct and that secretaries had to listen to the dictation and check them against the letters that they received back. They told us that this was inefficient, as they could have typed the letters themselves in the time it took to check them. However, they said that they had very firmly been told by their managers that they were not to type letters "even if they had the time".
- They gave us many examples of where incorrect translation of dictation could have been embarrassing to the trust or a risk to patients, in the case of medical terminology being incorrect. For example, one patient who, when describing their hearing as "symmetrical ears" was written as the patient having "magical ears". Another, where a lady had been recorded as having had a "vasectomy", a third where "brain scan" was recorded, rather than "bone Scan". Staff also said that peoples' titles were often recorded incorrectly. The example given was that "mothers" were being recorded as "madams".
- The trust rates for patients not showing up for their appointments were consistently higher than the England average. In July 2014, 3,301 patients had failed to attend their appointments (DNAs) in August 2014, 2,442 patients had failed to attend. The trust had an 'opt in' system for text message reminders for appointments. Staff we spoke with told us that there were issues around appointment letters being sent. One doctor wrote to us, saying, "One of the patients was a member of staff, when I asked her she had had no letter from the trust advising her of an appointment. This has not been an unusual scenario since central booking came in to place."
- The maxillofacial unit (MFU) had produced a report investigating DNA rates in evening clinics. They found that, in their clinics running from 9am to 5pm, Monday to Friday, 11.8% of patients did not attend. Whereas, in clinics running Monday to Friday, between 5pm and 8pm, the percentage went up to 25%. The results of this survey were fed back at the clinical governance meeting for MFU.

Meeting people's individual needs

- The OPD was able to access telephone translation services for patients.
- The OPD shared information booklets with the relatives or carers of patients with learning difficulties, to help

them to understand what would happen at their appointment. For example, we were shown a booklet which explained in an easy-to-read format, what would happen during a breast examination.

- The audiology department had hearing loops to assist patients with hearing impairment.
- Information leaflets were available in different languages upon request. The department was also able to access information leaflets in easy-to-read formats.

Learning from complaints and concerns

- We discussed complaints with the matron and OPD sisters, who all demonstrated a good understanding of the trust's procedures when dealing with complaints.
- We spoke with the Patient Advice and Liaison Service (PALS), who told us that there had been a sharp rise in the number of complaints about OPD, particularly in the booking of appointments since the changes to the service. They had received 33 complaints on the Conquest Hospital site, relating to OPD bookings in August 2014.
- We did not see evidence from staff meeting minutes that complaints were discussed with staff during these meetings. Staff that we spoke with could not tell us how complaints were discussed and service improvement made as a team.
- We were able to see examples on noticeboards around the department where the OPD had listened to patients feedback on patient surveys and had improved the service as a result. When we talked about complaints, staff referred to these examples.
- One relative came to our listening event to describe the poor response they had received from the trust regarding a complaint they had made about their spouse's care in the OPD. They felt that they were "bullied" by the consultant because they had made a complaint against them. They said that mistakes had been made by the consultant and they said, "All I wanted was an apology." They told us that there complaint was ongoing and that they were struggling to get an appointment with the consultant to discuss their concerns.

Are outpatients services well-led?

Inadequate

Vision, values and strategy had not been developed with staff in the department. Staff felt undervalued. Staff were not invested in the department changes as they felt they had been forced upon them. This had resulted in unhappy staff and a poorer experience for patients.

Strategies were in place to centralise services. The impact of the changes which had been made too fast and without consulting staff about the essential roles in the department had meant that processes were not robust which had affected the delivery of care to patients.

We were unable to see clear leadership within the department. Many issues were raised during our inspection that had not been recognised and raised as problems. Where the Trust was aware of issues such as the 18 week waiting time breaches and lack of appointment slots for follow up appointments. There were no robust systems in place to deal with this.

Many administration staff sought us out during our inspection to tell us how unhappy they were in their roles following the recent changes in the service and their job roles. They told us that they felt undervalued, and not listened to. Many of these staff did not know who their manager was and felt unable to raise their concerns.

Some staff wanted to discuss with us a culture of bullying in the Trust. They told us that when they had raised concerns they had been disadvantaged as a result of this.

Vision and strategy for this service

- Staff we spoke with were aware of the current changes in their department and were aware that the vision and strategy for their department was to centralise services and booking in systems. Staff were feeling concerned about the strategy for the OPD future. Staff were aware that services were being centralised, they also understood that their roles were either changing, had changed or were under review. However, they felt that patients were receiving a poor service from their department currently and felt frustrated. For example one staff member said, "We all want to do a good job, but the decisions made by management who don't even ask our opinion have left us doing a poor job. I go home at night in tears sometimes it is so demoralising".

- Although some staff told us that they understood the reasons behind the changes that had been made to the department they all told us that these changes had been made too fast and without a full understanding of the functions within the department.
- Strategies were in place to centralise services. The impact of the changes which had been made too fast and without consulting staff about the essential roles in the department had meant that processes were not robust which had affected the delivery of care to patients.
- Vision, values and strategy had not been developed with staff in the department. Therefore staff felt undervalued. Staff were not invested in the department changes as they felt they had been forced upon them. This had resulted in unhappy staff and a poorer experience for patients.
- Trust wide communications had been displayed in staff areas for staff to read.
- The OPD matron told us that the disruption to the service caused by the changes meant that they were "fire-fighting constantly". They said, "I am problem solving from the minute I walk in each day."

Governance, risk management and quality measurement

- The OPD collected data monthly for the Trust Clinical Governance Report. There was a governance board in operation at the trust. The OPD matrons attended a regular trust wide quality meeting where governance data was discussed and analysed.
- There were no leadership meetings within the department although these were to be implemented from September 2014. This meant that senior staff missed opportunities to manage a team approach to governance and feedback any learning from governance to staff.
- There was some alignment with what staff perceived as a problem and the issues that were on the departments risk register such as issues with Health records. However, many of the issues raised with us during the inspection had not been identified as a risk within the department. Two examples of this are the recording of patient pathway documentation not being completed, and health records no longer being tracked.

Leadership of service

- We were unable to see clear leadership within the department. Many issues were raised during our inspection that had not been recognised as issues such as the tracking of health records. Without leaders identifying issues robust mechanisms to manage them were not in place.
- Administration managers did not have the capacity to deal with the numbers of problems that had been raised in their department due to the demands of the service and the breakdown of systems following the recent redesign of the services.
- This had left staff dissatisfied with the management arrangements within the trust with many staff unaware of who their direct line manager was.
- Where staff were raising issues they were telling us that managers were ignoring them or impotent to offer them assistance.
- Where the Trust was aware of issues such as the 18 week waiting time breaches and lack of appointment slots for follow up appointments. There were no robust systems in place to deal with this. Staff were showing us conflicting emails with instructions that contradicted themselves from different managers. Staff were unsure of what appointments they should be booking. We were shown emails as evidence of conflicting advice given to staff on booking follow up appointments for patients.
- Communications we were shown indicated a sense of panic and an unstructured approach to sorting out the issues with a lack of appointment slots.
- Many staff told us about a sense of mistrust in the management in the Trust. They talked of data being manipulated, and we were told by a few members of staff that the Trust had decided it was cheaper to pay the fines imposed for breaches in the 18 week pathway than it was to put on the extra clinics required to sort the issue out.
- Staff from all groups told us that they were feeding their concerns regarding the changes to the service and their job roles back to their managers during one to ones and staff meetings but that they felt nothing was being resolved, and their questions were not being answered by the Trust.

- All of the nursing staff that we spoke to told us that they felt supported by the matron and sisters in the OPD. Nurse Managers also told us that they were in turn supported by their manager.
- Most staff told us did not feel engaged with the executive team, and felt that they were not interested in hearing their views.
- The matron and sisters of the OPD had not had a meeting for over 18 months. This had been raised as a concern and as a result a meeting was scheduled to take place in September 2014.
- Estates staff were concerned about cuts being made to their service. They told us that there were not enough staff and that staff were not being developed in their roles. One member of estates staff described the Trusts strategy as, "Oil bought in cheaply to run the engine".

Culture within the service

- We had some examples bought to us during our inspection from staff who felt that they had been bullied by managers in the Trust these were mostly staff working in administrative roles within the trust. Some of these staff told us that they had raised their concerns formally but had been dissatisfied with the response to their concerns. Two people told us that despite their concerns being formally acknowledged and their complaints of bullying upheld they had been disadvantaged in their career as a result of making the complaint. One of the staff described this as feeling, "persecuted for speaking out".
- We also had examples bought to us where staff had felt unable to report their concerns for fear of retribution. One manager told us that they had staff crying in their office regularly due to bullying from a senior member of staff, they said "They wear the number of grievances staff have raised against them like a badge of honour, they boasted about staff that had complained about them previously. They said that they had made them leave, and then ensured that they didn't get jobs elsewhere".
- Occupational Health staff raised concerns with us about the numbers of staff referrals that were related to stress following the recent changes in the Trust. They told us that they were struggling to cope with the current high demand of referrals. Other staff told us that managers dissuaded staff from writing stress down as their reason for sickness and absence from work. In the Staff survey of 2013 the Trust rated worse than the national average for work pressure felt by staff, and staff suffering from work related stress.
- We saw staff interacting with their managers and saw that they did this in a relaxed and friendly way. The managers were seen supporting more junior members of staff when it was required.

Public and staff engagement

- The Trust had redesigned the service to create a central booking system with administration reallocated to generic roles. Staff were seeking us out during the inspection across both sites to tell us a consistent message about the failings in this process that they felt had been done far too quickly, and without fully consulting staff and understanding their roles. As a consequence essential administration roles had been missed in the redesign such as the tracking of patient health records and the recording of appointment outcomes. These omissions put patients at risk of missed appointments, and lost health records.
- Staff we spoke to were aware of the issues in the OPD around the new booking system. Staff told us that they were sometimes dealing with the stress that managing sometimes angry patients due to the problems this bought about. One member of staff described this by saying, "We are the face patients see and they are frustrated, it's not our fault but we bear the brunt of it".
- Another member of booking staff told us, "most days I will have patients shouting and swearing at me down the phone, I always ask them not to swear at me, but I can understand their frustration".
- Staff felt that they had been forced to make decisions about their roles without the support that they required to do this. For example administration staff had been told that they needed to make a choice between two job roles. They told us however, that they had not seen the job description for either role and were forced to make a decision without a full understanding of their choices.
- Staff were passionate about wanting to do a good job and wanting to work as advocates for their patients. They felt that their voices were not being heard. We spoke with many Administration staff across both sites who all repeatedly used the same words to describe

how they felt – 'undervalued, overworked, not listened too, deskilled'. They also said that they were open to change but that they wanted it to be done with consideration so that patients were not adversely affected.

- Patient views were gathered through continuous patient surveys. Notice boards in all OPD areas showed visitors and patients how their comments and complaints had been used by the OPD to improve patient's experience of the service.

Innovation, improvement and sustainability

- Staff told us they felt impotent in making positive changes to the service. They said that, where they had raised concerns or issues, that their questions were not being answered. One member of staff described this as, "We were told about the changes, and we were told they were going to happen regardless. When we raised issues with the problems that we have found, we are told it's not going back to how it was. We understand this; we know we need to make it work. We just feel that they are not listening to us when we tell them what is going wrong. I think they feel we are just all moaning for the sake of moaning, but we aren't. The system is failing patients and staff and changes need to be made urgently."
- Staff from administration and nursing roles, including department managers, all told us that they had not been consulted about the changes that had been made in the redesigning of the service. They all gave examples of where a misunderstanding of their job roles and responsibilities had meant that routine jobs were no longer being done. For example, medical records not being tracked. Staff told us that these were decisions that were made and influenced outside of their department and did not, therefore, feel able to make changes.
- In the 2013 staff survey, the trust fell below the national average for staff being able to contribute towards improvements at work, and good communication between senior management and staff.
- The department relied on the goodwill of its staff in being flexible with their shifts and taking on extra hours. This meant that the way that the department was staffed may not be sustainable in the long term.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:** Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. **Why you are failing to comply with this regulation:** • Staffing levels do not take into account the patient acuity and turnover. • There is inadequate medical cover throughout the Conquest hospital. • There are inadequate staffing levels of managers, consultant midwives and labour ward coordinators to meet the recommended minimum standards detailed in Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour, (RCOG, RCM). RCA, RCPCH, 2007). • Women in established labour do not receive one to one care from a registered midwife

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:** Safety and suitability of premises

This section is primarily information for the provider

Compliance actions

15. (1) The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of—

(a) suitable design and layout;.

(b) appropriate measures in relation to the security of the premises; and.

(c) adequate maintenance and, where applicable, the proper—.

(i) operation of the premises, and.

(ii) use of any surrounding grounds,.

which are owned or occupied by the service provider in connection with the carrying on of the regulated activity.

(2) In paragraph (1), the term "premises where a regulated activity is carried on" does not include a service user's own home.

Why you are failing to comply with this regulation:

- Facilities do not actively promote normal births.

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Supporting workers

23. (1) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by—

(a) receiving appropriate training, professional development, supervision and appraisal; and.

This section is primarily information for the provider

Compliance actions

(b) being enabled, from time to time, to obtain further qualifications appropriate to the work they perform..

(2) Where the regulated activity carried on involves the provision of health care, the registered person must (as part of a system of clinical governance and audit) ensure that healthcare professionals employed for the purposes of carrying on the regulated activity are enabled to provide evidence to their relevant professional body demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise.

(3) For the purposes of paragraph (2), "system of clinical governance and audit" means a framework through which the registered person endeavours continuously to—

(a) evaluate and improve the quality of the services provided; and.

(b) safeguard high standards of care by creating an environment in which clinical excellence can flourish.

Why you are failing to comply with this regulation:

- Staffing arrangements for the community midwifery service are not compliant with the European Working Time Regulations 1998.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Care and welfare of service users

9. (1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of—

(a)the carrying out of an assessment of the needs of the service user; and.

This section is primarily information for the provider

Compliance actions

(b)the planning and delivery of care and, where appropriate, treatment in such a way as to—.

(i)meet the service user's individual needs,.

(ii)ensure the welfare and safety of the service user,.

(iii)reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment, and.

(iv)avoid unlawful discrimination including, where applicable, by providing for the making of reasonable adjustments in service provision to meet the service user's individual needs..

(2) The registered person must have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services, in order to mitigate the risks arising from such emergencies to service users.

Why you are failing to comply with this regulation:

- Handovers on the labour ward do not ensure that the service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe
- Multidisciplinary team working at the Conquest Hospital does not ensure that the service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe
- There is not consistent compliance to the management of VTE

Regulated activity

Maternity and midwifery services Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Consent to care and treatment

This section is primarily information for the provider

Compliance actions

18. The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Why you are failing to comply with this regulation:

- Staff do not have a sound understanding of how to obtain and record that informed consent has been sought before any clinical intervention.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Records

20. (1) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of—

(a)an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and.

(b)such other records as are appropriate in relation to—.

(i)persons employed for the purposes of carrying on the regulated activity, and.

(ii)the management of the regulated activity..

(2) The registered person must ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are—

(a)kept securely and can be located promptly when required;.

(b)retained for an appropriate period of time; and.

(c)securely destroyed when it is appropriate to do so.

This section is primarily information for the provider

Compliance actions

Why you are failing to comply with this regulation:

- The outpatient department was not protecting patient's confidential data. Patient records were left in public accessible areas without staff present and failing to comply with the Data Protection Act 1998.
- The outpatient department were not tracking patient health records because this job had not been considered during the redesigning of the service. The location of medical records were often unknown and resulted in delays or temporary notes being used. Trusts have a responsibility to track all patients' health records (Records Management - NHS Code of Practice Part 2 January 2009).

Ensure that medical records and other sources of confidential personal information are managed such that the service is compliant with the requirements of the Data Protection Act 2003 and the guidance issued by the professional associations and Royal Colleges.

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states: Safety, availability and suitability of equipment 16. (1) The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is— (a) properly maintained and suitable for its purpose; and. (b) used correctly.. (2) The registered person must ensure that equipment is available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs.

This section is primarily information for the provider

Compliance actions

(3) Where equipment is provided to support service users in their day to day living, the registered person must ensure that, as far as reasonably practicable, such equipment promotes the independence and comfort of service users.

(4) For the purposes of this regulation—

(a)"equipment" includes a medical device; and.

(b)"medical device" has the same meaning as in the Medical Devices Regulations 2002(1).

Why you are failing to comply with this regulation:

- Resuscitation equipment in the out patients departments was not all fit for purpose.
- Emergency equipment is not regularly checked.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states: Management of medicines 13. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. **Why you are failing to comply with this regulation:** • The management of medicines within the ED, including storage and recording of temperatures, was not being carried out in accordance with national guidelines • In Outpatients it could not be assured that medicines were stored at the correct temperatures.

This section is primarily information for the provider

Compliance actions

- In Outpatients medicines were not being prescribed and dispensed in line with relevant legislation. The department had not ensured that when medicines were prescribed and dispensed the prescription and dispensing complied with relevant legislation.

Regulated activity

Maternity and midwifery services Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Assessing and monitoring the quality of service provision

10. (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to—

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and.

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity..

(2) For the purposes of paragraph (1), the registered person must—

(a) where appropriate, obtain relevant professional advice;.

(b) have regard to—.

(i) the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19,.

This section is primarily information for the provider

Compliance actions

(ii) any investigation carried out by the registered person in relation to the conduct of a person employed for the purpose of carrying on the regulated activity,.

(iii) the information contained in the records referred to in regulation 20,.

(iv) appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a)),.

(v) reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these Regulations, and.

(vi) periodic reviews and special reviews and investigations carried out by the Commission in relation to the provision of health or social care, where such reviews or investigations are relevant to the regulated activity carried on by the service provider;.

(c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to—.

(i) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and.

(ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies;.

(d) establish mechanisms for ensuring that—.

(i) decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person (P), and.

(ii) P is subject to an appropriate obligation to answer for a decision made by P, in relation to the provision of care and treatment for a service user, to the person responsible for supervising or managing P in relation to that decision; and.

(e) regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are

Compliance actions

employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users..

(3) The registered person must send to the Commission, when requested to do so, a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (1) are being complied with, together with any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

Why you are failing to comply with this regulation:

- The governance and incident reporting structure and the way information is collected does not ensure that data is accurate and robust in order to be used to inform service improvements.
- Outpatient staff do not report incidents in accordance with Trust policy and statutory requirements.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Respecting and involving service users

17. (1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure—

(a)the dignity, privacy and independence of service users; and.

(b)that service users are enabled to make, or participate in making, decisions relating to their care or treatment..

(2) For the purposes of paragraph (1), the registered person must—

(a)treat service users with consideration and respect;.

This section is primarily information for the provider

Compliance actions

(b)provide service users with appropriate information and support in relation to their care or treatment;.

(c)encourage service users, or those acting on their behalf, to—.

(i)understand the care or treatment choices available to the service user, and discuss with an appropriate health care professional, or other appropriate person, the balance of risks and benefits involved in any particular course of care or treatment, and.

(ii)express their views as to what is important to them in relation to the care or treatment;.

(d)where necessary, assist service users, or those acting on their behalf, to express the views referred to in sub-paragraph (c)(ii) and, so far as appropriate and reasonably practicable, accommodate those views;.

(e)where appropriate, provide opportunities for service users to manage their own care or treatment;.

(f)where appropriate, involve service users in decisions relating to the way in which the regulated activity is carried on in so far as it relates to their care or treatment;.

(g)provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement; and.

(h)take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have.

Why you are failing to comply with this regulation:

- The privacy and dignity of patients is not being upheld. There are same sex breaches within the Clinical Decision Unit (CDU).

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Maternity and midwifery services Surgical procedures
Treatment of disease, disorder or injury

Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:

Complaints

19. (1) For the purposes of assessing, and preventing or reducing the impact of, unsafe or inappropriate care or treatment, the registered person must have an effective system in place (referred to in this regulation as "the complaints system") for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf, in relation to the carrying on of the regulated activity.

(2) In particular, the registered person must—

(a)bring the complaints system to the attention of service users and persons acting on their behalf in a suitable manner and format;.

(b)provide service users and those acting on their behalf with support to bring a complaint or make a comment, where such assistance is necessary;.

(c)ensure that any complaint made is fully investigated and, so far as reasonably practicable, resolved to the satisfaction of the service user, or the person acting on the service user's behalf; and.

(d)take appropriate steps to coordinate a response to a complaint where that complaint relates to care or treatment provided to a service user in circumstances where the provision of such care or treatment has been shared with, or transferred to, others..

(3) The registered person must send to the Commission, when requested to do so, a summary of the—

(a)complaints made pursuant to paragraph (1); and.

(b)responses made by the registered person to such complaints.

Why you are failing to comply with this regulation:

- The complaints handling process does not ensure that the services learns and improves as a result.