This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

**Hospital sites at the trust**

**Service Overview:**
East Sussex Healthcare NHS Trust (ESHT) is a provider of acute and specialist services that serves a population of 525,000 people across East Sussex. It provides a total of 833 beds with 661 beds provided in general and acute services at the two district general hospital (Eastbourne District General Hospital and Conquest Hospital, Hastings) and at local community hospitals. In addition there are 45 Maternity beds at Conquest Hospital, and the midwifery led unit at Eastbourne District General Hospital and 19 Critical care beds (11 at Conquest Hospital, 8 at Eastbourne District General Hospital).

At Bexhill Hospital, East Sussex Hospital Trust provide outpatients, ophthalmology, rehabilitation and intermediate care services. At Rye, Winchelsea and District Memorial Hospital, ESHT provide outpatient and inpatient intermediate care services. At Firwood House the trust jointly provide, with adult social care, inpatient intermediate care services. The trust provides some services at Uckfield community hospital. Community staff also provide care in the patient’s own home and from a number of clinics and General Practitioners (GP) surgeries in the area.

The trust’s main Clinical Commissioning Group’s (CCG) are Eastbourne, Hailsham and Seaford Commissioning Group, Hastings and Rother Clinical Commissioning Group and High Weald Lewes And Havens Clinical Commissioning Group. Eastbourne Hailsham and Seaford CCG, Hastings and Rother CCG, East Sussex County Council and the Trust are partners in the East Sussex Better Together programme.

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

At the last inspection undertaken in 2016, the trust was found to be in breach of the following regulations under HSCA (RA) Regulations 2014. These were: Regulation 18 – Safe staffing

The hospital sites are listed below. A full list is provided in the link in the source:

<table>
<thead>
<tr>
<th>Name of hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexhill Hospital</td>
<td>Holliers Hill, Bexhill, East Sussex, TN40 2DZ</td>
<td>Diagnostics, Outpatients, Surgery, Community inpatients, Adult community, Sexual health</td>
<td>Bexhill Hastings and surrounding areas</td>
</tr>
<tr>
<td>Conquest Hospital</td>
<td>The Ridge, St Leonards-on-Sea, East Sussex, TN37 7RD</td>
<td>Critical care, Diagnostics, End of life care, Gynaecology, Maternity, Medical care (including older people's care), Services for children and young people, Surgery, Urgent and emergency services, Adults Community</td>
<td>East Sussex</td>
</tr>
<tr>
<td>Crowborough War Memorial Hospital</td>
<td>Southview Road, Crowborough, TN6 1HB</td>
<td>Adult community, Community sexual health</td>
<td>Crowborough</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Kings Drive, Eastbourne, East Sussex, BN21 2UD</td>
<td>Critical care, Diagnostics, End of life care, Maternity, Medical care (including older people's care), Outpatients, Services for children and young people, Surgery, Urgent and emergency services, Adults Community</td>
<td>East Sussex</td>
</tr>
<tr>
<td>Rye, Winchelsea and District Memorial Hospital</td>
<td>Peasmarsh Road, Rye, East Sussex, TN31 7UD</td>
<td>Adult community, Community services for children, young people and families, Community inpatients</td>
<td>Rye area</td>
</tr>
<tr>
<td>Uckfield Community Hospital</td>
<td>Framfield Road Uckfield, TN22 5AW</td>
<td>Adult community, Community dental, Community sexual health</td>
<td>Uckfield</td>
</tr>
</tbody>
</table>

Financial Status:

This trust was placed in financial special measures in October 2016 because of a large financial deficit. The Finance Director reports a Financial Special Measures Update to each board meeting. The Finance Director reported in February 2018 that the trust's financial position at the end of month 9 had led to the need for a formal reforecasting of the financial position for 2017/2018. The
reforecasting had been discussed at the Finance and Investment Committee and had been discussed and agreed with NHSI.

The trust had planned to deliver a £36.4 million deficit, before Sustainability and Transformation Funding (STF), but the updated forecast was £57.4 million deficit, before SFT funding. Key drivers for the changed position were the non-delivery of £6.1 million of Cost Improvement Programmes (CIP), a reduction in elective activity and increased costs associated with drugs, clinical and supporting equipment and adverse mediation. Financial improvements being introduced were intended to be both realistic and sustainable in order to realise greater improvements during 2018/2019.

The CEOs report for the Trust Board Meeting held in Public on 6 February 2018 showed that an external consultancy firm has undertaken a review of the Trust’s underlying deficit for 2016/2017 and had shown this to be £57 million. The trust was forecasting a deficit of £57 million for 2017/2018 with an underlying position of £54 million. This appeared to show the trust financial position was stabilising and that this demonstrated improved control and financial grip had been achieved. This improved control was expected to deliver a £4.6 million saving during quarter 4 of 2017/2018.

Is this organisation well-led?

Leadership

As part of the inspection process, we interviewed all the members of the board, both the executive and non-executive directors, and a range of senior staff across the hospital. We looked at performance and quality reports, audits and action plans. We attended a board meeting, looked at previous board meeting minutes and papers to the board. We also attended an embedded learning event and visited operational areas of the hospital to speak with staff about how they perceived the trust culture and the impact of the financial situation on their work. We attended a board sub-committee meeting and site management meetings.

We looked at investigations of deaths, serious incidents and complaints. We sought feedback from patients, local people and stakeholders. We spoke with a wide range of staff and asked their views on the leadership and governance of the trust.

The trust had continued to make improvements since the last inspection, despite being placed in financial special measures. The trust leaders were very aware of the gravity of their financial situation but were unanimously committed to ensuring the ongoing quality and safety of patient care. The trust leadership team had a comprehensive knowledge of current priorities and challenges across all sectors, and took action to address them.

The work of East Sussex Healthcare NHS Trust was overseen by the trust board, which had a statutory responsibility for the trust. The trust board had the appropriate range of skills, knowledge and experience to perform its role.

The board consisted of a chair (non-executive), five other non-executive directors (voting members), the chief executive, and five executive directors (voting members). Other directors (non-voting) also attended the board, and contributed to its decision-making.

Non-executive directors are members of the public who live in the area that the trust serves and who responded to advertisements for the posts. The Secretary of State for Health, via NHS Improvement, appoints the chair and the other non-executive members. Technically, they are not
employees of the trust (and have no employment rights), and the terms of their appointment (including their remuneration) are set by NHS Improvement.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience.

Dr Adrian Bull joined the trust as Chief Executive on 11th April 2016. Dr Bull was previously the Managing Director of Imperial College Health Partners and chair of the National Academic Health Science Network. He was also the Chief Executive of another NHS Trust from 2008 to 2013.

The Chief Operating Officer, Joe Chadwick-Bell, joined the trust as in November 2016. Joe has significant experience of the NHS having worked in Ambulance and Acute Provider Trusts and at the Strategic Health Authority. Joe joined the trust from the UK's largest independent provider of health and social care, where she was Regional Director for London. Prior to that she was a Board Director at another NHS Trust.

The Medical Director, Dr David Walker, is a consultant cardiologist who was appointed in August 2016. He is currently Vice President of the British Cardiovascular Society and a member of the board of the ACCA at the European Society of Cardiology. He was the national clinical lead for heart failure 2007-13. Dr Walker is the Caldicott Guardian for the trust.

The Director of Nursing, Vikki Carruth, joined the trust in October 2017 having been Director of Nursing and Quality at another NHS Trust for three years and previously Deputy Chief Nurse in London prior to that.

The Director of Finance, Jonathan Reid, joined the trust on 13th June 2016. Jonathan has worked in public finance for over 20 years. After training as a chartered accountant he joined the National Audit Office, where he worked across a number of government departments, including a number of years working across health and local government at the Audit Commission. Jonathan joined a community NHS Foundation Trust in 2011 as Director of Finance and has been Deputy Chief Executive of that trust since 2014. Jonathan is the SIRO (Senior Information Risk Officer) for the Trust.

The Director of Human Resources, Monica Green, was appointed in June 2002. Monica has worked within the NHS since 1987 in a wide variety of Human Resources roles, both within the acute hospital sector and at a Regional Health Authority level.

The Director of Strategy, Catherine Ashton, has worked in health, social care and the voluntary sector in both provider and commissioning organisations for nearly thirty years. Prior to working at East Sussex Healthcare NHS Trust, Catherine was associate Director of Strategy and Whole Systems with local Clinical Commissioning Groups.

The Director of Corporate Affairs, Lynette Wells, joined the trust in February 2012. She has responsibility for corporate governance, including legal and communications. She is a qualified company secretary, with a Masters in Medical Law. Prior to joining the NHS in 2008 she held company secretarial positions in the commercial sector.

The board chair, David Clayton-Smith, joined the trust on 11th January 2016. David is Chairman of the Kent, Surrey & Sussex Academic Health Science Network and was previously the chair of NHS Surrey for three years from 2010. He was also the chair of NHS Sussex between 2012 and 2013 and has been a non-executive director at an NHS Foundation Trust for the last three years including involvement in the acquisition of the another Foundation Trust.

The trust had five non-executive directors. They had a variety of backgrounds, which included previous experience as a Director of Operations in an NHS trust, the Dean of Human and Health
We spoke with the non-executive directors and were assured that collectively they had a clear understanding of their roles and responsibilities. Most non-executive directors were very well informed and engaged with the strategic development of the trust but this was not universally so.

The executive team told us they had healthy challenge and debate from the non-executive directors and we observed a board meeting which confirmed this was the case. However, the minutes of the board meetings did not always reflect the level of challenge provided by the non-executive directors.

The chair of the trust board and its non-executive directors are independently appointed by NHS Improvement. The chief executive and other executive posts serving on the trust board are appointed by the trust in liaison with NHS Improvement. All members of the trust board were subject to a performance framework which stipulates that: The chair of the trust board is appraised via a national framework operated by NHS Improvement; non-executive directors and the chief executive are appraised by the chair; executive directors are appraised by the chief executive.

The service had a service level agreement with a local mental health trust to Mental Capacity Act administration and training staff on MCA (2005). The SLA was overseen by the COO and the executive lead was the Director of Nursing.

Mental health services were commissioned from a local mental health trust which supported people with mental health problems in the acute hospitals. Staff from the mental health trust worked out of the emergency departments and could provide a timely response to people in mental health crisis. The safeguarding team had a lead for ensuring compliance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

We reviewed six of the executive and non-executive files and saw the administrative and employment processes to ensure fit and proper persons were employed were in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust board secretary managed the quality of confidential record keeping and documentation control, along with regular reviews.

Fit and Proper Person checks were in place. All of the records referred to in the fit and proper person’s requirement and due diligence checks were retained within the individual files to indicate the checks had been undertaken.

The dates when appraisals were undertaken was noted on the fit and proper person’s requirement checklist for executive directors where they had been in post sufficient time for this to have taken place. In relation to the non-executives, the appraisal documentation was held on individual fit and proper persons requirement files which confirmed the appraisals were undertaken by the chair.

The non-executive directors were provided with training and support to fulfil the obligations of their roles. The Chair of the Quality and Safety Committee told us they attended NED Updates at least annually, had completed training on HR appeals and on Strategic Models for Integrated Care. There was a clear delineation between mandatory and non-mandatory training for non-executive directors.

The trust had five clinical divisions. These were the Emergency Care division, Medicine Division, Diagnostics, Anaesthetics and Surgery Division, Women, Children and Sexual Health Division and Out of Hospitals Division.
Each division was managed by a triumvirate team, consisted of a clinical lead, a head of nursing and a divisional manager.

The People and Organisational Development Committee had been created in response to the previous “Done to” culture. The non-executive directs that we spoke with about the work of this committee felt that they had much improved assurance around the organisational culture. They felt that there was greater pride in the organisation across all workforce groups and grades. They felt that there was now good leadership with strong individual executive directors who were supported and challenged by the non-executive directors.

There was a feeling amongst the non-executive directors that the changes to date had been very executive led and management focussed (by necessity) but moving forward there was a need to empower staff at all levels to take ownership more. They talked about an earned autonomy where local teams with demonstrable effectiveness could be given greater control and allowed to innovate more at a local level.

Board members were encouraged to visit departments. There was a programme of board visits to services and staff fed back that leaders were approachable. We saw reports to the board which detailed visits by various board members to different areas of the trust, which indicated this was occurring. The non-executives that we spoke with could identify where their engagement and visits had led to changes or provided them with assurance that the information provided in the board papers was an accurate reflection of the services being provided.

Between 1 July 2017 and 31 October 2017, 22 formal Quality Walks were recorded. Executive directors visited more frequently but these were not logged formally as Quality Walks. The information from the Quality Walks was analysed and themed for reporting to the full board. The reports focussed on communication and engagement, incidents and safety issues, staffing, patient feedback and any other issues.

Staff told us they felt the leadership team were visible and the non-executive directors met with staff both informally and on request. Staff were particularly impressed by the level of contact and accessibility of the Chief Executive Officer; they felt he knew everyone’s names and remembered things about them as individuals.

We were told in a focus group of senior nurses that the culture had changed because of the leadership provided by the CEO. They described him as a natural leader, a calm role model and a consistent presence. It was said that all roles and grades of staff found him approachable and that his influence has rippled across the trust. It was felt that the senior manages now listened more effectively and understood the challenges staff faced.

Succession planning was in place throughout the trust. The workforce strategy incorporated leadership and talent management. Succession planning and talent management within the divisions was managed through the appraisal process and business planning and development opportunities were available dependent on individual need.

We heard about an example of succession planning when talking with the Head of safeguarding. They had identified that they wanted to retire within a relatively short timeframe. In order to ensure the service was able to remain properly resourced they had offered job sharing opportunities and have attracted new staff as well as developing existing staff by offering secondment to complete master’s level modules in safeguarding which was a pre-requisite for the role.
Several organisational development initiatives had been put in place focussing on improving the culture by developing manager’s leadership skills through training and reflection. Opportunities and support included

- “Leading Excellence” an 18 month bespoke development programme
- New manager induction training
- 1st line manager programmes for bands 5 – 7
- Band 1-4 development as part of the ‘grow your own’ ethos
- A coaching and mentoring programme
- Improved mediation opportunities.

We looked at 10 staff files and saw they were complete, contained job descriptions, qualifications, professional registration checks, disclosure and barring service checks, references, occupational health clearance, fitness to practice declarations and evidence of right to work. We saw examples where staff had undergone capability reviews and evidence all meetings were documented and clear processes followed.

**Board Members**

Of the executive board members at the trust, there were no British Minority Ethnic (BME) and 62.5% were female.

Of the non-executive board members there were no BME and 50.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>57.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity)

**Vision and strategy**

The trust had a clear vision and set of values with quality and longer term sustainability as the top priorities. The trust’s vision was to combine community and hospital services to provide safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex.

The trust’s stated aim was to be an outstanding organisation by 2020 and the objectives and actions that they need to undertake to make sure they achieve this aim. All staff we met knew the vision and frequently quoted “Outstanding by 2020”.
They aimed to deliver their vision through their core values:

- Respect and compassion
- We care about acting with kindness
- Engagement and involvement
- We care about involving people in our planning and decision making
- Improvement and development
- We care about striving to be the best
- Working together
- We care about building on everyone’s strengths.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. Staff knew and understood the trust’s vision, values and strategy and how the achievement of these applied to the work of their team. Staff we spoke with during the inspections knew the trust’s’ values and felt they delivered their services in line with them. Some talked about their involvement in creating the values.

This was to be achieved through five strategic objectives for the organisation:

- Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
- All ESHT’s employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
- We will work closely with commissioners, local authority, and other partners to plan and deliver services that meet the needs of our local population in conjunction with other care services.
- We will operate efficiently and effectively, diagnosing and treating patients in timely fashion and expediting their return to health.
- We will 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.

The trust was committed to providing clinical services that achieved and demonstrated the best clinical outcomes. Leaders wanted every staff member to feel valued and respected. The leadership team had identified elements which would be key to developing a culture of quality improvement. They were:

- Providing quality and safety as the top priority
- Good leadership and culture throughout the organisation
- A clear clinical strategy to fulfil their role as the lead provider of hospital and community healthcare services in East Sussex
- A commitment to meet all access and operational delivery targets
- Management of the trust finances and capital development.
An example of changes to practice resulting in reduced costs was shared by one of the nonexecutive directors. Using the Model Hospital Framework the trust had brought together the work of the orthopaedic teams on both sites and reduced costs whilst improving patient outcomes.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The trust strategy had been designed to provide a guide as to how the trust would need to evolve over the next five years to fulfil its vision. The trust had aligned its vision with the Five Year Forward View. The NHS Five Year Forward View was published in October 2014 and set out a new shared vision for the future of the NHS based around new models of care. This included the need for acute trusts to provide services with community based service providers.

There was a robust and realistic strategy for achieving the priorities and developing good quality, sustainable care across all sectors. Local providers and people who use services had been involved in developing the strategy. The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. The trust had planned services to take into account the needs of the local population. The trust worked in partnership with commissioners, other providers, our staff and volunteers as part of a locally focused and integrated network of health and social care in the county called East Sussex Better Together (ESBT). The alliance focussed on early intervention and keeping people well, whilst ensuring the provision of high quality hospital care and specialist services. ESBT had already created integrated health and social care teams to support this work, for example nurse led Crisis response teams and a multidisciplinary frailty team.

The trust strategy was developed from a clinical strategy. The ESBT initiative allowed an opportunity to redesign pathways from end to end. The trust looked at priorities and took this approach for the following ten clinical areas.

- Maternity & Obstetrics
- Cardiology
- Acute Paediatrics
- Dementia interface with ESHT
- Community Paediatrics
- Mental Health interface with Acute Medicine
- Respiratory
- Diabetes and Endocrinology
- Trauma & Orthopaedics
- Ophthalmology

We looked in depth at the redesigned Supportive and Palliative Care Service provided by ESHT, as this was a service that reached across all areas of the trust. It had been an area that required improvement following our previous inspection visits in March 2015 and October 2016. There had been a lack of clarity about leadership and confusion about referral criteria. Between the two inspections, many of the concerns raised by members of the public directly with CQC were linked to poor end of life care. There were separate palliative care services on each acute site with differing working practices. In response a new Supportive and Palliative Care service (SPCS) was developed to improve the care being delivered. The work streams for the new service fed into the trust End of Life steering Group and was chaired by an assistant director of nursing. This group reported to both the Quality and Safety Committee and externally to the ESBT Clinical Reference group.

Leadership of the team had improved with a clinical lead consultant who worked across the trust and at the local hospice. The referral criteria had been left as open as possible to encourage ward and community staff to make contact and seek advice. In-reach referrals were also accepted by members of the team who were visiting wards to discuss patients or to engage with ward staff about end of life care. This has led to a significant increase in referrals with a single point of
referral on each site and a high presence in clinical areas. The local hospice provided advice and support out of hours. There was funding for an additional consultant post to allow expansion to a seven day service and to offer extended hours but the trust had been unable to fill the post.

There was clear evidence that the newly designed service had brought about improvements in patient care. During 2017 and 2018, there have been very few concerns raised directly with CQC about end of life care at the trust. There had been a 32.5% increase in referrals across the trust with a 58.5% increase on the Conquest Hospital site. There had been a steady increase in the referral of patients with non-malignant conditions. The majority of patients (88%) were seen within 1 working day by a member of the team. The team managed to review 60% of patients referred on the same day. A team of junior doctors were working with the team auditing the Individualised End of Life Care Plan against NICE QS 144 on a monthly basis. Results from the staff feedback survey showed an improved awareness of the team and services they provided with 72% of staff saying they were fully aware of the SPCS and a further 27% acknowledging some awareness.

The redesign of the service has undoubtedly improved patient care as they approach the end of their life and this was the primary reason for making the changes. There were capital costs involved in supporting the provision of an additional consultant and appointing a nurse team leader but in the longer term these costs will be offset by the cost reductions generated by higher quality care.

The introduction of the ESBT Alliance provided the trust with a chance to design the system as it should be. They were not restricted by the current organisational structures and funding arrangements. It allowed the trust and other stakeholders to build services around the patient. ESHT secured Improvement Methodologies training from NHS Elect and all those involved in the ten clinical areas were invited to attend one of the three training sessions. Over a hundred people attended including patients, staff from ESHT, primary care, the local mental health trust, public health and the third sector. The NHS Elect training equipped the trust to define a strategic aim, diagnose and identify the areas where they could make improvements and provided them with a range of approaches to implement the improvements.

The minutes of the Trust Board Meeting in Public dated September 2017, evidenced ongoing work with partner organisations and the evolution of the proposed Sussex and East Surrey Sustainability and Transformation Plan (STP). A programme board of 24 organisations was proposed with an executive group sitting below this, chaired by a part-time executive chair. A clinical board had already been established and sat alongside the financial board. The current structure was felt to be sufficiently robust to make difficult decisions as was evidenced by a discussion about the siting of a tertiary centre at Brighton.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. The Clinical Strategy was to be reviewed and refreshed annually/ Additional work was being undertaken to align the clinical strategy, the long term financial plan and business planning into a future state model.

It was apparent from the minutes of board meetings that the non-executive directors provided challenge and questioned elements of the strategy. There was a query raised about whether a reduction in bed numbers conflicted with a potential 11% population growth. The discussion showed that further work as needed with the wider stakeholder community and that there had to be changes to how and where services were delivered.

The minutes of the Trust Board Meeting in Public dated November 2017 showed that the board had ratified the Clinical Strategy and noted that it was an iterative strategy that would be developed alongside clinical teams moving forward into 2018/2019.
As part of the overall clinical strategy, there were four work streams that included a workforce, estates’, digital and quality and safety

The trust's vision overarched the values, which delivered the strategic objectives and helped to support the strategic focus.

**Culture**

The trust recognised engagement and communication with staff had historically been a serious concern, which had impacted significantly on the culture of the organisation. The Chair and Chief Executive acknowledged that when they took up post, ESHT was an organisation where they had had to build bridges and regain the trust of the staff.

A non-executive director told us that they had visited the emergency department to thank the staff for working on the four week challenge and improving the four hour wait performance so that more patients were seen more quickly. They were told by one of the consultants that this was the first time they had received thanks in this way.

The trust’s strategy, vision and values underpinned a culture which was patient centred. Staff felt positive and proud about working for the trust and their team. We found throughout the organisation an open and honest culture. Staff felt able to raise concerns amongst their peers and with leaders. Leaders and staff understood the importance of staff being able to raise concerns. Staff spoke positively about the organisational leaders and felt them to be both recognisable and approachable. The trust had held a series of roadshows with staff to reach as many employees as possible.

It was recognised by the board that there had been a divided consultant body based on the site where they mainly worked. There was also a culture of bullying behaviour and many consultants appeared to role model a 1960s way or working (directive, remote, apportioning blame). The CEO met with the consultant body within his first two days in post. About 150 out of the total 230 attended a meeting where the new expectations were set out explicitly. These included:

- The trust was dependent on the consultants for clinical leadership.
- A divided trust was not an option and there was to be no relationship divide across the two sites.
- Any inappropriate behaviour would be dealt with.
- It was necessary to involve consultants in the wider leadership issues facing the trust and that the board was keen that they work together with the consultants.

A clear example of taking swift and strong action to deal with poor behaviour towards other staff was given by several people we spoke with. The message was clear that consultants shouting at other staff would not be tolerated. This message had spread and reached all levels of the organisation quickly.

The CEO talked to us about pockets of issues that had been “festering for years” without being properly addressed. It was clear that action was taken to ensure that the cultural norm of bullying and nepotism was no longer tolerated. Formal action was taken in several departments where there were particular longstanding concerns.

There was evidence that the medical director had recommended disciplinary action and made referrals to the GMC during his two year tenure. This demonstrated that the trust took action where behaviour or clinical competence was an issue.
We were also told about an issue where a doctor was not adhering to best practice and trust policy around being bare below the elbows. The medical director had intervened and made it clear that the doctor was required to follow the trust policy and idiosyncratic behaviour would not be tolerated.

The minutes of the Trust Board meeting in Public, dated November 2017, showed that there had been six disciplinary hearings between April 2017 and September 2017. Two cases resulted in dismissal, three is a final written warning and one had no sanction applied. This demonstrated that although the trust wanted to build a positive culture, they were prepared to take action to address poor practice and inappropriate behaviour, when necessary.

Other trust staff used social media to spread positive messages about the work that staff were doing. One campaign #our marvellous teams celebrated the work of staff and volunteers across the trust. The posts were as diverse a sharing the ‘Sock it to Sepsis campaign, the pharmacy team having a baking day for Macmillan, CCU and ward staff celebrating International Nurses day and spinning classes for staff.

The trust had appointed a Freedom to Speak-up Guardian in line with the principles and role profile produced by the National Guardian and following recommendations of the Francis report. The Freedom to Speak Up Guardian is a mandatory role within all NHS and Foundation trusts. The National Guardian Office recommends that the board receive regular reports from the Speak Up Guardian. The CEO meets monthly with the Speak Up Guardian and was said to have responded to any concerns that required support.

The Freedom to Speak Up; Raising Concerns (Whistleblowing) Policy was ratified by the Patient Documentation and Policy Ratification Group in June 2017. The policy was developed in consultation with the HR team, the Speak Up Guardian, the Workforce Policy Group, the Joint Staff Committee, the Trust Policy Group and Counter Fraud.

The Speak Up Guardian was involved in work that included

- Monitoring behaviours including bullying and harassment through the electronic incident reporting system and then working with HR to ensure a robust investigation and resolution.
- Introducing a tool to help staff manage level 1 and level 2 incidents.
- A review of incidents involving violence or aggression.
- Supporting staff returning to work with wellbeing concerns after a period of absence.
- Attending team meetings to ensure that staff are aware of the role and how to make contact if they have concerns.

The Speak Up Guardian Log for 2017/2018 showed that in quarters 1 there were 75 contact and in quarter 2 61 concerns were raised.

A concern raised through the electronic incident reporting system, showed that a staff member was concerned about the response when a member of the public collapsed. The Speak Up Guardian was involved and working with several teams across the trust, a new protocol was put in place, posters were designed to heighten awareness and feedback was given to the team member who reported the incident.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. A local survey of staff who had used the Speak Up Guardian resulted in positive feedback about the Speak Up Guardian service. Whilst the level of returns was low, the survey provided
significant feedback in narrative form with ideas and suggestions about how the service could be improved.

Staff felt the Speak Up Guardian was accessible with 93% stating that it was easy or very easy to contact the Speak Up Guardian. All staff, 100%, who completed the survey said they had received a timely response. Most staff, 89% felt that they had been completely supported by the Speak Up Guardian and 96% would recommend the Speak Up Guardian to a colleague.

The Speak Up Guardian benchmarked the level of contact they received with other NHS trusts. ESHT was an outlier in terms of the number of cases raised but more work is needed to understand whether this is because the Speak Up Guardian is both accessible and perceived as approachable, or whether there are more concerns across ESHT. The role at ESHT was full time, which was not the case in many other trusts, and this conceivably increased visibility and consequently the contact they received from staff.

Most staff that we spoke with told us they felt the human resources team were very approachable and open. They felt employee relations had improved significantly and were now fair and consistent. The human resources team told us there were a decreasing number of disciplinary actions as they had worked with staff and managers to resolve matters informally at an earlier stage.

There were a small number of staff who remained unhappy with the way historic concerns had been dealt with and who felt that the human resources team had not always addressed their concerns in an appropriate way.

Staff told us they would be happy to challenge poor performance. We saw personnel files which detailed actions taken with staff as a result of concerns in line with the trust’s performance management policy. This included fitness to practise assessments and referrals to professional bodies.

The trust worked appropriately with trade unions. We met with representatives from staff organisations including the Society of Chiropody, GMB, Unison, the RCN and the Chartered Society of Physiotherapy. We were told that the culture was “Beginning to turn” and the CEO and board were more open and candid. The representatives reported a more accessible executive with a CEO who knew their names and who responded to their emails. There was some concern about middle managers who had not moved as fast as the rest of the organisation and where there were still some episodes of bullying being reported as being at band 8a level. It was said that not all staff organisation representatives were offered protected time for union work. Representatives reported a very positive relationship with the Speak Up Guardian.

Implementing the Workforce Race Equality Standard is a requirement for NHS commissioners and NHS healthcare provider. It provides information and data so that the trust can ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

We saw the trust had completed the Workforce Race Equality Standard reporting template and had an action plan arising from it. This was included in the annual equality report and monitored by the director of workforce and through the workforce committee.

The trust had lesbian, gay, bisexual, transgender, disability and cultural diversity networks in place. Staff told us they welcomed them and they were well supported by managers.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust staff could access an employee assurance line, which could be used by family members too.
Sickness and absence figures were not outliers. A trust's sickness level can be an indicator of culture within an organisation. The trust's sickness levels between November 2016 and October 2017 followed the England average trend for the whole time period. The trust sickness absence rate was better than that of the England average and found to be around 3% at April 2017 compared to around 4% for the England average.

The trust had achieved 100% compliance with medical revalidation, which was better than other trusts. The nursing revalidation rates were also good with just a single nurse forgetting to complete the process initially.

We attended an Out of Hospital embedded learning event for staff working in the community including nurses, administrators, physiotherapists, speech and language therapist and occupational therapists. This was the third event in a year with around 80 people attending. Sessions included How to feel empowered in uncomfortable situations and looked at bullying and harassment and was a balance of presentations, group work and light hearted interludes. The session was attended by the Freedom to Speak Up Guardian, Heads of Nursing, the Health and Wellbeing Lead and the Equality and Diversity Lead. The staff groups felt engaged and there was a focus on making staff feel valued.

At the learning event we spoke with a group of allied healthcare professionals. They reported an open culture with a focus on learning and improving. All of the staff we spoke with understood the role of the Freedom to Speak Up Guardian. All were positive about the visibility of senior leaders and the CEO in particular who was described as “Very present”.

We spoke with a senior nurse who had left because of bullying but returned 2 years ago when the CEO changed. They reported an excellent culture with a focus on learning and where all leaders were approachable and where difficult conversations around concerns were now accepted. They told us the trust values were lived by the senior leadership team.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>46.6%</td>
<td>73.4%</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.3%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>21.5%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Black</td>
<td>2.8%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>3.4%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>21.0%</td>
<td>12.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity)

Staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. Staff networks were in place promoting the diversity of staff.

The community served by the trust has a very white demographic with 10.5% identifying as black or minority ethnic including white Irish). Excluding white Irish participants, the figure reduces to 8.5% BME people living in East Sussex. East Sussex is less ethnically diverse that the South East
region (14%) or nationally (17%). The trust had representation of 17% BME staff at band 7 and above although there were no visibly BME directors.

The trust equality and diversity lead spent time on the wards meeting with staff and discussing issues staff felt were important.

There was a BME group and a LGBT plus group for staff although attendance was said to be variable. The trust was represented at Pride events in both Eastbourne and Hastings. The LGBT plus group was moving towards becoming a virtual group via social media.

The BME group first met in 2016/2017 and has continued to meet bi-monthly since then. The group has oversight of the Workplace Race Equality Standards (WRES) report and their views feed into the trust board via the People and Organisational development subcommittee.

The trust had an Equality and Diversity Strategy with four key objectives. These objectives were created using the Equality Delivery System for the NHS – EDS2 and the WRES indicators.

- To review all incidents reported via the electronic incident reporting system and to ensure they were considered from an equality perspective. There had been no serious incidents related to discrimination or around protected characteristics.

- To increase representation of black or minority ethnic staff at a senior level. Where interviews are being conducted without a black or minority ethnic interviewer on the panel, the equality and diversity lead will sit in on the interview.

- To ensure all policies and procedural documents underwent an Equality Impact Assessment. At the time of the inspection visit, all trust policies and protocols had an Equality and Diversity Impact Assessment as an appendix to the main body of the document.

- The fourth objective related to translation services for patients.

There was an increase in BME staff in non-clinical bands 8a and 8d during 2016/2017. There was a simultaneous reduction in the number of BME staff at band 7, 8b and 8c but this was seen as a positive step as it was mainly due to career progression.

Clinical bands 1, 2, 3, 4 5, 8a and dental staff have all seen an increase in the number of BME staff.

The trust provided Cultural Support Workshops to support overseas doctors with their written and spoken English skills.

The proportion of BME staff who believed they were provided with equal opportunities for career progression or promotion had improved from 63.7% in 2015/2016 to 75.2% in 2016/2017.

The Equalities Analysis Report 2016/2017 showed key areas for focus of the trust’s equalities work. These included

- A further review of the disabilities access audit to identify areas where improvements were required. This was being managed by the disability staff network, the Equality Steering Group and the Estates department.

- An area for disabled changing and public lavatories with a hoist is to be developed as part of the 5 year 2016-2021 estates strategy.

- A scoping exercise to consider employing bilingual staff to support delivery of patient care to those who do not use spoken English as their primary method of communication.

The trust supported Project Search whereby 15 people with learning disabilities were offered work experience each year. Several people had been offered permanent employment through this route.
The trust relied on volunteers. There were said to be “Hundreds” at the Eastbourne site, with a volunteer manager and an induction and training programme. They underwent the same employment checks as permanent staff.

NHS Staff Survey 2016 – results better than average of acute trusts

The trust has five key findings that exceeded the average for similar trusts in the 2016 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>48%</td>
<td>45%</td>
</tr>
<tr>
<td>KF24. Percentage of staff/colleagues reporting most recent experience of violence</td>
<td>69%</td>
<td>67%</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>3.13</td>
<td>3.11</td>
</tr>
<tr>
<td>KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months</td>
<td>35%</td>
<td>36%</td>
</tr>
<tr>
<td>KF16. Percentage of staff working extra hours</td>
<td>70%</td>
<td>71%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2016 – results worse than average of acute trusts
The trust has 21 key findings worse than the average for similar trusts in the 2016 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. Staff appraised in last 12 months (%)</td>
<td>83%</td>
<td>86%</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.03</td>
<td>4.07</td>
</tr>
<tr>
<td>KF20. Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.69</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.56</td>
<td>3.68</td>
</tr>
<tr>
<td>KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>62%</td>
<td>55%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the trust as a place to work or receive treatment</td>
<td>3.63</td>
<td>3.71</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.89</td>
<td>3.94</td>
</tr>
<tr>
<td>KF7. Percentage of staff able to contribute towards improvements at work</td>
<td>68%</td>
<td>71%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.87</td>
<td>3.92</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.25</td>
<td>3.28</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.45</td>
<td>3.47</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.72</td>
<td>3.74</td>
</tr>
<tr>
<td>KF3. Percentage of staff agreeing that their role makes a difference to patients / service users</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.87</td>
<td>3.92</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.59</td>
<td>3.68</td>
</tr>
<tr>
<td>KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>29%</td>
<td>26%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2016)

The minutes of the Trust Board Meeting in Public dated 26 September 2017 showed that issues raised by the staff survey were considered and addressed. The lower than national average appraisal rate was raised by a non-executive director and discussed. The executive directors were
able to say what action had been taken to improve the appraisal rate through working directly with directorates.

The draft minutes of the Trust Board Meeting in Public dated February 2018 showed that staff turnover was better than the national average at 11.3% Retention remained a challenge that the board were aware of, and attempting to address.

**Workforce race equality standard**

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2016</th>
<th>Average (median) for combined acute and community trusts</th>
<th>Your Trust in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 26%</td>
<td>27%</td>
<td>32%</td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 27%</td>
<td>22%</td>
<td>32%</td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 88%</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>Q17b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the 12 last months have you personally experienced discrimination at work from manager / team leader or other colleagues?</td>
<td>White 7%</td>
<td>6%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Of the four questions above, two questions showed a statistically significant difference in score between White and BME staff:

- KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

(Source: NHS Staff Survey 2016)

The trust had an increasingly diverse workforce and was actively recruiting from overseas. There was evidence that there was due consideration of how the needs of the changing workforce could best be met.
The Workplace Race Equality Standards (WRES) report was considered by the board. The minutes of the Trust Board Meeting in Public dated 26 September 2017 showed that the Equality and Diversity Steering Group had reviewed the WRES metrics in detail. It was noted that some of the staff sample sizes were very small and led to disproportionate statistical outcomes.

The WRS report had also been discussed by the People and Organisational Development Committee (POD). No significant items of concern were identified. It was noted that cultural awareness training was becoming increasingly important for the organisation due to the changing workforce.

One non-executive director noted that the board was not representative of the workforce and that there was no visibly BME board members. It was agreed that as board vacancies arose consideration would be given to addressing the diversity of membership.

The Chair asked that a report be submitted to the POD later in the year with a focus on the positive action taken in response to the WRES report.

**Friends and Family test**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. It was recognised by all the staff that we spoke with that whilst much progress had been made there was still further work to do to ensure all staff felt engaged and positive about their work within the trust.

The trust scored about the same as the England average for recommending the trust as a place to receive care from December 2016 to November 2017.

(Source: Friends and Family Test)
The quarterly Staff Family and Friends Test showed a significant year on year increase in two questions asked.

- If a friend or relative needed treatment would you be happy with the standard of care provided by the organisation? The score increased from 61% Q4 2015 to 77% Q4 2016
- Would you recommend your organisation as a place to work? The score increased from 38% Q4 2015 to 66% Q4 2016

The minutes of the Trust Board Meeting held in public dated 6 February 2018 showed that the trust had changed how it dealt with HR issues raised by staff. Where appropriate the trust HR team were pursuing a mediation based approach in order to resolve issues at an earlier stage than had previously been the case. The trust procedures were being reviewed to soften the language that was used in order to make them less of a barrier for use.

The Board Assurance Framework dated November 2017 stated that “Work continues following staff feedback in the National Staff survey – working on the three corporate priorities and each division has own action plan. Latest Staff FFT identified an increase in the number of staff who would recommend the trust for care and treatment to 80% but there has been a reduction in the number of staff who would recommend us as a place to work. Leaders were engaging with teams to find out more about these responses and what they feel will make a difference.”

The Governance Team commenced an improvement plan in October 2016 with an ambition for the inpatient FFT response rate to reach 50%. This was being done through engagement with the departments and improving the feedback provided to them from the data. The trust was 8th nationally on the number of responses at November 2017. All responses from the patient experience questionnaires and FFT surveys were sent to departments monthly for sharing with the teams.

We were told in a focus group of senior nurses that improved teamwork had mitigated some of the risks that caused staff stress. It was felt there was now joint ownership of risk. Staff wellbeing was acknowledged as an area where changes had resulted in improved morale. There had been space for team building days, the divisional structures were stable and supportive and there was now opportunity for the trust to “Grow their own staff” at all grades and in all disciplines.
Sickness absence rates

The trust’s sickness absence levels from September 2016 to August 2017 are below:

The sickness absence levels at the trust were generally similar to the England averages.

(Source: NHS Digital)

The Board Assurance Framework dated November 2017 stated that, “There was continued work on ensuring that staff feel valued and that wellbeing is key priority.” The board recognised that staff culture and staff feeling listened to was integral to ensuring low absence rates.

An Unsung Hero’s roadshows and celebration event took place in in October 2017.

A range of health and wellbeing activities were available to staff including:

- Health Checks for those staff aged 40-70
- Flu vaccination in the workplace.
- Staff listening conversations to share views on what the trust could do better about stress in the workplace which will inform a new Stress at Work policy,
- A physiotherapist in the occupational health team was supporting staff with muscular-skeletal (MSK) injuries as well as trying to raise the profile of how to prevent MSK injuries.

Very well received and successful Schwartz rounds had taken place at EDGH, Conquest and Bexhill hospitals. Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence showed that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other’s roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care.
All staff had access to occupational health services by appointment. It was necessary to be referred by your line manager. Access to counselling and psychology services was by self-referral.

General Medical Council – National Training Scheme Survey

In the 2016 General Medical Council Survey the trust performed worse than expected for three indicators (Clinic Supervision, Induction and Feedback) and the same as expected for the remaining 11 indicators.

(Source: General Medical Council National Training Scheme Survey)

We spoke with four junior doctors during the well led inspection and with both junior doctors and consultants during focus groups in December 2017. We also spoke with medical staff as part of the core services inspection site visits.

We were told that the culture was improving and that consultants were much more supportive of the new board. Consultants said the CEO had, “Fired some warning shots” when first appointed but made it clear he wanted to engage and work with the consultant body and expected them to take ownership of clinical service leadership across the trust. Most consultants saw this as a positive step and were working within, and across directorates to ensure that junior doctors were supported to learn and to provide good clinical care.

The Medical Engagement Scale Report (MES) for ESHT, dated November 2017, showed the results of a medical engagement survey for ESHT and benchmarked it against 110 UK trusts.

- For all responding medical staff, all MES scores fell within the high relative engagement banding.
- Consultants were strongly engaged with respect of 7/10 scores and showed a high relative engagement for the other 3/10 scores.
- Medical staff at the Conquest were strongly positively engaged with average staff ratings of 9/10 scores falling in the highest relative engagement band.
- The Medical Division was associated with highly engaged average ratings across all ten scores.

There was, however, a wide range of medical engagement profiles when the results were disaggregated by speciality. The survey results did not consider the potential reasons for this.

Governance

Board assurance Framework

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The Board Assurance Framework (BAF) is a key mechanism which boards should be using to reinforce strategic focus and better management of risk. The BAF brings together in one place all of the relevant information on the risks to the board’s strategic objectives. The trust board had sight of the most significant risks and mitigating actions were clear.

The trust provided their Board Assurance Framework (BAF), which details five strategic objectives within each and accompanying risks. A summary of these is below.

- Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
• All trust employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

• We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.

• We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.

• We will 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."

(Source: Trust Board Assurance Framework)

The minutes of the Board Meetings in Public dated February 2018, September 2017 and July 2017 showed the Board Assurance Framework was a standing agenda item. Discussions about changes to the framework were recorded. The board confirmed at each meeting that the main inherent and residual risk and gaps had been identified in the BAF, and that actions were appropriate to manage those risks.

Assurance mapping was overseen by the Director of Corporate Affairs who had responsibility for developing and maintaining board assurance arrangements and producing a BAF. The assurance mapping process and the illustration of the results using the BAF gave confidence to management and the board that they had a broad and deep understanding of how the trust was performing and the key strategic risks.

The assurance mapping process identified and recorded the key sources of assurance. This informed board members of the effectiveness of how key strategic risks were being managed or mitigated, and of the key controls and processes that were relied on to manage risks. As a result the BAF supported the achievement of the organisation’s strategic objectives.

A Red/Amber/Green (RAG) rated classification system was used to identify the level of control that was in place and whether there was sufficient information to provide assurance to the board. The BAF was based on the strategic objectives with identified risks which might impact on the trust ability to achieve the original objective in each risk area. Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their ‘worry list’.

The majority of the Strategic Objectives were rated green with appropriate key controls and positive assurance in place. The March 2018 BAF showed the single red rated concern being around the trust’s ability to provide ongoing assurance on the controls in place to deliver the financial plan for 2017/2018. There were regular updates on this gap/risk at the board meetings.

Examples of board level oversight of the BAF and challenge provided by board members was evident. The minutes of the Board Meeting in Public, dated July 2017, showed that the gap in control concerning patient transport had been removed as the service was much improved following a transfer to a new supplier.

Two non-executive directors were recorded in the minutes of the Board Meeting in Public, dated July 2017, discussing mortality and the work that had been done to improve the mortality figures. They felt that there had been a real improvement and were assured that there were appropriate
measures in place to manage the associated risks. The rating was moved from amber to green as the mortality level was within the expected range and there were effective controls in place.

Management of risk, issues and performance

Governance Framework

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures.

The Risk and Quality Delivery Strategy v1.5 ratified by the board in October 2016 made explicit the governance structures and accountabilities of both individuals and committees/groups that fed into the governance of the trust. It was a very clear document that avoided any ambiguity within the accountability framework.

The trust board retained overall responsibility for ensuring the effectiveness of the risk management systems and internal controls within the trust. Feeding into the full trust board were five subcommittees.

- The Strategic Development Group
- Quality and Safety Committee
- People and Organisational Development Committee
- Audit Committee
- Finance and Investment Committee.

Sitting below the formal sub-committees of the board are five sections defining the Governance framework. Within each section is a committee structure. The executive team are the conduit between the board and the Governance framework. The executives also led the integrated performance reviews (IPRs) and they had responsibility for approving new corporate risks prior to uploading to the trust risk register which were signed off at the IPR meetings.

Within each division there were governance meetings, risk meetings and speciality meetings. These fed into both the five sections of the Governance Framework (through specific groups that they reported to) and through the IPRs. In the same way, the Corporate Team Meetings and senior Leadership Forum also fed into both the five sections of the Governance Framework (through specific groups that they reported to) and through the IPRs and provided a route for the governance of IT, Finances, estates clinical administration, human resources and corporate teams to escalate risks and provide data.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. Ward, clinical unit and department teams fed directly through the divisional structures using the meeting structures to raise concerns and share learning.

Staff spoken to confirmed that team and divisional meetings took place regularly and that they were able to raise concerns or suggest ideas to improve practice.

Information about ward or clinical unit performance was displayed on whiteboards in each area. The ward dashboards showed the number of falls over time, the number of pressure sores, the planned and actual staffing levels and the incidence of certain infections.
The Associate Director of Governance reported to the Director of Nursing but worked closely with the Director of Corporate Affairs and Director of Strategy.

Non-executive and executive directors were clear about their areas of responsibility.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. We reviewed the last six board papers and attended a board meeting. There was a standard agenda for meetings that included declarations of interest, a review and formal acceptance of the preceding minutes, the Board Assurance Framework, feedback from committees and the CEO’s report to board.

There was a separate section of the meeting minutes which demonstrated the board’s consideration of the Integrated Performance report (IPR). The IPR provided the board with comprehensive information on

- Quality and Safety

This provided current data and showed trends and benchmarking data for key performance indicators such as the number of falls, the number of ward moves and bed moves made at night, pressure damage and infections. Serious Incidents and Mortality were considered during this part of the meeting. The board also reviewed complaints and the Friends and Family Test results at this point.

- Access and Delivery

Performance data, benchmarking data and trends were considered by the full board as part of the IPR review. The figures around attendance, waiting times, ED performance, referral to treatment times and the inherited backlog, waiting list size and cancellations were reported.

- Leadership and Culture

During this part of the meeting the board looked at the costs of temporary staff, appraisal rates, vacancy, sickness rates and recruitment. The Safer Staffing model data was reviewed as was the mandatory training completion rates.

- Finance

The Finance section of the IPR provided updated information with a Financial Summary, key information about efficiencies, the balance sheet, cash flow and the capital programme. Divisional financial performance was also reviewed.

- Sustainability and Strategy

This contained updates relating to the trust strategy, ESBT and the STP.

- Activity

This section of the report contained information relating to trust activity with key performance indicators around Urgent Care attendances, day case activities, outpatient attendance, length of stay and maternity activity.

The board papers also contained a Mortality Report about learning from deaths including learning from deaths dashboard, a report on the Equality Delivery System (EDS2) with the Equality Analysis report, the annual Fire Safety Report and the Annual Safeguarding Report.

The Medical Director chaired the weekly safety meeting and the Clinical Outcomes group and had oversight of all medical staff employed by the trust.

Under his leadership there had been improvements in the assessment of risk and prophylaxis to reduce the risk of venous thromboembolism (VTE). VTE is a condition where a blood clot forms in
a vein and which presents a significant risk to some patients particularly where the lungs are affected.

There had also been improvements in how well the trust responded to patients presenting at the emergency departments with potential sepsis. The trust had been a CQC mortality outlier for sepsis excluding maternity in 2016 but trust data shows that the response to sepsis is no longer a concern. A trust wide campaign had taken place and antibiotics were now given within an hour of the patient being triaged.

An “Excellence in care” model was being introduced. This was a ward accreditation system using a range of quality indicators to assess and benchmark the quality of care and risks on individual wards and departments. There were nine outcomes related to safety, access, finance, leadership and delivery. Four wards were already using the tool and a further six were being involved from May 2018. One key change of the Excellence in Care model was that the dashboard would be available to all staff; the current dashboards based on the electronic reporting systems were not visible to staff.

The IPR for Month 4 (July 2017) showed that the mortality indicator SHMI was 1.09 for January 2016 – December 2016. This was within the expected range for similar trusts.

The governance pathway for Mortality and Morbidity was as follows –
Minutes from meetings at each stage of the governance pathway showed that there was an effective flow of information in both directions. Information discussed at divisional level correlated with information provided to the board. There were clear terms of reference for each meeting within the overall structure.

A service level agreement was in place to support the partnership arrangement for provision of psychiatric liaison services and crisis response. Staff from the local mental health trust worked out of the hospitals and provided assessments and a response to patients presenting with acute mental ill health. The administration and assessments under the Mental Health legislation were also provided as part of the SLA.

**Learning from Incidents, complaints and safeguarding incidents.**

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.

The governance team regularly reviewed the systems. Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed.

In 2016 the trust had ineffective and insufficient oversight of incident reporting and did not have a sufficiently robust response to serious incidents (SIs). An Associate Director of Governance was appointed and spent time mapping the SI process which identified skills gaps, for staff completing RCAs and reviews. The governance team took over responsibility for all reviews to clear the backlog. The new process incorporated tracking of the responses under the duty of candour regulation.

Lessons learned were now tracked on the electronic reporting system and a new ‘Closing the Loop’ stage has been introduced. A year after a serious incident the team go back and look for evidence that the changes have been implemented and embedded.

There had been three Never Events within the reporting period. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Discussion with the non-executive directors including the Chair of the Quality and Safety Committee showed an awareness of the incidents. The non-executive directors told us they had asked to be informed as quickly as possible about any further Never Events. They were able to talk about the actions that the trust had taken in response to the Never Events including:

- Increased auditing and observation in theatres focussing on the World Health Organisation Five Steps to Safer Surgery checks.
- Monitoring of outcomes for patients.
- A review of the electronic reporting system so that the process had to identify learning before the incident could be closed.
- A regular assurance report provided to the Quality and Safety Committee members.

An external review of theatre practice was completed following the never event related to hip surgery.

Of the SIs we reviewed in detail, the non-executive directors were aware of two of the incidents but not one relating to gynaecology. We were told that the incident had been reported as an SI in December 2017 but there had not been a Quality and Safety Committee meeting subsequent to this, so information would not have been shared as it wasn’t a Never Event.
We reviewed the documents including the Root Cause Analysis report for six serious incidents. The documentation was completed thoroughly and thoughtfully. We discussed with the Director of nursing and medical director the details of one serious incident that we felt was a potentially avoidable incident but had been logged as unavoidable. They agreed and recognised that this may have reduced the learning for the individual member of staff and the wider organisation.

The percentage of incidents reported that were categorised as no harm or near misses was 84% of all patient safety incidents as a rolling 12 month average in November 2017. This was an indicator of a good reporting culture. There were no overdue serious incidents as reported in November 2017.

A weekly patient safety summit took place with representatives from each division, all incidents scoring over level 3 was discussed at this multidisciplinary meeting. The outcomes from discussions were shared with ward matrons and the wider ward and departmental teams. There was a standard agenda and any themes or trends identified were sent to a specialist group for review.

Patient falls remained the second largest theme with 5.5 per 1000 bed days for 2017/2018. This was a reduction in the level of falls from 2016/2017. The trust had signed up to working with NHSI on the National Falls Collaborative. A new falls Risk Assessment Tool was being piloted and a deep dive into the last 20 serious or moderate harm falls was being undertaken and would report to the Patient Safety and Quality Group.

Duty of candour compliance for all moderate and above harm incidents remained at 85% informed verbally, 87% followed up in writing and 78% findings shared with patient or family on completion of the investigation.

There was a reduction in the number of complaints received over the year 2016/2017 with a fall from an in month rate of 3 per 1000 bed days in April 2016 to 1.9 per 1000 bed days in October 2017. Rates of 1.7 per 1000 bed days in February 2017 and April 2017 suggested this was a sustained improvement.

Since April 2017 there were seven cases referred to the Parliamentary and Health Service Ombudsman (PHSO) and two were partially upheld.

Safeguarding adults was given a high priority at the trust. The Safeguarding Adults Policy v2 was ratified in July 2015, was under review again and used in conjunction with the Sussed Policy and Procedure for Safeguarding Adults in line with the Care Act 2014. The policy incorporated domestic violence, modern slavery, and the PREVENT strategy. The Safeguarding Children Policy has also been recently reviewed (2017) in line with the LSCB Pan Sussex Child Safeguarding Policy.

The Annual Safeguarding report for 2016-2017 was presented to the board in September 2017. The trust had agreed governance and accountability arrangements which included reporting on the safeguarding arrangements to the trust board via the patient Quality and Safety Group, the Safeguarding Strategic Group and the Safeguarding Operational Group.

The CEO had overall executive responsibility for Safeguarding and the Director of Nursing was the nominated executive director with local responsibility, supported by the Deputy Director of Nursing. The Director of Nursing attends the quarterly East Sussex Local Safeguarding Children's Board (LSCB) and the East Sussex Local Safeguarding Adults Board (SAB) meetings along with the Head of Safeguarding.

The Safeguarding Adults and Children’s Teams were led by the Head of Safeguarding with a team of Named Nurses Safeguarding. There was a MCA lead post which was held by the Named Nurse.
for Adults. The PREVENT lead role was held by the Head of Safeguarding and the Named Midwife had responsibility for the FGM lead post.

The Child Safeguarding Policy and Procedures v3 were ratified in November 2017 and due for review in January 2020. The policy had been created in consultation with the midwifery team, the Child Protection teams from both acute and community healthcare services, the locality clinical manager at a local authority and the child health manager. It contained specific guidance on domestic abuse, fabricated and induced illness, forced marriage, sexually active children, child trafficking, e safety, female genital mutilation and vulnerable adults with dependent children.

The Head of Safeguarding was in post for a year on an interim contract before they were appointed to the substantive post in March 2107. Working within the team for adult, and child safeguarding they lead the Named Midwife, deputy Named Midwife, a Named Nurse for Looked after Children, a community Named Nurse (job share) and a Named Nurse for the acute children’s services. There is also a Learning Disability nurse specialist who works jointly with the local mental health trust.

There were two Named Doctors, one each for community and Children in Care and one for acute services.

There was a paediatric clinical safeguarding risk meeting each week chaired by the Head of Safeguarding and attended by the safeguarding specialists and named professionals from acute, community, children in care and mental health staff where vulnerable cases were discussed. Additionally there was a monthly paediatric perplexing cases review. A separate vulnerable adults meeting also took place weekly which was attended by the Head of Safeguarding, Named Nurse and specialist Safeguarding Nurse on the Conquest Site.

Key performance indicators had been agreed for safeguarding across the trust.

The trust participated in the Children Act 2004 Section 11 Audit Report that was co-ordinated by the LSCB. Section 11 reports are one way of monitoring compliance with the requirements of the Act. The most recent submission by ESHT to the Section 11 audit was in March 2016; results from the 24 participating agencies (including ESHT) showed improved compliance over the preceding 3 audits. The Section 11 Audit was due to be sent to ESHT for review in May 2018.

The Annual Report provided evidence of learning from safeguarding incidents within the organisation and also from external reviews and investigations.

In May 2016 an ESHT Internal Management Review (IMR) was requested by the LSCB regarding a case where two children had been exposed to significant neglect. The SCR report was not published at the time when the Annual Safeguarding report was presented to the board but the ESHT safeguarding team had already created an action plan in response to their recommendations from the IMR. The learning and action plan was shared across midwifery services, health visiting and school nursing as well as with primary care providers. The action plan was monitored closely by both the trust Strategic Group and the LSCB. The action plans from the SCR were included in the ESHT Safeguarding Work plan.

The police led Operation Dunhill resulted in a hearing at the Central Criminal Court and a prosecution of a man who had been a high ranking member of the clergy. An independent review of the way the initial allegations were dealt with was commissioned and the finding shared through the SAB and LSCB. The trust reflected on the need for transparency and a need to treat all allegations with equal seriousness regardless of the seniority of the person who the allegations were about.
The Head of Safeguarding also oversaw compliance with mandatory safeguarding adults and children’s training and safeguarding supervision and took action if there appeared to be a shortfall in staff completing the appropriate level of training. The safeguarding team had arranged to combine the acute and maternity safeguarding training and increase the time spent delivering the sessions.

Infection Prevention and Control was identified as a concern in many areas of the trust during the previous inspection visit dated March 2015. A more recent visit in October 2016 found improvements but noted areas that still fell short of an acceptable standard.

During the core service inspection visits of this inspection, dated March 2017, we did not find any concerns relating to infection prevention and control. We noted improvements in infection control practice and in the environment.

The Infection Prevention and Control Annual Report 2016 – 2017 provided details of the infection prevention and control activities at ESHT. Prevention and control of healthcare associated infections remained a priority for ESHT.

The Director of Nursing was the executive lead for infection prevention and control (DIPC) within the trust. The trust employed four microbiologists who were involved in infection prevention and control. Two worked on each site and were readily available for advice. The DIPC was supported in their role by a team leader and six infection prevention and control nurse specialists.

The Medical Director was the lead for sepsis within the trust. There was a Sepsis Steering Group which was consultant led and attended by a microbiologist and nursing staff. One of the IPC nurse specialists was seconded to this group.

The Trust Infection Prevention and Control Group was chaired by the Director of Nursing and met monthly. There was wide representation from across the trust with attendees from clinical units, occupational health, pharmacy, the commercial division and also external membership from Public Health England.

The Trust Infection Prevention and Control Group reported monthly to the patient Safety and Quality Group regarding performance and operational issues. It also reported quarterly to the Quality and Standards Group regarding compliance the Health and Social Care Act 2008 Regulation 12; Cleanliness and Infection Control.

Each of the clinical units reported directly to the Trust Infection Prevention and Control Group and reported on compliance with the regulatory standards for infection prevention and control.
The measures put in place and the ethos of ensuring all staff felt responsibility for infection prevention and control resulted in improvements which included –

- During 2016/2017 the number of MRSA bacteraemia cases reported decreased to one (in December 2016) compared to four in the previous year.
- The trust scores for the audits against the National Specification of Cleanliness in the NHS were much improved from previous inspection visits. The overall score was above 95% although the trust recognised a few areas where scoring was lower.
- The introduction of the band 1 Clinical Orderly role to support cleaning of clinical equipment was linked to a significant improvement in compliance scores.
- Two apprentices had been employed working with the IPC team.
- A weekly huddle had been introduced which focussed on IPC issues. This was an open forum with invitations to all band 7s and the Director of Nursing.

There was, however, no reduction in the number of cases of Clostridium Difficile infections. The 46 cases reported were reviewed and 11 were found to have no lapses in care and 27 to have lapses in care that were unlikely to have contributed to the patient developing the infection. There were two outbreaks of Clostridium Difficile infections that were reported as serious incidents.

ESHT had maintained the required mandatory surveillance study programme devised by the Surgical Site Infection Surveillance Service of Public Health England since 2010. Surgical site infection rates for prosthetic hip surgery at 0.6% were marginally worse than the national average.
of 0.7%. Prosthetic knee surgery had infections rate of 0.3% which was better than the national average of 0.6%.

The critical care areas of the trust did not participate in the national Infections in Critical Care Quality Improvement Programme but were active in the national Audit of Intensive Care Units (ICRACR). There were designated audit teams in both critical care units.

There was evidence of learning and using data to bring about improvements in IPC. The regular hand hygiene audits had shown a dip in practice within the emergency departments in December 2017 and January 2018. The IPC team prioritised this area and worked with local staff to bring about improvements which were demonstrated through further audits.

The trust had an Antimicrobial Stewardship Group with a core membership of an antimicrobial pharmacist, a consultant microbiologist, a medical consultant, a clinical pharmacy manager and a CCG representative. During 2016/2017 the Antimicrobial Prescribing Guidelines for Adults and Children was updated. The guidelines were available as a smartphone app so that it was readily available to prescribers.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£356.2m</td>
<td>£379.3m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£47.7m)</td>
<td>(£44.3m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£403.9m</td>
<td>£423.6m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£35.2m)</td>
<td>(£31.3m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview)

The trust was placed in Financial Special Measures by NHSI in October 2016.

The minutes of the Board Meeting in Public, dated July 2017, showed that NHSI had approved the trust’s financial plan for 2017/2018. Key development areas had been identified to help the trust meet financial targets with a focus on seven key work streams. The financial plan required the trust to realise efficiency savings of £28.7 million during 2017/2018.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. The trust board and senior staff were all aware of the gravity of the financial challenges faced by the trust. They understood that they needed to reduce the deficit and maintain cash flow in the procurement processes but were unanimously committed to ensuring that the necessary savings came about without impacting negatively on the safety and quality of patient care.

The minutes of the Board Meeting in Public dated July 2017 showed the chair had explicitly stated the importance of ensuring that quality and safety within the trust was not affected by financial...
issues. He was supported in this stance by the CEO who explained the trust was trying to save money by reducing waste and becoming more efficient, not by affecting quality.

Service redesign through the ESBT initiative was seen as key to driving down costs and ensuring people received the right care in the right place moving forward.

Senior nursing staff we spoke with in a focus group were positive about the way the financial situation was being handled. They talked to us about the trust spending money in the short term to save money in the longer term. They confirmed that there was much improved oversight of procurement and that ordering was now done on the basis of clinical need rather than idiosyncratic preferences.

The ESHT 2020 – Strategic Planning Process and Governance Document provided detail of how the trust intends to deliver safe and sustainable services. It says that the trust will need to address its £15 million structural deficit and achieve long term financial and clinical sustainability by moving beyond incremental performance improvements to deeper internal transformation and greater external collaboration.

The trust has been in deficit for a number of years: A deficit of £51-£57m for 2017/2018 will represent an improved or static deficit position for the trust. In the financial year 2016/2017 the allocated control was £26 million with a goal set of reaching a £37 million deficit by end of the 2017/2018 financial year. There had been expenditure for several one off large costs such as service redesign and some difficulties created by the clinical commissioning group also facing financial difficulties. It was also recognised that the board should perhaps have been clearer about what was achievable and the budget they were signing up to but that as a newly established board they were not in a strong position to do this.

The target from NHSI for next year was a £21 million deficit but the trust recognises this was not achievable whilst maintaining quality and with increased demand on services. Their own goal was to get to £47.7 million which was considered “safe and sensible”.

A new Strategic Plan was due for publication in June 2018. This will outline the return to financial stability and will include the underlying financial strategy, correlation with the clinical strategy and the broad model. It was felt that financial success could not rely purely on efficiency savings.

There were three identified key ‘buckets’ for savings

- Structural issues around sustainability of services which will involve wider consultation and continued work with partners in the ESBT group. It was estimated that this had potential to save £15 million to £20 million annually.
- Efficiency and productivity savings. They have delivered circa £12 million but felt this could be £15 million - £20 million in the coming year.
- Pricing structure.

Throughout all discussion about financial sustainability and recovery the board members and staff talked about maintaining quality and ensuring the changes were in the best interests of patients. We were told repeatedly about the solution was joint working to ensure a deliverable 5 year system recovery plan. The current collective system wide deficit was £100 million and it was felt that solution also had to be system wide.
The Finance Director explained that the current board had inherited a significant financial deficit and that the trust had a turnaround team four years ago that made savings that allowed the trust to just about break even in 2014/2015 but that this has created a clinical quality deficit with significant impact on the quality and safety of the services patients were receiving.

In the year to December 2017, the trust has improved its underlying deficit by just under £8m, mainly as a result of the delivered CIPs and reclassified CIPs (which included tariff adjustments and vacancy holds)

In the second half of the year, the trust was forecasting its financial position to deteriorate by £1m, despite delivery of £5.3m of CIPs, of which NHSI consider there is a £2.8m risk of non-delivery but for which the trust has a contingency of £1.5m

There have been additional costs related to the ESDBT initiative but it was felt by all board members that this would reap longer term benefits both in patient outcomes and in costs.

There were also unexpected additional costs related to the delivery of council awarded contract to provide Muscular-Skeletal services after termination of contract with another provider.

Costs related to the management restructure impacted on the deficit and was also thought to be a short term increase in spending that would bring benefits in the longer term. It involved reorganising divisional leadership across the trust, establishing new posts, governance structure and reporting lines. A positive impact from this spending was already tangible.

The 2017/2018 month 6 data showed an overall increase of 0.94% in total referrals across the 14/15 -16/17 period with significant increase in total referrals this financial year to date compared to 2016/17 (5.1%). This financial year is showing significantly more variance than the change from 14/15 to 16/17.

Benchmarking data for 2017/2018 shows agency staff spending as the single biggest variance from comparators. The trust had taken steps and the amount of agency staff use was reducing with improved recruitment, more use of the trust’s bank staff and ongoing work on retention.

The minutes of the Board Meeting in Public, dated July 2017, showed that the Audit Committee had undertaken a review of effectiveness with a positive feedback that showed good scrutiny and challenge being provided by the committee. The Finance and Investment Committee had also undertaken a review of their effectiveness and several recommendations were made in light of the review.

The trust had received an internal audit opinion of limited assurance for the year 2016/2017 and the trust had looked at ways to improve the rating for 2017/2018. The audit recommendations had not been implemented in a timely manner during the first half of the financial year but that picture had improved significantly during the second half of the year as the trust had taken greater control of the issues.

There were robust Quality Impact Assessments that was signed off by the medical director and chief nurse. They were supported in this by the People and Organisational Development sub-committee. The Finance Director told us that the trust had invested in the infrastructure to get the staffing and leadership structures in place and to ensure there was a strong safeguarding system. This corroborated what the senior nurse focus group told us about one off expenditure increasing the deficit but which was intended to see longer term savings.

The minutes of the Board Meeting in Public, dated July 2017, stated that the Financial and Investment Committee were determined to ensure the trust’s stringent financial targets did not affect the quality of care provided by the trust. There was acknowledgement of substantial improvements to quality within the organisation and the cost implications of these.
The minutes of the Trust Board Meeting in Public dated November 2017 showed that the board were keeping the financial situation under close review and were receiving detailed information about ongoing financial risks and mitigating actions. There were clear examples of concerns and the reaction to these including:

- Where the trust had identified a significant and continued fall in its elective activity (offset by non-elective work), they had responded by introducing theatre productivity work to maximise in-house throughput.

- Agency premium costs were identified as being mitigated by vacancies elsewhere in the trust. In response, the trust has revamped its vacancy control process and created a detailed workforce efficiency work stream and plan.

**Trust corporate risk register**

The trust provided a document detailing their highest profile risks. A full list of these can be found at the link below.

The table below includes the 10 risks with a current risk score of 20:

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Title</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/04/2015</td>
<td>1289</td>
<td>Longstanding vacancies at consultant level in histopathology</td>
<td>There is a risk to patient safety due to delay in completing analysis and reports to inform patient care, caused by insufficient substantiate consultants and an inability to recruit, leading to a reporting backlog, reduced out of hours support service and MDM support.</td>
<td>20</td>
<td>3</td>
<td>30/10/2017</td>
</tr>
</tbody>
</table>
There is the risk that the organisation will be non-compliant with Fire Safety Legislation. This is caused by a number of defective buildings and systems which may lead to failure of statutory duty inspections.

1. Inadequate Fire Compartmentation at EDGH;
2. Inadequate Emergency Lighting Conquest Maternity Area:
3. Failing Emergency Lighting Conquest central battery system:
4. Inadequate testing of Fire Dampers EDGH and Conquest:
5. Non-compliant fire alarm systems ESDG residency blocks.
<table>
<thead>
<tr>
<th>Date</th>
<th>Number</th>
<th>Description</th>
<th>Action</th>
<th>Frequency</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/02/2016</td>
<td>1458</td>
<td>Non-Compliance with NICE guidance NG19 (Diabetic Foot)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There are risks to in-patient and outpatient diabetic patient safety, quality of care and experience caused by insufficient resources and staffing to ensure high risk patients with an active foot wound are seen within 24 hours by the specialist Foot Protection Team. This has impacted on compliance with the diabetic foot pathway and NICE guidance NG19 (Diabetic Foot); and may lead to patients requiring limb amputation and/or an increase in hospital stay. Currently ESHT is the second highest outlier in the country for length of stay for patients with foot wounds and has higher than the national average for amputation rates.

This risk is to be managed and monitored by Medicine and OOH Divisions.
<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>22/02/2016</td>
<td>1459</td>
<td>Diabetic Eye Screening IT performance issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is a risk to patient safety and patient data stored on software due to issues with IT performance and server. It is caused by sub-optimal performance of the Diabetes 3 software due to the speed of the computers and network infrastructure. Server crashes/data loss linked to faulty disks within server. This could lead to non-compliance with KPIs and national targets, poor patient and staff experience due to delays/cancellations to appointments. Also delays in diagnosis and issuing of results and permanent loss of patient data from server.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>04/10/2017</td>
</tr>
<tr>
<td>10/06/2016</td>
<td>1502</td>
<td>Non-compliance with 4 hour Waiting Time Standard and delay in the provision of optimal care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is a risk that the Trust will be non-compliant with the 4 hour emergency waiting time standard. This is caused by staffing shortfalls and limited environmental capacity within the Emergency Departments (EDs). Which will impact on timely assessment and the provision of optimal care, compliance with pathways of care, use of gateway areas and Ambulatory Care, length of stay and patient flow?</td>
<td>20</td>
</tr>
</tbody>
</table>
### Liquidity

There is a risk that the Trust's financial performance will be significantly worse than the original deficit plan for the financial year 2016/17. This will create pressure on the Trust's liquidity (in simplest terms - cash). This will initially affect the ability to pay invoices and may lead to an impact on meeting payroll obligations. Poor payment history affects the Trust's relationship with suppliers, reputation and ultimately patient care.

Planning now for 2017/18 which initially will be to secure funding to cover the planned deficit. 2017/18 planned deficit to be covered by monthly applications. No guarantee of success but all applications made to date have been accepted.
<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Summary</th>
<th>Page</th>
<th>Line</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2017</td>
<td>1617</td>
<td>There are the financial and reputational risks that the Trust (all divisions and directorates) will overspend its allocated budget for 2017/18 due to previous, current and future spending. The financial plan is contingent on significant clinical and operational improvements. The impact of non-delivery of the plan is that there will be challenges to the sustainability of the organisation and capital/cash constraints.</td>
<td>20</td>
<td>12</td>
<td>29/09/2017</td>
</tr>
</tbody>
</table>
There is a risk to patient safety and quality of care due to the adverse numbers of patients (non-elective) requiring admission and the potential whole system issues of adequately discharging patients to the right place of care and no clinically agreed and signed off full Capacity protocol in place.

The higher levels of patient admissions and low levels of discharges could have an impact/effect on safe patient care, positive patient experience and staff health and well-being. For example patients may be cared for in inappropriate areas; non-compliance with mixed sex accommodation guidance; medicines management issues; increased length of stay and lack of isolation facilities; non-adherence to patient pathway documentation process; failure to achieve 4 and 12 hour A&E standards; reduced compliance with RTT; inadequate staff numbers, orientation; skill mix and staff well-being; increased incidents, serious incidents and complaints.
<table>
<thead>
<tr>
<th>Date</th>
<th>Number</th>
<th>Description</th>
<th>Priority</th>
<th>Risk Level</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>18/08/2017</td>
<td>1658</td>
<td>Interpretation and escalation of antenatal/ intrapartum CTG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is a risk to the safety of babies caused by the misinterpretation of antenatal and intrapartum CTG's and the failure to act on and escalate CTG's of concern. Despite action planning within the Unit concerns are still evident, incidents continue to occur and risks are ongoing. Training, development and structured improvement work flows are required to improve the overall risk. This could lead to an impact/effect on the quality and safety of care provided the Trust's reputation and the experience of the families involved.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>10</td>
<td>06/10/2017</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There is a risk that the Trust will be subject to cyber-attack which will result in ESHT information systems becoming unavailable for an extended period of time.

It is caused by global malware attacks infecting computers and server operating systems. It should be recognised that the circumstances we face are a global issue. There are well organised and funded groups whose sole purpose is to profit from compromising information systems. In 2016 the cost to UK businesses from cyber-crime has been estimated as £29 billion.

The business of trading and deploying Malware has matured in 2017 which has resulted in criminal groups being more organised. This in turn resulted in more frequent, wider ranging and effective attacks.

(Source: Trust Corporate Risk Register)

The board reviewed all risks scored as over 15. The review of the risk register at board level determined whether the risk should be included on the BAF. The Risk register was reported at the full board, at the Quality and Safety Committee, at specific groups and through the divisions and clinical units.

The corporate risk register contained the high level risks which could pose a threat to service delivery or safety for the organisation. The risks were stored on the electronic reporting system, and remained as a permanent record, whether they were closed or remained open. Sign off for these risks was by an executive director either through the IPR or, if a corporate function, the executive lead for the department.

Risks scoring below 15 were managed through the divisional risk registers. These local risks are also stored on the electronic reporting system and were subject to ongoing monitoring and regular review. If the score for any risk increased to 15, it was added to the corporate risk register.

Generic corporate risks assessments required by legislation (such as Fire Safety Risk Assessments and Lift safety) were recorded on a separate reporting system, and only escalated if
there had been a number of incidents or an increased risk for a specific generic risk that could not
be managed within the department.

Staff concerns matched those on the risk register. We spoke to many staff during both the core
service inspection site visits and the well led inspection site visit. We also spoke with staff from
both sites, across all disciplines and at all grades during a series of focus groups held in
December 2017 and during the site visits. Staff talked to us about what they considered the
greatest risks to be. These included

- Workload and capacity
- Staffing levels
- The premises and repairs to estates

Staff also identified risks outside their control such as a limited Child and Adolescent Mental
Health service through a third party which impacted on the children and young people’s services
within the trust.

Directorates had oversight of risks for their areas. They used the risk register and SIs from their
area to develop the annual audit programme.

Where the risks were reviewed by the Quality and Safety Committee, the risk holder was often
invited to attend the meeting to speak about the risk and answer questions that the board might
have.

We saw from various sources that the board was addressing the issues on the risk register within
the constraints of the financial challenges. Staff felt that good teamwork and joint ownership
mitigated the risks with more people being prepared to support a focus on solutions. They also felt
that shared risk felt less stressful.

A focus group of senior nurses felt that patient flow and capacity was their biggest challenge. The
trust had responded and was continuing to find ways to address the increasing demand. These
included creating a Crisis Response team, ambulatory care management and supporting urgent
care through good liaison and communication across the divisions. The Crisis response team
offered a bridging service until care packages were started.

The Safe Staffing meeting and site meeting linked up both sites using videoconferencing to look at
staffing and capacity issues across the whole trust twice a day. The number of meetings increased
when the trust was at its highest capacity risk level. The meeting was led by an assistant director
of nursing working with three heads of nursing and a clinical site manager. There was
representation and attendance from the adult social care team, hospital liaison, heads of nursing,
medical staff and the COO.

The meeting used a staffing tool that linked with the rostering and staff register to ensure that ward
staffing was visible at a senior level by those making decisions about capacity and flow. In
addition to the Safer Staffing tool, there was a physical check on ward staffing with the clinical site
leader providing staffing information from their discussion with ward staff. Their information
included skills mix, acuity and special needs of individual units.

The Integrated Performance Report for Month 2 (May 2017) showed that the Accident and
Emergency performance had improved greatly following a four week challenge undertaken within
the trust. The improvements had come at no additional cost and had been realised by building on
existing plans. One non-executive director asked whether the improvements in the four hour
performance were sustainable. The trust expected performance of 90% to be sustainable but
acknowledged that this would be harder to maintain throughout the winter.

The Department of Health’s standard for emergency departments is that 95% of patients should
be admitted, transferred or discharged within four hours of arrival in the ED. The trust breached the standard in every month from January 2017 to December 2017.

However, from January 2017 to December 2017 performance against this metric showed a trend of improvement.

A system-wide plan for the management of urgent care was introduced in August 2017 to provide continuity of management of capacity across all providers throughout the winter pressures.

Innovative ideas were introduced to improve patient flow and increase the hospitals’ capacity to admit patients via the emergency department. This included a Breakfast Club on the Eastbourne site which encouraged patients to be up, dressed and ready for discharge early in the day.

Staffing was a persistent and recurring entry on the divisional and corporate risk register. Recruitment was an ongoing challenge and the trust had done much to try and overcome the difficulties.

The vacancy rate had dropped from 12% to 8% overall with medical staff vacancies dropping from 14% to 4%. Posts were filled with permanent staff rather than bank staff. Agency staff spending had decreased but bank spending had increased (although not by as much as was saved from agency spending). In house bank staff was seen as the preferred option as staff became familiar with the trust ways of working and might consider permanent posts if their circumstances changed.

New roles had been introduced that released core staff to carry out more clinical work. This included doctors’ assistants, matrons assistants and band 1 clinical support workers.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed.

Fire safety featured on the Corporate Risk Register. The minutes of the Board Meeting Held in Public, dated November 2017, showed that fire safety was considered by the board. The Board received the Annual Fire Safety Report which showed that the board had appropriate qualified and experienced fire safety risk assessors, systems, training and fire safety risk assessments in place which met the requirements of HTM 05-01 (2013). Attendance at mandatory fire safety training from clinical staff had improved.

The level of risk related to fire was expected to reduce over the following five years through investment arising from the 2016/2017 Capital Plan. The Board discusses increased fire safety scrutiny following the Grenfell Tower fire and the trust’s obligations to comply with the regulations.
It was agreed that the Audit Committee would have oversight of the trust’s statutory fire safety responsibilities.

There were plans in place for emergencies and other unexpected or expected events. For example adverse weather, a flu outbreak or a disruption to business continuity. We saw the Business Continuity Plans for the trust and spoke with operational staff about how the plans worked in practice.

Board members and operational staff told us about a major public safety incident that occurred on 27th August 2017 when a chemical cloud caused the emergency services to evacuate the Birling Gap area and which resulted in over 150 people needing hospital treatment at the Eastbourne site. Initially those attended had required treatment with full decontamination. The hospital staff had been praised in a local review and it was clear that the emergency planning processes put in place by the trust were effective.

Where cost improvements were taking place, they did not compromise patient care. There were specific times when cash flow had been a serious issue and where there was a risk that payment to suppliers might be compromised but this had been addressed and systems put in place to ensure ongoing supply of consumables and essential equipment. It continued to be a challenge but the procurement team had better oversight and greater spending controls. At no point had patient care actually suffered; there had been a real risk that some cardiology procedures might have to be cancelled but this had been managed and no cancellations were necessary.

**Information management**

The NHS information governance framework mandates the appointment of two senior roles, typically at Board or Governing Body level within each organisation. These are the Caldicott Guardian and the Senior Information Risk Owner (SIRO). These are distinct but complementary roles.

Whilst Caldicott Guardians were introduced to the NHS in 1998 and to social services in 2002, the SIRO role was not mandated for the NHS until June 2008. Caldicott Guardians are primarily responsible for maintaining the confidentiality of personal information; SIROs have responsibility for understanding how the strategic business goals of the organisation may be impacted by any information risks, and for taking steps to mitigate them.

The Caldicott Guardian was also the Medical Director. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people’s health and care information and making sure it is used properly. All NHS organisations and local authorities which provide social services must have a Caldicott Guardian. Their details were up to date on the Caldicott Guardian Register.

The SIRO was the Executive Financial Director.

The Caldicott Guardian had a member of staff to assist with the work of this role. Their focus at the time of the inspection visit was preparing the organisation for the introduction of the General Data Protection Regulations which came into force from April 2018.

The trust had completed the Information Governance Toolkit assessment. An independent team had audited it and the trust took action where needed. The most recent Information Governance Audits gave an assurance rating of Good.

Information governance systems were in place including confidentiality of patient records. This was an area of significant improvement from the previous inspections in March 2015 and October 2016 when records storage was chaotic and many patient records simply could not be found. A new electronic record tagging system, better use of electronic recording and an off-site records
archive had transformed the way confidential personal information was handled. Records were available for clinics and admissions but were stored securely when not required. Around the hospitals, staff were more aware of the need to protect patient information with notes trollies being kept in more secure areas, less detailed personal information on whiteboards in public areas of wards and a greater understanding of their responsibilities for information security.

There had been one complaint received by the trust relating to information security where documents had been released by the trust to a court.
The board received holistic information on service quality and sustainability. The Integrated Performance Review report that provided comprehensive data and provided assurance to the board and committees.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Data was collated used to populate a dashboard that was shared within the divisional meetings and fed up to inform the IPR.

When we visited wards and clinical areas, staff we spoke with were better informed about how they were performing and how this compared to other areas of the division and to other divisions. Ward leaders could talk to us about improvements in key performance indicators and about action they had taken where data had identified a possible concern (such as an increase in the number of falls compared to previous months).

**Engagement**

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans and in particular through the ESBT initiative. Improvements in external and internal engagement was seen as a real achievement by the board and staff that we spoke with.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The ward and service teams and division had access to feedback from patients, carers and staff and were using this to make improvements. This was through the formal Friends and Family Test survey (FFT) results for the Division and for individual clinical units. Team leaders used the results for discussion at team meetings and to benchmark against other wards and services within the division. Results from the Friends and Family test were displayed on ward information boards.

The Inpatient FFT response rate had improved significantly over a 12 month rolling period. In September 2016 the response rate had been 14%. In September 2017 it was 45.6%.

The rolling 12 month average scored also showed a general improvement. With an inpatient average of 97% of patients reporting they would recommend the hospitals. The emergency department FFT score had also improved significantly over a 12 month rolling period with an average of 87.4% of patients recommending the hospitals. The maternity FFT score was 97.7% in September 2017 compared to a worse 94.8% in September 2016. These scores showed an improved patient experience with the response rate improvements demonstrating better engagement.

Focus groups held in December 2017 showed that most of the attending staff felt much more positive about the organisational culture and their ability to influence the way the services were provided.
Staff said that the CEO and Director of Nursing were particularly visible but also mentioned non-executive directors Quality Walks. Staff spoken to all knew who the Freedom to Speak Up Guardian was and how to contact them.

The minutes of the Board Meeting Held in Public dated September 2017, showed that feedback from Quality Walks was positive and that staff had felt comfortable talking about both improvements and concerns.

In addition to the Quality Walks non-executive Directors had attended some team meetings and reported some of their concerns about the telephone system to the full board. There was a response from the CEO that provided assurance that the issue was known and was being acted upon.

The trust sought to actively engage with staff in a range of equality groups including the BME group and the LGBT group.

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives.

Members of the public did attend the board meetings but not in large numbers. There was a discussion about how more people might be encouraged to attend moving forward. Where members of the public asked questions, these were responded to immediately or there was an agreement to follow up the issues raised. For example, a person asked about the safety of the trust car parks. Ticket machines had been relocated and were difficult to read in sunny weather and the path markings for pedestrians were unclear. The CEO offered to follow up both issues.

The trust had developed a positive relationship with the local Healthwatch, who were very proactive and innovative in their work with the trust and local community. Healthwatch volunteers were regular visitors to the trust and had participated in ‘around the clock’ observational activity in emergency departments, a maternity user’s survey, a joint ‘hospital at night’ visit with the Director of Nursing and engaging with hard to reach group in the local community. Information from Healthwatch was provided as formal reports which the trust now acted on.

Patients, staff and carers were able to meet with members of the trust’s leadership team and governors to give feedback. The board had patients or their relatives attend and tell their stories. The wife of a patient attended a Quality and Safety Committee meeting in July 2017 and spoke about her husband’s experience of care in the trust. The focus of this discussion was to ensure that there was learning embedded.

The ESBT End of Life Strategy (2018-2021) showed that there had been engagement and consultation with the public to find out what local people said was most important to them at the end of life. There was also engagement with carers who were asked about their experiences for caring for someone at the end of life.

In late 2017 the trust designed a survey to be given to relatives when they attended the hospital to collect the death certificate. There has been a positive response so far and the trust used the information provided to improve services.

In response to feedback from patients, a bell has been installed in The Judy Beard Day Unit at Conquest Hospital so that patients, who had received treatment for cancer, rung it to mark when they have finished their course of chemotherapy treatment. Many patients said they felt it was important to mark the end of their journey through their chemotherapy treatment and ringing the bell gave them the opportunity to do this and to signify the end to their journey, giving them hope and strength for the future.
A support group had been established for people fitted with complex pacemakers and defibrillators.

The CEOs report to the board, dated September 2017, showed that senior members of staff had been identified to apply to participate in Cohort 2 of leading Excellence programme that commenced in February 2018.

A Masterclass on Systems Leadership took place in November 2017 as part of the Leading Excellence programme.

The Infection Prevention and Control team had been supported by an external company who completed six staff engagement workshops. The workshop provider worked with the Infection Prevention and Control Team to support the setting of clear and achievable IPC objectives with involvement of trust staff. The outcomes were incorporated into the Infection Prevention and Control Team programme of work for the year.

During 2017 the trust redesigned their website to improve information that is accessible to patients so that they can better navigate trust services and ultimately self-manage their condition. The trust aimed to focus on health promotion and wellbeing; the website gave details of services which patients can access in the community.
Learning, continuous improvement and innovation

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 Working Days</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30 Working Days</td>
<td>100%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>45 Working Days</td>
<td>100%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>3331 (605 formal complaints in this period)</td>
<td>01/11/2016 - 31/10/2017</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview)

Number of complaints made to the trust

The trust received 612 complaints from November 2016 to October 2017. Medical Care core service received the most complaints with 353.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>353</td>
<td>58%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>79</td>
<td>13%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>56</td>
<td>9%</td>
</tr>
<tr>
<td>Surgery</td>
<td>34</td>
<td>6%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>21</td>
<td>3%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>18</td>
<td>3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>16</td>
<td>3%</td>
</tr>
<tr>
<td>Adults Community</td>
<td>12</td>
<td>2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>Community Children, Young People and Families</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>Community Dental</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>612</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints)

The Associate Director of Governance had oversight of all complaints. All complaints were reviewed to see whether they contained incidents that should be reported and investigated under the incident reporting processes. This was done by the associate director working with the patient safety lead.
Complaints were tracked by the board and non-executive directors challenged delays in responses and where there appeared to be trends. Complaints response had indicators included on the Integrated Performance Report (IPR) that went to the Quality and Safety Committee and the full board. This greater scrutiny at board level ensured there was a “Closing the loop” and that individual complaint responses were considered fully in a timely way.

Patients and/or their relatives attended the meetings of the Quality and Safety Committee or sometimes the full board to share their stories and the trust responses to their complaints.

‘Matron’s assistants’ was a new role developed to release matrons’ time for greater input in to the quality of clinical care being provided. They collated complaint response data and the information necessary for the response. This had led to a more timely response to patients and their families.

The bereavement team asked whether there were any complaints after someone had died. Where there were, these were escalated by either the division or the PALS team depending on the nature of the complaint.

Staff and directors all felt there was good learning from complaints within the divisions. Robust local systems were in place for local learning across each division. This meant in practice that a complaint about surgical care at one site would be reviewed and learning shared with all surgical teams across the trust through the divisional governance structures. The board had assurance about the management of complaints through the data provided but there was still scope for improved lateral learning across divisions and between acute and community services.

**Learning, continuous improvement and innovation**

The trust actively sought to participate in national improvement and innovation projects. The trust and other stakeholders in ESBT considered cost when redesigning the End of Life Care Strategy (2018-2020). They used the NHS Right Care (a national NHS England supported programme) to create a strategy that would be able to deliver the best care to patients whilst making the NHS money go as far as possible at the same time as improving outcomes for patients.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. One example was the new Medication Passports which had been launched at Conquest Hospital to help people keep track of their medicines. The Medication Passport listed a person’s medicines and dosage. It was given to health professionals to help substantially reduce the risk of any communication mix up about an individual’s medication.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. The Special Care Baby Unit (SCBU) at Conquest Hospital scored well in a national initiative to reduce avoidable admission of full term babies to Neonatal units. The national initiative called ATAIN, set up in February 2017, aimed to reduce harm leading to avoidable admissions to neonatal units for babies born at or after 37 weeks. The target was for units to have less than 6% of births to be term babies admissions admitted to Neonatal Units. The Special Care Baby Unit at Conquest Hospital was consistently less than 4% and performed better than many similar (Level1) neonatal units.

The trust was actively participating in clinical research studies and used current research to improve practice. An Eastbourne patient was the first in the UK to be implanted with an innovative Cardiac device to modulate the heart’s beat. This new device sent the heart messages to modify the heart cells as they beat in process known as Cardiac Contractility Modulation. This device differs from a pacemaker which tells the heart when to beat. It is suggested the unique mechanism of this device stimulates abnormal heart failure genes to
work normally. Studies in Germany indicated this device had been shown to reduce hospital admissions for heart failure and major cardiac events helping to reduce the risk of death resulting in patients living longer.

Staff had training in improvement methodologies and used standard tools and methods. All the staff we spoke with talked about improved opportunities for training and a commitment to learning. When we spoke with staff from the SPCS we were shown new trust wide Individualised End of Life Care Planning tools that had been introduced in response to different practice on each site. Training had been provided and one of the key aims of the ESBT End of Life Care Strategy (2018-2021) was to improve the skills, confidence and capability of those who care for people at the end of life by providing training and learning for staff across the whole health economy.

Effective systems were in place to identify and learn from unanticipated deaths. The Learning from Deaths report dated April 2016 to March 2017 showed that the trust mortality database had been changed to reflect the requirements set out in the Care Quality Commission review “Learning, candour and accountability: A review of the way NHS trusts review and investigate the death of patients in England”. The NHS England Learning from Deaths dashboard was used as the recording and reporting tool.

For the reporting period April 2016 – March 2017, the majority of deaths were reviewed in accordance with the updated policy. In quarter 3, of 500 recorded deaths, 414 had been reviewed. In data for May 2017 showed that for the year to date there were no deaths that were definitely avoidable or where there was strong evidence of avoidability. Of the total 1397 deaths across the trust, 88.4% were categorised as definitely not avoidable. A further 10.6% showed slight evidence of avoidability.

The trust was still considering how best to provide sufficient expert medical reviewers for the death review work. The preferred option was specially trained people who worked for the organisation to allow for more robust oversight and governance. Every death that is referred to the coroner was rated amber and every death where there were concerns raised by family or others was considered by the Oversight Group.

A mortality index is a ratio of an observed number of deaths to an expected number of deaths in a particular population. The index is simply the number of observed events divided by the number of expected events.

The most recent published Summary Hospital-level Mortality Indicator (SHMI) for the period April 2016 to March 2017 was within the expected range at 1.11. SHMI is the English hospital-level indicator used for reporting mortality across acute trust providers. The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patients who died in hospital plus those who died within 30 days of discharge from the hospital.

The Risk Adjusted Mortality Indicator (RAMI) is another mortality indicator but specifically excludes deaths within 30 days of discharge, maternal and neonatal deaths and deaths where patient is receiving palliative care. The RAMI for ESHT during period August 2016 – July 2017 was 93 compared to a score of 106 in the same period during the preceding year. This indicated a reduced mortality risk for patients admitted to the hospitals.

External organisations had recognised the trust’s improvement work. Individual staff and teams received awards for improvements made and shared learning. The trust has adopted the “Care without Carbon” model developed by a neighbouring NHS community trust. ESHT had received an award in 2017 for its carbon reporting.
Paediatric and Adult Audiology services at the trust received the Quality in Physiological Services (IQIPS) accreditation, a national accreditation in recognition of the high quality of care and service they provided. The Improving Quality in Physiological Services (IQIPS) accreditation is given to services that can demonstrate the highest levels of quality of service, care and safety for patients undergoing physiological diagnostics and treatment.

The Heart Failure Team at the Trust received two awards at the regional Heart Failure Collaborative “Enhancing the Quality of Heart Failure Care”. The Heart Failure Collaborative was a Kent, Sussex and Surrey Academic Health Science Network event in partnership with the British Heart Foundation.

**Accreditations**

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</td>
<td>Audiology (Adult &amp; paediatric) subject to achievement of recommendations by 16/01/2018 - on target</td>
</tr>
<tr>
<td>Quality Network for Perinatal Mental Health Services (QNPMH)</td>
<td>Perinatal Midwife and consultant lead attend Sussex perinatal mental health network</td>
</tr>
<tr>
<td>Your Welcome Accreditations DoH</td>
<td>Sexual Health - Eastbourne &amp; Hastings - Ongoing Accreditations 2017</td>
</tr>
<tr>
<td>Faculty Registered Trainer (FART) FSRH</td>
<td>Nurse Consultant in Contraception 2016</td>
</tr>
<tr>
<td>British Society of Urogynaecologist</td>
<td>Accreditation awarded Jan 2017</td>
</tr>
<tr>
<td>ISO 9001:2008 to Laundry, Transport, Telecommunications, EME and the Estates and Facilities</td>
<td>Accreditation awarded June 2017</td>
</tr>
</tbody>
</table>

(Source: *Routine Provider Information Request (RPIR) – Accreditations*)
Acute services

The Conquest Hospital

The Ridge
St Leonards On Sea
East Sussex
TN37 7RD

Urgent and emergency care

Urgent and emergency services are provided at Conquest hospital to adults and children primarily in the East Sussex area. It is a trauma centre and the nearest major trauma centre is Royal Sussex County hospital located in Brighton.

The emergency department at Conquest Hospital has a four-bedded resuscitation bay, eighteen major cubicles, a mental health assessment room, three minor injury assessment bays/cubicles emergency nurse practitioner bays, plaster room and eye examination room. There is a clinical decision unit connected to the emergency department by a corridor that has seven bed/trolley bays and is used to observe patients or await investigation results. A paediatric resuscitation bay, waiting area and a designated paediatric treatment cubicle are available. There is an x-ray facility in the emergency department.

The hospital does have an inpatients paediatric ward but does not have paediatric intensive care support. Children requiring intensive care are transferred to a specialist paediatric unit in London or Brighton. Children under the age of one year old after registering in the emergency department are sent directly to the paediatric ward. The department has a newly built primary care suite, which at the time of inspection was not fully functional. The future plan for the primary care suite is to develop a fit-to-sit General Practitioner and advanced nurse practitioner assessment service co-located in the emergency department.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them. Urgent and emergency services were last inspected in 2016 when overall we rated it as requires improvement. We rated safe as inadequate, caring as good, responsive, effective and well-led as requires improvement. Our inspection was announced and we inspected all five key questions. We spoke 11 patients and carers and over 20 staff from different disciplines, including support and administration staff, nurses, doctors, managers and ambulance staff. We observed daily practice and viewed 21 sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.
Facts and data about this service

Details of emergency departments and other urgent and emergency care services

<table>
<thead>
<tr>
<th>Name of Site</th>
<th>Teams or wards</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Emergency Unit, Clinical Decision Unit</td>
<td>The Ridge, St Leonards-on-Sea, East Sussex TN37 7RD</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Emergency Unit, Clinical Decision Unit</td>
<td>Kings Drive, Eastbourne, East Sussex BN21 2UD</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

Activity and patient throughput

Total number of urgent and emergency care attendances at East Sussex Healthcare NHS Trust compared to all acute trusts in England

There were 109,998 attendances from April 2016 to March 2017 at East Sussex Healthcare NHS Trust as indicated in the chart above.

(Source: NHS England)
The percentage of A&E attendances at this trust that resulted in an admission increased from 2015/16 to 2016/17. In both years, rates were higher than the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>23,344</td>
<td></td>
</tr>
<tr>
<td>Discharged*</td>
<td>65,04</td>
<td></td>
</tr>
<tr>
<td>Referred*</td>
<td>20,031</td>
<td></td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,178</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>164</td>
<td></td>
</tr>
<tr>
<td>Left department#</td>
<td>5,629</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills to all staff.

Mandatory training completion rates

The trust set a target of 90% for the completion of all mandatory training with the exception of information governance, which had a training target 95%. No target was provided for training on the Mental Health Act.

Trust-wide

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>93</td>
<td>99</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>87</td>
<td>99</td>
<td>88%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>86</td>
<td>99</td>
<td>87%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85</td>
<td>99</td>
<td>86%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>84</td>
<td>99</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>83</td>
<td>99</td>
<td>84%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for nursing staff was 87%. The target was met for two of the seven mandatory training modules.

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical and dental staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>31</td>
<td>41</td>
<td>76%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>30</td>
<td>41</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>28</td>
<td>41</td>
<td>68%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>27</td>
<td>41</td>
<td>66%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>27</td>
<td>41</td>
<td>66%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>18</td>
<td>41</td>
<td>43%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>86</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>
The trust’s overall mandatory training completion rate for medical and dental staff was 48%. The target was not met for any of the six mandatory training modules for medical staff. In addition, none of the 86 eligible medical staff had completed Mental Health Act training, which had no trust target.

**Conquest Hospital**

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing staff in urgent and emergency care at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>51</td>
<td>53</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>48</td>
<td>53</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>47</td>
<td>53</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>47</td>
<td>53</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>46</td>
<td>53</td>
<td>87%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>42</td>
<td>53</td>
<td>79%</td>
<td>No</td>
</tr>
</tbody>
</table>

Conquest Hospital’s overall mandatory training completion rate for nursing staff was 89%. The target was met for three of the seven mandatory training modules.

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical and dental staff in urgent and emergency care at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>13</td>
<td>19</td>
<td>68%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>13</td>
<td>19</td>
<td>68%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>11</td>
<td>19</td>
<td>58%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>11</td>
<td>19</td>
<td>58%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>11</td>
<td>19</td>
<td>58%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>7</td>
<td>19</td>
<td>37%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>35</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

Conquest Hospital’s overall mandatory training completion rate for medical and dental staff was 44%. The target was not met for any of the six mandatory training modules. In addition, none of the 35 eligible medical staff had completed Mental Health Act training, which had no trust target.

Updated data supplied by the trust showed that the trust target for mandatory training had been met in nine out of the 15 modules which included doctors and nurses.

The service provided mandatory training to staff, training was a mixture of on-line and face to face. Mandatory training compliance had improved since our last inspection, although still required further improvement, in particular, amongst the medical and dental staff group.

The emergency department practice development educator organised and managed mandatory training. Staff received email notifications when their training was due to expire and booked staff onto training courses.
We saw a noticeboard within the department, which showed when staff were booked on mandatory training and which module. This meant staff had an additional reminder of when their training was booked for. In addition, we saw when staff were undertaking mandatory training this was highlighted on the staff rota.

The practice development educator produced a weekly report of compliance rates and gave details of approaching expiry dates for individual staff. The report was shared with the deputy head of nursing and head of nursing for the emergency department. This meant senior staff monitored completion rates for mandatory training of staff against the trust’s minimum 90% target. The medical clinical lead in conjunction with the service manager monitored mandatory training compliance amongst the doctors. We saw in the March 2018 Emergency Department meeting minutes that the medical clinical lead had reminded all doctors of the need to ensure they are up to date with training. Mandatory training compliance was a standard agenda item on the Emergency department meeting agenda. This meant overall compliance was monitored.

Previously, monitoring took place for the urgent care clinical unit as a whole across both hospital sites, this was now monitored by hospital site. This meant senior staff had a better oversight of mandatory training completion within their department.

Staff told us that previously it had been difficult to undertake mandatory training due to staff shortages however, this had improved and staff were allocated protected time.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

**Trust-wide**

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>99</td>
<td>99</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>99</td>
<td>99</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>29</td>
<td>31</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>92</td>
<td>99</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>90</td>
<td>99</td>
<td>91%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing staff at the trust was 96%. Nursing staff met the trust target for all five of the safeguarding modules.

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for medical staff in urgent and emergency care at the trust is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>41</td>
<td>41</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>41</td>
<td>41</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>9</td>
<td>12</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>30</td>
<td>41</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>25</td>
<td>41</td>
<td>61%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff at the trust was 83%. Medical and dental staff met the trust target for two out of five of the safeguarding modules.

### Conquest Hospital

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing staff in urgent and emergency care at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children L3</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults L1</td>
<td>53</td>
<td>53</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>53</td>
<td>53</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>51</td>
<td>53</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>51</td>
<td>53</td>
<td>96%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing staff at the Conquest Hospital was 98%. Nursing staff met the trust target for all five of the safeguarding modules.

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for medical staff in urgent and emergency care at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>12</td>
<td>19</td>
<td>63%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>11</td>
<td>19</td>
<td>58%</td>
<td>No</td>
</tr>
</tbody>
</table>
The overall completion rate for safeguarding training modules by medical and dental staff at the hospital was 79%. Medical and dental staff met the trust target for two out of five of the safeguarding modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children L1</td>
<td>46</td>
<td>46</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults L1</td>
<td>46</td>
<td>46</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>41</td>
<td>46</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>14</td>
<td>16</td>
<td>88%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>39</td>
<td>46</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

All staff in urgent and emergency services, including therapies staff, had adult and child safeguarding training to level one and higher levels of training were then completed, based on the level of responsibility each member of staff had. For example, all nurses were required to complete adult and child safeguarding to level two and senior nurses and doctors completed the training to level three. This in line with the Safeguarding Children and Young People – Roles and Competencies for Staff Intercollegiate Document updated in September 2010.

Safeguarding training compliance was low when we last inspected the service in 2016. During this inspection compliance had improved with 100% of nursing staff compliant; however, compliance amongst doctors failed to meet the trust target. This meant doctors might not have the skills and knowledge to recognise safeguarding concerns.

The department had a clear system and process in place for the identification and management of adults and children at risk of abuse (including domestic violence). The department had two safeguarding link nurses, one in paediatrics and one in adults. The safeguarding policy was available on the trust intranet.

Safeguarding referrals were completed electronically via the trust intranet. Staff demonstrated the on-line system for making adult safeguarding referrals to the local authority. An incident form was also completed in conjunction with raising a safeguarding alert.

Staff told us that children with a previous safeguarding referral or who were well known to the service were flagged up on triage on the computer with a symbol next to their name. This enabled staff to identify that there had been previous safeguarding involvement or concerns.

Staff we spoke to told us that there was a policy and internal safeguarding team they could access if advice was required. Staff were aware of the trust safeguarding leads and the department’s safeguarding link nurses. We saw there was a safeguarding noticeboard within the department, which identified the trust and department link nurses and contact details.

Staff had a good awareness and knowledge of safeguarding and were able to give examples of when they had made a safeguarding referral. Staff recognised that safeguarding children, young people and adults at risk was a shared responsibility amongst all staff.

Staff were aware of other safeguarding issues such as child sexual exploitation, female genital mutilation and adults and children at risk of radicalisation and there were guidance and proformas
available. We saw posters within the department, which detailed what action to take if a patient was identified as being subjected to female genital mutilation.

There was a child protection information board within the department, which was changed quarterly. This included where to access relevant guidance, changes in national guidelines and legislation. This ensured staff were kept up to date with child protection guidance and legislation.

All parents and carers that attended the emergency department with a child under 16 were given a confidential patient information form to complete. This form gave consent to share details of the child’s reason for attendance with other professionals. We saw completed forms within the records we reviewed; these forms were then scanned into the electronic patient record system.

There was a weekly department paediatric safeguarding meeting when any safeguarding concerns, which had been identified, were discussed. The meetings were attended by a variety of staff including consultants and paediatric nurses.

We saw details of safeguarding concerns were included in the departments “start of the week message” which was written by the deputy head of nursing on a weekly basis. This meant all staff were aware of any safeguarding concerns raised during the previous week.

The department had recently joined the child protection information sharing project supported by NHS digital. The project helps the NHS give a higher level of protection to children who present in unscheduled care settings. A database enables healthcare staff working in these areas to identify if a child was subject to a child protection plan or was looked after by a local authority. A computer was specifically allocated in the department in a confidential area to allow staff to check the database. Staff checked the database for all children who attended the department, stamped, and signed their records to confirm the check had been completed.

If a patient was assessed to be at risk of suicide or self-harm, increased observation was carried out in addition, security guards could be present if required. Urgent referrals to mental health liaison for consultation and assessment were made as soon as risk was identified.

Staff were aware of the Mental Health Act holding power and could access the mental health liaison and safeguarding team for urgent advice.

**Cleanliness, infection control and hygiene**

The department was clean, tidy and uncluttered. Cleaning services were provided by staff employed by the trust. The same housekeepers worked in the department to provide cleaning services. Dedicated housekeeper cover was available 24 hours per day Monday to Friday and 23 hours per day Saturday and Sunday. This provided continuity of cleaning and ensured a good relationship between the housekeepers staff and emergency department staff. Staff we spoke to knew the names of the domestic staff responsible for the cleaning of the department and were embedded as part of the emergency department team.

The housekeeper supervisor and the deputy head of nursing undertook weekly audits. The audits were undertaken with the cleaning staff, this ensured immediate feedback was give and action taken promptly. In a cleaning audit undertaken in February 2018, the department scored 87%.

A rapid response cleaning team was available 24 hours a day seven days a week. If a “deep clean” or additional cleaning was required, the team were bleeped and attended the department quickly. During our inspection, we saw both the rapid response team and the regular domestic staff undertaking cleaning in the department.
The department completed hand hygiene audits. We observed that the most recent hand hygiene audit results were displayed on the department’s noticeboard and were at 100%. The most recent cleaning audit score was also displayed on the noticeboard. This meant staff and visitors were aware of hand hygiene and cleaning compliance.

Staff adhered to the infection control policy and used personal protective equipment correctly when delivering care.

We observed staff caring for patients requiring isolation, there were three isolation rooms in the department. Signage was used to advise staff not to enter without appropriate protective clothing, and visitors to speak to a member of staff. We saw department staff informing x-ray staff when additional personal protective equipment was required before they entered the patient’s room.

We observed medical and nursing staff generally followed the trust policy for hand washing and ‘bare below the elbows’ guidance in clinical areas. We observed an exception to this after the resuscitation of a patient when not all medical staff washed their hands when they removed their gloves.

There were adequate hand washing facilities throughout the department and hand alcohol gel dispensers were available in each cubicle, on the corridors and next to the entry and exit doors.

Decontamination products were stored securely and were risk assessed using the control of substances hazardous to health (COSHH) guidelines.

Health care assistants cleaned the sluice in the department; there was a rota in place, which ensured it was kept clean and tidy.

We saw there was a schedule in place to clean the toys in the paediatric waiting area on a daily basis and these records were complete.

During the inspection, one of the domestic staff showed us cleaning schedules and cleaning audits, which were fully completed.

The hospital had a designated Director of Infection Prevention and Control (DIPC), in line with the recommendations of the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of Healthcare associated infections and related guidance.

The hospital had a designated infection prevention and control (IPC) team, in line with the recommendation of criterion one of the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of Healthcare associated infections and related guidance. The team included the designated lead for infection control, qualified infection control nurses, and a consultant microbiologist with infection control responsibilities.

We observed staff decontaminating equipment after use to minimise the spread of infection. For example, we saw staff cleaning the patient trolleys, which was done thoroughly. The mattress was removed and inspected for any holes in the material and cleaned.

We saw all yellow sharps bins had been correctly assembled and labelled. This was in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

We saw all waste was segregated and stored correctly in line with national guidance. We saw domestic staff regularly changed waste bags to ensure they did not overflow.

There was a trust policy in the management of patients with suspected flu. We saw there were posters displayed on the process to follow if they had or were suspected to have flu. During our inspection, we saw staff following the process, which was outlined, on the posters. This was to ensure the risk of spreading the virus to others was minimised.
We saw staff inserting vascular access (inserting a small tube into a vein) minimised the risk of infection by completing specified procedures during insertion. For example, we saw staff cleaned the skin before inserting the device. This was in line with the National Institute for Health and Care Excellence guideline QS61. A proforma was completed by the staff member, which confirmed the specified procedures had been undertaken. We observed the same process was adhered to when inserting a urinary catheter, this was in line with National Institute for Health and Care Excellence guideline QS61.

Staff undertook infection control and prevention as part of their mandatory training. Compliance with this training was good amongst the nursing staff (90%) which met the trust target but poor amongst medical staff (59%). This meant doctors may not be adhering to infection control and prevention policies and processes.

Environment and equipment

The service had suitable premises and equipment and looked after them well. Since our last inspection, some areas in the department and been refurbished.

There was a newly built primary care suite, which was not yet fully functioning, as some adjustments were required to the reception area. It was hoped that this area would take some pressure off the main department as patients with minor illnesses or injuries would be streamed directly there. The primary care suite had its own waiting room which would increase capacity of the main waiting room. There was four assessment/treatment cubicles in the primary care suite.

The designated paediatric waiting area had also been newly refurbished to better reflect the needs of children. However, the environment was better suited to very young children. There was a television and DVD player in the room, which was controlled by the paediatric nurses. This ensured that what was playing on the TV was appropriate for children to watch.

The mental health assessment room had also been refurbished since our last inspection.

The electronics and medical engineering department managed a programme of planned maintenance of the department’s equipment and provided ad-hoc support to staff 24-hours, seven days a week. An effective monitoring system enabled staff to plan equipment maintenance in advance. We checked 12 pieces of equipment during our inspection all of which had undergone servicing and electrical safety check within the last 12 months. Staff we spoke to understood the reporting and escalation procedures for faulty equipment.

Documented daily safety checks of resuscitation trolleys were fully completed, including for paediatric equipment. In the two months prior to our inspection, there were no missing checks. We checked all six resuscitation trolleys in the department and found three pieces of equipment, which were out of date. This meant the equipment may not be safe or as effective is used. This was despite documentation to confirm the equipment had been checked and was in date. We raised this with the deputy head of nursing who arranged for the items to be replaced immediately. The deputy head of nursing assured us that they would follow up with the staff member who undertook the checks.

During the last inspection, we noted that there was a lack of confidentiality for patients who arrived in the department on foot and were booked in at the reception window. This was because conversations between the receptionist and patient could be overheard by others in the waiting room. During this inspection, we saw this had been addressed as there were signs advising patients that they could speak to a member of reception staff privately if required.
We observe equipment was easy to locate, clearly organised, labelled and sufficient to meet the needs of patients.

There was a fully equipped paediatric resuscitation bay and resuscitation trolley with all sizes of equipment. This and the other adult resuscitation bays were checked on a daily basis to ensure they were ready for use and we saw records, which confirmed this.

There was audio and visual separation of the paediatric waiting room and treatment room. This was in line with the Royal College of Paediatric and Child Health: Standards for Children and Young People in Emergency Care Settings 2012.

The mental health room used for conducting mental health assessments was mostly compliant with the Quality Standards for Liaison Psychiatry Services Fifth Edition 2017. For example the room had no cables, heavy weight furniture and no ligature points. However, there was not a panic button or alarm system should staff need help immediately. In addition, the glass door panels were not shatterproof or obscured glass, which did not provide a sufficient level of privacy. We discussed this with the deputy head of nursing who said the risk of no alarm was mitigated because there were two doors from which staff could access in close proximity to alarm bells. In addition, staff could request a personal alarm and the department would provide one. The deputy head of nursing told us they would discuss with the estates department options for obscuring the windows to provide privacy.

The adult waiting areas had separate male, female and disabled toilets. We identified potential ligature points in the toilets, which could be used by mental health patients. This was escalated to the deputy head of nursing who said they would immediately undertake a risk assessment of the toilets in conjunction with the trust’s estates department. Each toilet had a panic button or pull cord to alert staff if help was needed.

The department was close to car parks and had a drop off area for police and ambulances.

The department was located near the x-ray department and CT scanner to allow for easy access. Panic alarms and call bells were tested daily as part of the daily checklist and we saw records, which confirmed this. Staff told us that the panic alarms system had recently been upgraded, as there was an issue with hearing the alarm in all areas.

All doors were unobstructed and fire escapes were clear. In the reception area, we saw that there were easy clean chairs for patients to use whilst waiting for treatment and there appeared to be sufficient seating in the waiting areas.

The department did not have a separate viewing room for family to see their relative’s body if they had died. The Royal College of Emergency Medicine: End of life care for adults in the emergency department 2015 recommends this as good practice. The department had recently refurbished the relatives room, which met the criteria set out in the same guideline.

**Assessing and responding to patient risk**

The department were effectively using a system to monitor acutely ill patients.

The department was using the National Early Warning Score system for the monitoring of vital signs in adult patients on wards to highlight early signs of deterioration of a patient’s conditions. The National Early Warning System score prompted staff to take further action. For example, increasing the frequency of monitoring vital signs and informing medical staff so they could review patients and escalate treatment if required. We checked 15 adult patient records and saw all of the
early warning score charts were fully completed and scores calculated correctly and action taken when required. This was an improvement from our last inspection when four out of ten records did not have a score recorded.

Data supplied to us by the trust showed between April 2017 and January 2018, 100% of patients had their observations taken and documented and 98% of patients had a National Early Warning Score documented. This showed patients were being monitored and any signs of deterioration would be highlighted.

The department also used a Paediatric Early Warning Score system for the monitoring of vital signs, and early signs of deterioration in children. We checked six paediatric patient records and found although five of the charts were completed and a score calculated the frequency of vital signs monitoring varied. For example, one patient had observations undertaken twice in a four hour period and another patient had five sets of observations in four hours. One patient did not have a full set of observations undertaken and therefore a score could not be calculated. This meant signs of early deterioration in the patient’s condition may have been missed.

There was evidence staff used escalation procedures correctly. For example, a patient in the resuscitation area was acutely unwell and the doctor contacted the critical care outreach team for support. The critical care team arrived in the department to review the patient within 10 minutes. This ensured the patient received prompt specialist care.

Staff escalated patients with deteriorating National Early Warning Scores by bleeping the critical care outreach team who were able to provide clinical support. The team also arranged transfer to the intensive care unit or high dependency unit if required. A nurse also attended all cardiac arrest calls in the department and we observed this during a cardiac arrest.

The department used a rapid assessment and treat model during busy times and when staffing allowed this enabled them to assess and treat majors patients more quickly. It was only undertaken on an ad-hoc basis but it was hoped to be permanent in the future.

During our last inspection, we identified that patients were often left without their call bell within reach. During this inspection, we saw inpatient essential care rounds had been introduced. The care rounds were undertaken every two hours and one of the checks was to ensure call bells were within reach. Other checks included but were not limited to; patient positioning/pressure areas, fall risk hazards, a drink within reach and if the patient required the toilet.

Data supplied to us by the trust showed between April 2017 and February 2018 95% of patients had essential care rounds recorded if in the department for more than four hours.

Every patient had a safety checklist completed whilst in the department. The safety checklist was broken down into three sections; checks undertaken within one hour, two hours and three hours of arrival in the department. The checklist included a variety of checks, which included but were not limited to; vital signs measured, identification wristband on patient, suspected sepsis (infection), blood tests and pain score. We saw completed safety checklists in all the notes we reviewed.

If patients were delayed in the department for more than four hours or transferred to the clinical decision unit the inpatient documentation was completed. This included a variety of risk assessments including risk of falls, venous thromboembolism, risk of malnutrition, pressure areas and frailty score. This ensured risks were assessed and measures put in place to mitigate the risks.

Staff used body maps to document injuries to patients, this helped with assessment of injuries or in cases of unexplained bruising or injuries where there was a safeguarding concern. The body maps were all used to document and pressure areas or pressure ulcers a patient had. This meant
a record of a patient's pressure areas where recorded when they first admitted, and any new areas were easily identified. Data supplied to us by the trust showed between April 2017 and January 2018 78% of patients had a completed body map within their records. This was an improvement since our last inspection when they were poorly completed but there was still room for improvement to ensure every patient had a completed body map. In the patient records we reviewed, we saw completed body maps, completion of the body map was included in the safety checklist.

The service used an Acute Sepsis Screening and Treatment Tool for adults and paediatrics, which was based on Sepsis Six. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce deaths and serious illness associated with sepsis. The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis.

The six paediatric patient records we reviewed showed that they were all seen within 15 minutes for initial assessment and had a pain score recorded. This meant children were assessed quickly to ensure care and treatment was given quickly.

A nurse triaged all patients and category assigned one to five depending on their condition. These categories were immediate resuscitation (1), very urgent or seriously ill (2), urgent patients with serious problems but stable (3), standard cases without immediate danger or distress (4) and non-urgent patients conditions are not true accidents or emergencies (5). All the patient records we viewed the patient had been assigned a category.

After patients had been triaged, they were streamed to the most appropriate part of the department or hospital. Alternatively, children under the age of one and known non-accidental injuries were transferred to the inpatient paediatric ward, minor injuries were streamed to the primary care suite and major illness and injuries streamed to majors or the resuscitation area.

We saw the plastic aprons worn by staff in the resuscitation area were colour coded this meant staff could be easily recognised by their apron in an emergency when many staff were present. For example, the team leader wore a red apron.

Patients brought in by ambulance occasionally had to wait in a non-treatment area when the department was very busy. When this occurred staff were allocated to supervise them, and the nurse in charge was informed. We did not observe any patients waiting in non-treatment areas during our inspection.

There was a trust lead for sudden, unexpected deaths in infancy and childhood who could be easily accessed to provide support and guidance. We saw the department had sudden, unexpected deaths in infancy and childhood box, which contained items that might be required.

De-briefs were regularly undertaken for staff to provide support after involvement in distressing situations. Staff gave an example of when a child was seriously injured and a consultant undertook a de-brief with the staff involved. This provided support to staff, gave them the opportunity to ask questions and obtain further information. Staff were extremely positive about the de-briefs.

There was access to mental health liaison twenty-four hours seven days a week. This meant there was specialist support and advice available for patients attending the department with mental health needs.

Five hospitals in Sussex provided a place of safety, which the service could access. The Mental Health Act gives police powers to take people who appear to be suffering from a mental health disorder to a place of safety for assessment for up to 72 hours - in the interests of the health or safety of the person, or the protection of the public.
Emergency Department Survey 2016

The trust scored worse than other trusts for one of the five questions on the Emergency Department Survey relevant to safety and about the same as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (01/09/2016 - 30/09/2016))

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was consistently better than the overall England median over the whole of the 12 month period from December 2016 to November 2017.

Ambulance – Time to initial assessment from December 2016 and November 2017 at East Sussex Healthcare NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Conquest Hospital

From December 2016 to November 2017 the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Conquest Hospital was stable at around 72%.

Ambulance: Number of journeys with turnaround times over 30 minutes - Conquest Hospital
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Conquest Hospital

(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From November 2016 to October 2017 the trust reported 952 “black breaches”, with a downward trend over the period. This information was not provided at hospital site level.

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

Nurse staffing

The trust has reported the following nurse staffing numbers in urgent and emergency care by site as of October 2017:
<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>50</td>
<td>47</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

A team of 47 nurses, supported by a team of healthcare assistants, led nursing care in the department, including the clinical decision unit. The management of the ambulatory care unit was within the Medicine Division.

There were three staff nurse vacancies, however these had recently been appointed to.

The senior management team had recently reviewed of safe nursing levels and had prepared a business case, which was currently under review by the trust’s executive team. This was undertaken to ensure there were sufficient numbers and grades of staff to ensure patients were kept safe. It was planned that an increase in nursing numbers would allow the extra staff to undertake rapid assessment and treatment of patients when triaged. Currently this only happened when staffing allowed, this would improve flow through the department and ensure patients were assessed quickly.

There was one band six nurse or above who co-ordinated each shift which was scheduled in advance, one emergency nurse practitioner on the day time shift, one on a twilight shift, in addition there was a specialist trauma nurse on day shifts. Between 07:30am and 7:30pm, there were 10 qualified nurses and five health care assistants. Between 07:30pm and 07:30 am, there were eight qualified nurses and four health care assistants on each shift. We reviewed three months of the rota, which confirmed this.

During our last inspection, the emergency department had no permanent paediatric nurses and this was highlighted as a significant risk on the urgent services risk register. Since our last inspection, paediatric nurses had become part of the emergency department nursing establishment. There was at least one paediatric nurse on each shift between 10am and 10:30pm, we reviewed three months of the rota, which confirmed this. Outside of the hours adult nurses cared for paediatric patients with the support from paediatric nurses on the inpatient paediatric ward. During these hours, paediatric patients could be streamed directly to the paediatric in patient ward if required.

Staff told us that since paediatric nurses were employed by the emergency department the quality of the paediatric service had dramatically improved and had driven change.

There was a large noticeboard within the department, which was accessible to all. The daily staff levels were written on the board and corresponding pictures of faces. The smiley face meant that staffing levels were as planned and neutral face meant staffing levels were satisfactory and being monitored a sad face meant urgent action was required to address staffing and action was in hand. This acted as a good visual tool for staff and visitors on the current staffing status.

There is no recognised safer staffing tool for emergency departments, the department worked with one nurse to every four patients within the majors department and one nurse to two patients in the resuscitation department.

The service had a computer software system, which predicted the amount of attendances there would be on a daily basis based on the same day in previous years. This was taken into consideration when the rosters were developed and staffing allocated. Staffing was planned on an electronic system, completed by senior staff in the department.
Staffing was reviewed twice a day at handovers in the department and three times a day at the trust board meetings. If the department was short staffed, the staffing across the whole hospital was reviewed and additional staff sought from other areas in order to support the department. Staff told us that this did not happen as often as it used to as the vacancy rate was lower. Senior staff helped in the department when it was short staffed or busy. Staff gave us examples of when managers had come in from home at night or during the weekend.

Senior nurses told us that cross-site working between Conquest hospital and Eastbourne had improved. For example, Eastbourne staff worked at Conquest hospital to allow staff to attend a funeral and Conquest staff worked at Eastbourne hospital when they undertook a charity event. Staff said they felt this was positive and had helped to build a better relationship.

Seasonal variations and increased demand was managed by the department’s escalation plan and the trust’s business continuity plans. The department’s current escalation level was displayed on a television screen within the department this meant staff and visitors were aware of the current escalation status.

There was a nursing handover at the end of each shift to the incoming nurse in charge. The handover included any patients in the department who were acutely unwell, the escalation status, staffing status and any pressures effecting flow within the department.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 12% for nursing staff in urgent and emergency care, which was higher than the target of 10%. The vacancy rate for nursing staff in urgent and emergency care at Conquest hospital was 11%, which was slightly higher than the trust target.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 14% for nursing staff in urgent and emergency care, which was higher than the target of 10%. The turnover rate for nursing staff in urgent and emergency care at Conquest hospital was 11%, which was slightly higher than the trust target.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 6% for nursing staff in urgent and emergency care, which was higher than the target of 3%. The sickness rate for nursing staff in urgent and emergency care at Conquest hospital, was 7%, which was higher than the trust target.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and agency staff usage**

From November 2016 to October 2017, the trust reported a bank and agency shift total of 6,701 for nursing staff in urgent and emergency care. Of the 4,779 bank shifts that were filled, 1,384
were for registered nurses. In addition, there were 1,922 agency shifts were filled, 1,448 of which were registered nursing shifts. There were 1,844 nursing shifts not filled by bank or agency staff. Emergency department bank staff were offered a financial benefit if they undertook a certain number of bank shifts in a defined period. This was done to encourage bank staff who knew the department processes and policies to work rather than using agency staff.

Please note that we were unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and agency usage at both Conquest Hospital and Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/ agency</th>
<th>Healthcare assistant</th>
<th>Registered nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Bank</td>
<td>1,642</td>
<td>658</td>
<td>2,300</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>129</td>
<td>400</td>
<td>529</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>163</td>
<td>558</td>
<td>721</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical staffing**

During our last inspection, the emergency department did not meet the requirements of the Royal College of Emergency Medicine guidelines of consultant cover within the department. During this inspection, we found consultant cover within the department had been extended and now met the Royal College of Emergency medicine guidelines. Consultant cover in the department was until 2am on Monday, Tuesday, Wednesday and Friday with a consultant on call between 2am and 7am. Consultant cover in the department was provided until midnight on Thursday, Saturday and Sunday with a consultant on call between midnight and 7am.

A paediatric consultant was available on call out of hours to support the department and a senior grade paediatric doctor was on site to provide advice and support out of hours.

Vacancies in medical staffing were reflected in the risk register for urgent care services and was scored at the second highest risk. To mitigate this risk, existing consultants now provided extended cover and internal locum middle grade doctors were appointed. Using the same locum medical staff provided continuity to the department and they were familiar with the departments processes and policies.

Updated information received from the trust after our inspection showed there were now only two consultant vacancies one for a permanent locum and one for a locum consultant, both were currently being advertised.

The leadership team had actively been trying to recruit to the consultant and middle grade vacancies. During an interview with the leadership team during the inspection, they said they felt the medical rota would be fully established at Conquest hospital within the next three months. There were plans to introduce cross-site working for doctors, which would provide better cover at both hospital sites.

A handover was undertaken at the end of each shift to the oncoming team, this included a brief summary of each patient in the department and any who were acutely unwell and patients who required review. This ensured the oncoming team had oversight of the patients within the department. We did not observe any handovers during our inspection.
We received positive feedback regarding consultant cover within the department, this was an improvement since our last inspection when it was variable. All staff including doctors in training, nurses, allied health professionals such as physiotherapists said consultants were very supportive and approachable. We saw evidence of this during our inspection for example, we saw a physiotherapist discuss a patient’s type of cast and weight bearing status with a doctor.

A consultant clinical lead was not formally in post at the time of our last inspection. However, in November 2016 a new governance and unit structure was implemented. A triumvirate made up of a head of nursing, lead medical consultant and a director of operations led the department. Feedback from staff regarding the leadership team was positive.

There was a criteria for calling the consultant in from home out of their working hours, we saw this was predominantly displayed in areas around the department. This meant staff understood in what circumstances it was appropriate to request the consultant came in from home.

The trust has reported the following medical and dental staffing numbers in urgent and emergency care by site as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 23% for medical and dental staff in urgent and emergency care, which was higher than the target of 10%. At Conquest hospital, the vacancy rate in urgent and emergency care for medical and dental staff was 25%, which was higher than the trust target.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 17% for medical and dental staff in urgent and emergency care, which was higher than the target of 10%. At Conquest hospital, the turnover rate in urgent and emergency care for medical and dental staff was 25%, which was higher than the trust target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 4% for medical and dental in urgent and emergency care which was higher than the target of 3%. At the Conquest hospital the reported sickness rate for medical and dental staff was 1%, which was lower than the trust target.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and locum staff usage

From November 2016 to October 2017, the trust reported a bank and locum shift total of 1,944 in urgent and emergency care. Over 60% of these shifts (1,238) were for middle grade doctors. There were no shifts that were not filled by bank or locum staff.

Please note that we were unable to calculate bank and locum usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and locum usage of Conquest hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/locum</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Bank</td>
<td>75</td>
<td>135</td>
<td>0</td>
<td>400</td>
</tr>
<tr>
<td></td>
<td>Locum</td>
<td>85</td>
<td>681</td>
<td>250</td>
<td>1,016</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical agency locum)

Staffing skill mix

As of September 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the average for England.

Staffing skill mix for the 39 whole time equivalent staff working in urgent and emergency care at East Sussex Healthcare NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>29%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records
The department used paper records for patient notes and assessments and an electronic system for tracking lengths of stay, x-rays and tests. A paper based casualty card was used to record any treatments and procedures undertaken whilst the patient was in the department. The same one was used for adults and paediatrics.

Data supplied to us by the trust showed between April 2017 and January 2018 100% of patient records had full name, next of kin, National Health Service number, date of birth and known allergies.

We reviewed 15 adult patient records and six paediatric records. Patient files were signed, dated and legible. Pressure assessments were complete, where applicable, and early warning scores and pain scores were recorded.

A member of the administration team explained how all the paper casualty cards were reviewed for the previous 24 hours to ensure they were fully completed and the times recorded matched those on the electronic system. Once this was complete, they were scanned into the electronic system, they were kept for 24 hours in case the patient returned to the department, this enabled them to be found quickly and easily. After 24 hours they were stored in locked cupboards, we confirmed this during our inspection. They were kept in the department in the locked cupboards until the consultants secretary said all audit data had been obtained and then the paper casualty card was shredded. Any other associated paper work, for example medicine charts, were returned to the medical records department for filing.

During the inspection, we observed a doctor request access to a patient record who had attended the department the week before. We saw how the administration staff were able to access the information quickly and easily for the doctor.

Certain administration staff had authorisation to request a patients full medical notes if required, out of hours this could be done via the site manager. This meant there was access to the patients full medical records if needed.

Discharge summaries were generated and sent to the patients GP by post or faxed over if urgent.

A consultant and senior nurse undertook four hourly ‘intentional rounds’ in the department and every patient and their paperwork were reviewed. This provided quality control in relation to records as any issues were identified and rectified.

Between three and five patient records were audited on a daily basis this was a mixture of adult and paediatric records. Immediate feedback was given on the audit during the ‘board rounds’ that were undertaken during the day. This meant feedback was given to the staff that were working in the department on the day and completing the records.

We saw that mental health and physical health records were shared effectively to avoid unnecessary admissions. The mental health team included a summary of their assessment within the emergency department documentation. Staff could request the full mental health liaison documentation if required.

Monthly meetings were undertaken between mental health liaison team, local ambulance service, Clinical Commissioning Groups and emergency department leads to review frequent attenders. This ensured patients care plans were developed for patients and they received appropriate interventions to reduce unnecessary attendances to the emergency department.

The electronic patient system allowed alerts to be added to patients, there was a symbol next to the patient name. This meant patients with allergies or pre-existing physical or mental health illnesses were highlighted and prompted staff to look what the alert was.
Medicines

Medicines and controlled drugs were stored and dispensed using an electronic system that operated securely on staff thumbprint access. Controlled drugs are medicines liable for misuse that required special management. A double fingerprint of two different authorised staff was required to dispense controlled drugs. This ensured they were stored and dispensed in line with The Misuse of Drugs Regulations 2001. We checked the controlled drug records, which were fully completed, with no omissions. Pharmacy services monitored the electronic system centrally and were alerted if there was a problem with temperature maintenance or stock discrepancies.

Pharmacy were responsible for checking the expiry dates of the medicines and to ensure they were safe to use. Daily support was provided by a pharmacy technician who supplemented the central monitoring checks with stocktaking.

We asked a member of staff to dispense three different drugs, all were in date. However, we found four medicines in the fridge in the resuscitation area, which had expired. This meant they may no longer be effective or safe to use. We highlighted this to staff during our inspection who arranged for a replacement of the medicines and said they would highlight it to pharmacy services.

We saw there was a protocol in place for administering medicines to children. There was a policy, which set out specific medicines, which required two qualified members of staff to double check the preparation and administration. Medicines included but were not limited to any medicines given intravenously (into a vein), intramuscular (into the muscle), oral morphine (strong painkiller) and insulin.

There were a variety of adult and paediatric patient group directives used within the department. A patient group directive is signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines to patients using the nurses own assessment, without necessarily referring back to a doctor for a prescription. Staff were accessed by doctors before they could issue patient group directives, this ensured they had the skills and knowledge.

We saw medical gas cylinders were correctly stored and the correct signage was in place in line with legislation.

We saw intravenous fluids had recently been relocated to a different storage area which ensured they were kept in a locked cupboard. This was in line with national guidelines.

All the medicine charts we reviewed had any allergies clearly documented. This alerted staff to the patient's allergies.

Data supplied to us by the trust showed between April 2017 and February 2018 95% of patient medicine charts had medicines prescribed correctly and administered at the correct times. This reflected what we found during the inspection.

There was local microbiology protocols in place for the administration of antibiotics, for example for the management of sepsis. We saw these were available on the trust internet for staff to access.
Incidents

Staff recognised incidents and knew how to report them, an electronic system was used for reporting incidents.

Between 28 March 2017 and 27 March 2018 there was 293 incidents reported within the emergency department at Conquest hospital. Of these incidents 85% resulted in no harm, 12% resulted in minor harm, 2% resulted in moderate harm and 1% in major harm. The top three themes of reported incidents were no availability to or delay in provision of service, incorrect administration of drugs and communication - inadequate or failure of hand over of care.

One band seven was the lead for investigating incidents and had undertaken appropriate training. Staff told us that previously they did not always receive feedback about incidents, but this had now changed and were always contacted personally if they raised an incident and received feedback. Staff said incidents were investigated quickly, and shared lessons learned and changes in practice with staff.

In the 2017 staff survey 89% of staff said they agreed / strongly agreed that their organisation encouraged staff to report errors, near misses or incidents.

There was a noticeboard in the corridor outside the staffroom that highlighted the trends from incidents reported in the past month and the learning that had been disseminated from these incidents. Learning from incidents was also fed back at the daily handover meeting and staff meetings. Learning from incidents was also included in the ‘start of the week message’ and we saw confirmation of this within the communication folder.

For example, we saw there had been a change in practice after an incident involving a diabetic patient, a new diabetic protocol had been developed. We saw this had been communicated in the ‘start of the week message’ and discussed in the March 2018 Emergency Department meeting.

Staff were able to give us examples of when they had raised incidents and received feedback. For example, a staff member told us when they had raised a safeguarding concern and had received feedback and assurance that action was taken.

At the time of our inspection, there were less than 10 incidents that remained open. Senior staff were notified by email when an incident was completed. There was key performance indicators in place for the management of incidents for example how many were left open. This meant incidents were investigated quickly and learning identified.

Any incidents that were graded with a high severity score of three, four or five were presented by a senior nurse at the weekly incident review meeting. The purpose of this meeting was to assess the risk and adjust the severity of risk if required. For example, an incident maybe downgraded or upgraded and declared a serious incident. It was the responsibility of the head of nursing and deputy head of nursing in conjunction with the lead medical consultant to ensure incidents were discussed at the weekly meeting.

Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

We saw evidence that the duty of candour (DOC) regulation had been applied. The trust’s root cause analysis report and electronic incident reporting system contained a section for duty of candour. It included checks that the patient and/or relative had been given a verbal apology, they...
had received a trust letter and been given a point of contact as well as an offer to share the outcome of the investigation.

Monthly mortality and morbidity meetings were undertaken and attended by the multi-disciplinary team. Mortality and Morbidity meetings, review deaths as part of professional learning, have the potential to provide hospital boards with the assurance that patients are not dying as a consequence of unsafe clinical practice. We saw in the monthly meeting minutes that the meetings were used to improve patient care. For example, in the February 2018 meeting we saw the policy for the correct treatment of hypoglycaemia (low blood sugar) was reviewed and ensured it was based on the Joint British Diabetic Society guidance.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported are shown below:

![Graph showing types of serious incidents reported to STEIS]

The breakdown of incidents by site was:

- Conquest Hospital – four incidents

(Source: NHS Improvement - STEIS (01/12/2016 - 30/11/2017)
Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers or falls with harm and three new catheter urinary tract infections from December 2016 to December 2017 within urgent and emergency care. These catheter urinary tract infections occurred in March and April 2017.

Data supplied to us by the trust showed between April 2017 and February 2018 80%, of patients had a pressure ulcer plan completed and actions in place when identified. This meant 20% of patients did not have their pressure areas assessed and actions taken to reduce the risk of pressure ulcers.

Any patient who was going to be transferred to the clinical decision unit or admitted to a ward had a venous thromboembolism assessment undertaken. This was in line with The National Institute for Health and Care Excellence guideline QS3; we saw completed assessments within patient records.

Prevalence rate (number of patients per 100 surveyed) of catheter urinary tract infections at East Sussex Healthcare NHS Trust

![Graph showing prevalence rate](Source: Safety thermometer - Safety Thermometer)

Total CUTIs (3)

Major incident awareness and training

The trust had a major incident policy; this was accessible to staff on the trust intranet. There was a major incident file, which contained action cards and guidance.

Major incident and decontamination equipment was available on site in line with National Health Service England guidance on chemical, biological, radiological and nuclear provision. We saw there was an effective checking process, which ensured that the equipment was checked monthly to ensure it was in date and safe to use. The estates department and trust porters were trained to put up the decontamination tents.

We heard from staff that a major incident was declared at the trust involving the emergency department in the summer of 2017. The incident involved a ‘chemical flume’ on a busy beach on the South coast. Staff told us that the incident was well managed and they had identified learning from the incident, which had resulted in changes. As the incident involved a chemical, patients were required to remove their clothes and undergo rinsing with water. After this, they were
required to wear disposable clothing however, this was only available in one size and was too big for children involved in the incident. Because of this, the department had sourced a variety of different sizes of clothing. In addition, there was no bottled drinking water available for patients to drink whilst they were outside undergoing decontamination process.

Senior staff told us that training in chemical, biological, radiological and nuclear incidents had lapsed and only a few staff had in date training to perform this role. We saw evidence that four members of department staff were booked on training and once trained they would ensure they trained all staff.

A fire management policy was in place that met the requirements of the Department of Health’s Health Technical Memorandum 05-01 in relation to managing healthcare fire safety and was in date. This required fire wardens to complete weekly fire safety checks and to assume a leadership role in an evacuation. The policy required staff to take part in a fire drill or fire evacuation drill every 12 months. We reviewed records during the inspection, which confirmed these checks, and drills had been undertaken. Two fire wardens were in post and had responsibility for this.

There was an effective process in place, which ensured regular fire assessments were undertaken, and action taken as required. We saw the most recent fire assessment was undertaken on 05 January 2018. The assessment included any actions required, who was responsible for the actions and a completion date for the actions.

Two security officers were available 24-hours a day, this meant staff had rapid access to security support if needed to help with violent or threatening patients. During our inspection, we saw a member of staff request a security guard was present during assessment as the patient had previously been known to carry weapons. We saw the security guard arrived promptly within the department to provide support.

Staff told us that they felt supported by the security team and they had always responded promptly when assistance was requested.

**Is the service effective?**

**Evidence-based care and treatment**

A local audit programme was shared with the Eastbourne urgent care clinical unit and included individual audits used to benchmark and assesses care and patient outcomes against a range of targets and standards. The department also took part in national audits such as those identified by the Royal College of Emergency Medicine (RCEM).

We saw there were a variety of pathways in use that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine’s (RCEM) clinical standards for emergency departments. These aimed to promote early treatment and improve patient outcomes.

For example, we observed staff adhering to National Institute for Health and Care Excellence guideline Sepsis: recognition, diagnosis and early management (NG51). Patients were given a broad-spectrum antibiotic (at the maximum recommended dose without delay). This meant patients were given antibiotics without delay.

We saw staff followed National Institute for Health and Care Excellence guideline: Type 1 diabetes in adults: diagnosis and management (NG17). For example, we saw intravenous fluids were given to a patient.
Governance meeting minutes showed that National Institute for Health and Care Excellence guidelines were discussed. This enabled changes to guidance could be applied to systems and processes within the department.

Local audit information was displayed for staff on an audit noticeboard and was used to highlight areas of good practice and areas where improvement was needed.

Emergency nurse practitioners worked in accordance with national best practice guidance. For example, they followed National Institute for Health and Care Excellence Head injury: assessment and early management Clinical guideline (CG176). We saw this guideline was displayed within the department and was available for staff to access on the trust internet.

Staff who worked within the paediatric resuscitation unit followed South Thames Retrieval guidelines for the management of critically ill children. This meant they had access to a specialist retrieval team who transferred children to an intensive care unit at another hospital with the resources to provide care and treatment.

A trauma nurse service coordinator had been in post for nearly two years, which enabled the unit to contribute to the national trauma review programme, this helped to benchmark standards against other units nationally. The member of staff worked with another trauma rehabilitation nurse. They both supported nurses with trauma education and care supervision. They had presented at a local trauma network conference and were due to present nationally about the work they undertook at the trust. They also conducted a daily check of patient admission records to ensure staff had correctly identified trauma and collected audit data.

**Nutrition and hydration**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

*(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)*

Food was available for patients three times a day. We observed a lunchtime meal and there was a variety of food available. Hot and cold food was available, and sandwiches and biscuits were available 24 hours a day. Breakfast options were also available. Relatives of patients were also offered food.

We observed staff offering tea and biscuits to a patient and their relatives and asking their preferences on how they liked their hot drinks prepared.

Data supplied to us by the trust showed between April 2017 and February 2018 96% of patients felt adequate food and drink was provided to them whilst in the department.

There was a vending machine in the main waiting area. This offered hot and cold drinks and a selection of snacks such as biscuits, crisps and confectionery. During our inspection the vending machines were stocked and in use.

The hospital also had a large canteen, bakery and shop all within close proximity to the department.

All the patients we spoke to said they had been offered an adequate amount of food or drink.

**Pain relief**
Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.7 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 6.9 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was worse when compared to other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Three different pain assessment tools were in use. The adult pain tool was a score between 0 and 10, zero being no pain and 10 being the worst pain a patient had ever experienced. The paediatric assessment tool was picture of faces with different expressions; a smiley face meant no pain and a sad face being extreme pain. The Abbey Pain score was used for the assessment of pain in patients who could not verbalise for example patients living with dementia or patients with communication difficulties.

In our last inspection, there was an inconsistent approach to the management of pain. In ten sets of patient notes we looked at, four did not have a pain score documented. During this inspection, we reviewed six paediatric records and eleven adult patient records all had a documented pain score. Patients were asked to score their pain when they were assessed and subsequently when their vital sign observations were undertaken and when they had received pain relief.

Data supplied to us by the trust showed that between April 2017 and February 2018 86% of patients had a pain score documented in their notes and 94% of patients felt their pain was managed well. We saw in the records we reviewed that pain was regularly assessed.

Patients told us they were regularly asked if they were in pain or required pain relief and it administered quickly when it was required. We saw a patient in severe pain and the nurse asked a doctor to review the patient who prescribed strong painkillers, we saw these were administered and their pain reassessed to ensure the pain killers had been effective.

Patient outcomes

We saw that the trust had participated in national audits such as those identified by the Royal College of Emergency Medicine (RCEM). The results were used to benchmark and compare with other trusts nationally. There was a clinical audit lead in place for the department and they would lead on audit completion and compliance.

There were nursing audits undertaken by the department that fed in to monitoring patient outcomes, such as a pain audit and national early warning score audits.

Royal College of Emergency Medicine Audit: Moderate and Acute Severe Asthma 2016/17

Conquest Hospital

In the 2016/17 Moderate and Acute Severe Asthma report, the hospital failed to meet any of the RCEM standards.

The hospital was in the upper UK quartile for three standards:
Standard 5a: If not already given before arrival to the emergency department, steroids should be given within one hour of arrival (acute severe) – Hospital: 39%; UK: 19%

5b: If not already given before arrival to the ED, steroids should be given within four hours (moderate) – Hospital: 70%; UK: 28%

Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines – Hospital: 81.0%; UK: 52%

The hospital was in the lower UK quartile for one standard:

Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED – Hospital: 9.0%; UK: 25%

The hospital’s results for the remaining three metrics were all between the upper and lower UK quartiles.

RCEM Audit: Consultant sign-off 2016/17

This trust did not participate in this audit.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Conquest Hospital

In the 2016/17 severe sepsis and septic shock audit, the hospital was in the upper UK quartile for one standard:

Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to): Within one hour of arrival – Hospital: 74%; UK: 30%

The hospital was in the lower UK quartile for two standards:

Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival – Hospital: 39.0%; UK: 69.1%

Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival – Hospital: 0%; UK: 18.4%

The hospital's results for the remaining five metrics were all between the upper and lower UK quartiles.

Sepsis Six data showed between April 2017 and February 2018 there were only four months when compliance with the target (90%) for the screening for sepsis had been achieved. The lowest level of compliance was in November 2017 (68%) and the highest was in April 2017 (96%). Data in the same time period showed poor compliance with the overall delivery of Sepsis Six management. The lowest level of compliance (11%) was in August 2017 and the highest compliance (43%) was in February 2017. Data in the same time period showed better compliance with giving antibiotics within one hour of diagnosing sepsis compliance ranged between 100% (August 2017) and 64% (September 2017).

We reviewed five patient records that were undergoing treatment for sepsis. Four out of the five had all six tests and interventions undertaken within the hour. We escalated the one patient who did not to a consultant who undertook a review of the patient’s notes. There was a delay to the
patient undergoing initial triage assessment, however once triaged the sepsis was recognised and treatment given within one hour as per national guidance. The consultant informed us that they would complete an incident form to ensure the reason for the delay was investigated and lessons learnt.

Varied performance in the delivery of Sepsis Six might mean patients were not receiving care and treatment quickly placing them at an increased risk. The leadership team had identified poor compliance with sepsis management and had developed an action plan. We saw some actions had already been undertaken. For example, medical and nursing ‘sepsis champions’ and locating the fluid balance charts with the intravenous fluids to act as a reminder for staff to complete the fluid balance chart.

The department undertook a re-audit of Sepsis Six compliance in March 2018, data supplied to us after the inspection showed a marked improvement in compliance. For example, 100% of patients had their vital signs documented compared to 61% in the previous audit and 91% of patients were given oxygen compared to 82% in the previous audit. Overall compliance with Sepsis Six was more than 90% compared to 33% in the previous audit. This showed that the actions undertaken within the action plan had a marked improvement in the management of sepsis.

It was possible to add an alert to a patient on the computer system for patients with or suspected sepsis, this acted as a visual reminder for staff. In addition, it alerted consultants when reviewing patients within the department.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

Conquest Hospital

The hospital failed to meet any of the standards.

The hospital was in the upper England quartile for one standard:

Standard 1a: All children attending the emergency department with a medical illness should have a set of vital signs consisting of: temperature, respiratory rate, heart rate, oxygen saturation, Glasgow Coma Scale or Alert Verbal Pain Unresponsive score – Hospital: 51%; UK: 38%

The hospital’s results for the remaining five metrics were all between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16

Conquest Hospital

In the 2015/16 Procedural sedation in adults audit, the hospital failed to meet any of the audit standards (which were all 100%).

The hospital was in the lower England quartile for two standards:

Standard 5: Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG – Hospital: 0%; UK: 24%.
Standard 7: Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including 7a) Return to baseline level of consciousness, 7b) Vital signs within normal limits for the patient, 7c) Absence of respiratory compromise, 7d) Absence of significant pain and discomfort, 7e) Written advice on discharge for all patients – Hospital: 0%; UK: 3%.

The hospital's results for the remaining five metrics were all between the upper and lower England quartiles.

**RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16**

**Conquest Hospital**

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit the hospital failed to meet both of the audit standards (which were all 100%).

The hospital was between the upper and lower England quartiles for both of the standards.

**Unplanned re-attendance rate within 7 days**

From December 2016 and November 2017, the hospital's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally similar or better than the England average.

**Unplanned re-attendance rate within 7 days - East Sussex Healthcare NHS Trust**

(Source: NHS Digital - A&E quality)

**Competent staff**

The department employed a practice development facilitator. They were in addition to the planned staffing on the unit so was able to allocate their time to training, development, coaching and mentoring of staff in the department.

The department had employed four newly qualified nurses, previously newly qualified nurses had not been employed to work in the department due to the clinical complexity of patients. However, senior staff recognised the need to recruit staff and develop the skills and knowledge required to work in the department. We saw there was an extensive induction and preceptorship programme...
for these nurses and each nurse was allocated a mentor. The training programme was comprehensive and covered areas including: bereavement, life support (basic, intermediate and advanced), sudden death, record keeping, the Mental Capacity Act and Deprivation of Liberty Safeguards, resuscitation, fluids, early warning scores (adult, paediatric and maternity) and infection control and prevention. The practice development facilitator and the staff member’s mentor would then work with them to ensure they felt confident and comfortable working in the department.

The department had links with universities and staff were able to obtain funding to complete accredited courses. Training and development in the department was encouraged for all staff at all levels.

We saw evidence that competencies were in place for all medical devices details were held in staff members files. All staff had completed medical device training.

There were link nurses for various areas, there were both adult and paediatric nurses for each role. For example, safeguarding, child protection, dementia, organ donation, mental health, infection prevention and end of life care. Link nurses acted as a resource for staff and were able to provide support and advice. In addition, they attended specific meetings for their area and were able to provide updates to staff.

Every three months the band seven nurses had a cross-site away day. Band seven nurses had one management day a month.

Junior doctors were positive about the learning and teaching opportunities within the department. They had access to scheduled teaching sessions twice weekly usually undertaken by one of the department’s consultants and we observed consultants undertaking bedside teaching.

There was an induction programme for all permanent staff, we reviewed this and saw it was comprehensive. Agency and locum staff also received induction to the department and we saw completed induction plans. Locum doctors were used within the department, the same staff were used who were familiar with the department and its policies. Locum doctors also had access to teaching and training.

The trauma nurse service coordinator led a programme of major trauma nursing competencies amongst nursing staff to improve skills and knowledge. In-house education sessions were held regularly. For example, the mental health liaison team undertook informal teaching with staff, which included a variety of subjects such as the Mental Health Act.

We observed excellent standards of preparation in the resuscitation area, including the use of safety checklists and preparation of equipment according to best practice guidance and infection control principles.

If staff were unsure if they wanted to apply for a job within the department they could work two paid shifts when they were in addition to the planned staffing levels. This provided staff experience of working within the department and an opportunity to meet the team.

Since the paediatric nurses had become part of the emergency department team, an education programme had started to improve the skills and knowledge of adult trained nurses had employed nurses. We saw a recent paediatric study day was undertaken, which included sepsis management, paediatric early warning scores, assessment of a sick child and a safeguarding refresher. All band seven nurses were undertaking an advanced paediatric skills course. This ensured staff had the skills and knowledge to care for children. Staff spoke positively about this programme and how it had improved the paediatric service.
We observed staff had the skills to sensitively manage difficult behaviours that patients displayed. For example, a member of staff efficiently and sensitively cared for a distressed patient with dementia.

**Appraisal rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Trust-wide**

From April 2016 to March 2017, 82% of staff within urgent and emergency care at the trust had received an appraisal. In 2017/18 year to date, 90% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>5</td>
<td>6</td>
<td>83%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>66</td>
<td>77</td>
<td>86%</td>
<td>22</td>
<td>26</td>
<td>85%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>21</td>
<td>29</td>
<td>72%</td>
<td>13</td>
<td>13</td>
<td>100%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>7</td>
<td>11</td>
<td>64%</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Conquest Hospital**

From April 2016 to March 2017, 88.9% of staff within urgent and emergency care at the hospital had received an appraisal. In 2017/18 year to date, 87.9% of staff at the hospital had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>36</td>
<td>39</td>
<td>92%</td>
<td>13</td>
<td>17</td>
<td>77%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>14</td>
<td>18</td>
<td>78%</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Multidisciplinary working**

A trust system wide call was undertaken daily at 2pm, a representative from the department attended this call. It was a teleconference, which included multiple agencies such as clinical commissioning groups, social services and the local ambulance service. The purpose of this call was to highlight any pressures within the system and work cohesively together to ensure efficiency. Support and extra resources were facilitated by this call for example the availability of extra rehabilitation beds within the community.
Cross-site bed meetings were undertaken at least three times a day, these were undertaken via teleconference with the equivalent staff roles at Eastbourne hospital. The purpose of this call was to discuss patient discharges, admissions, staffing, infection control and extra resources required. We attended one of these meetings, which was run efficiently and had clear actions for staff to take away and action.

Staff knew how to refer patients to local services for additional support. For example, staff told us how they would access ‘snowflake beds’ for homeless people in the winter.

A hospital intervention team made up of physiotherapists, occupational therapists and nurses supported patients who required additional support to be discharged home. They worked in the department alongside the team and assessed patients before they were discharged home. They liaised with care agencies and social services to ensure patient had the necessary care in place before being discharged home.

The department had established links with mental health services, learning disability, autism and dementia services within both the trust and external agencies. We saw a contact list to assist staff in making referrals.

The department undertook a monthly multi-disciplinary interagency meeting with clinical commissioning groups, safeguarding, local ambulance service and mental health liaison. The purpose of this meeting was to co-ordinate care for frequent attenders and to develop care pathways and interventions to divert patients who do not need to attend the emergency department.

Generally, the staff spoke positively about the relationship with other specialities within the hospital. Staff identified the relationship with the general surgical team as an area where communication and engagement required improvement. However, staff said that relationships and communication with other specialities had improved since our last inspection. The biggest change was a cultural change from the four-hour wait target, this was now the responsibility of the wider multidisciplinary team and not just the emergency departments. This change in culture shift meant that there was a more cohesive and proactive approach to managing set targets and improving patients experience.

Each different speciality directorate for example, trauma and orthopaedics had a designated person on the team who held a bleep and took referrals from the emergency department. This was because previously there had been difficulty obtaining advice or referring patients to other teams as they were busy operating.

The department had specific pathways for patients who required admission to the hospital. For example, patients who attended with a broken hip were fast tracked through the department to a ward to avoid delay.

A frailty team made up of nurses and geriatricians supported the department and were directly employed by the trust. The frailty team assessed acutely unwell patients and identified the most appropriate care pathway.

We observed excellent multidisciplinary working within the department, friendly interaction between all grades of staff and the culture was very non-hierarchical.

Nurses, emergency nurse practitioners, General Practitioners and health care assistants worked together cohesively to meet the needs of the department and support their professional development. Health Care Assistants were able to undertake additional tasks supervised by nurses or emergency nurse practitioners for example, taking blood samples.
A dedicated pharmacist worked in the department who provided oversight of medicines management and support for staff.

A cardiac nurse practitioner was available in the hospital seven days a week from 7am to 7.30pm. The practitioner supported staff assisting in ordering diagnostic and reviewing tests and liaising with consultants and departments if intervention was required.

**Seven-day services**

The department was operational 24 hours a day, seven days a week. The x-ray department facilities were next to the emergency department and could be accessed easily from the unit, 24 hours, seven days a week.

Mental health liaison nurses were available 24-hours, seven days a week. They were provided by an external organisation and were permanently based in the hospital. A doctor was available overnight and provided additional support for patients with mental health needs.

Consultant cover exceeded the minimum 16 hours a day cover required by the Royal College of Emergency Medicine. This was an improvement since our last inspection when cover was less than 16 hours per day. There was consultant cover in the department between 7am and 2am on Monday to Thursday and 7am and midnight on Thursday, Saturday and Sunday. Outside of these hours, consultants were available on call. There was a middle grade doctor available in the department 24 hours a day.

A crisis response team, rapid discharge team, physiotherapists and occupational therapists were available seven days a week and pharmacy support was available on-call at all times. This met the clinical services seven day standard. This standard requires all emergency inpatients to be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant.

Speech and language therapy and dietetics was not available at weekends or out of hours.

**Health Promotion**

The department had banners, posters and leaflets on display. In the waiting areas, there were contact details of a variety of support groups and advisory organisations for example, patients living with a brain injury, drug and alcohol misuse and smoking cessation.

There was information on recognising sepsis and a variety of information leaflets regarding specific conditions and treatment.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff had good awareness of The Deprivation of Liberty Safeguards processes. The Deprivation of Liberty Safeguards is part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

During our last inspection, we observed inconsistency of mental capacity assessments and screening tools. During this inspection, we found mental capacity assessments and tools were used consistently. Staff used a dementia screening tool and the Glasgow coma scale to document cognitive function.
Data supplied to us by the trust showed between April 2017 and February 2018, 85% of patients had a completed mental capacity assessment.

Staff used a monthly audit to monitor the consistency of recording consent in patient records. We observed staff providing care to patients and obtaining consent to provide treatment.

Trust-wide

The trust reported that, from November 2016 to October 2017, Mental Capacity Act training had been completed by 90.1% of all staff within urgent and emergency care. The breakdown of training completion for nursing and medical staff at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>96</td>
<td>99</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>29</td>
<td>41</td>
<td>71%</td>
<td>No</td>
</tr>
</tbody>
</table>

Conquest Hospital

The trust reported that, from November 2016 October 2017, MCA training had been completed by 92.4% of staff within urgent and emergency care at Conquest Hospital. The breakdown of training completion for nursing and medical staff at the hospital is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>53</td>
<td>53</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>12</td>
<td>19</td>
<td>63.2%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust set a target of 90% for completion of Mental Capacity Act training. Deprivation of Liberty training completion was not reported by the trust. Data showed that 94% of staff were up to date with Mental Capacity Act training which was better than the trust target.

Is the service caring?

Compassionate care

We observed a number of interactions between staff, patients and relatives. Staff were always polite, respectful and professional in their approach in the interactions we observed. We observed staff responding compassionately to patient’s pain, discomfort, and emotional distress in a timely and appropriate way. We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed. Confidentiality was respected in staff discussions with people and those close to them. Comments from patients included “can’t fault it, magnificent” and “they have listened and acted upon it”.

We observed that the unit had received thank you cards from patients and relatives, thanking staff for the support and treatment they had received. The unit also had a noticeboard with letters that local school children had written to the staff in recognition of their work.
All patients we spoke to were positive about the care they had received and felt safe whilst in the department. Patients said even though the department was extremely busy staff still had time to show them compassion and care.

We observed staff asked patients what name they wished to be called by whilst in the department and checked if patients were warm enough. Staff displayed an understanding and non-judgmental attitude towards patients.

**Friends and Family test performance**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better in comparison to the England average before increasing above the England average from July to November 2017.

**A&E Friends and Family Test Performance - East Sussex Healthcare NHS Trust**

(Source: NHS England Friends and Family Test)

**Emotional support**

There was a room for relatives to use if needed, which had recently been refurbished. The room provided access to hot drinks and spiritual and religious materials were available.

There was support available for the bereaved from the multi-faith chaplaincy service. We were given examples when staff had accessed the multi-faith chaplaincy to provide support for patients and their relatives.

We observed staff supporting patients emotionally and providing assurance to anxious and distressed patients.

We saw a variety of stickers and certificates were available for children such as ‘I was brave today’ stickers. Children had access to an electronic tablet to play games or watch a film or programme this acted as a distraction.

De-briefs were undertaken for staff if they had been involved in a distressing or difficult patient interactions, deaths or experiences. This provided support and a forum for ask questions or voice anything they were concerned about. A room in the department had been allocated as a wellbeing room and was awaiting refurbishment. This would provide a quiet and calm space away from the department where staff could spend time.
Staff provided immediate signposting to support services, including emergency counselling services, for the relatives of babies who died from sudden infant death syndrome.

Staff could access a take home and settle service for patients, this provided patients with support when they returned home and ensured they had food and drink at home.

We observed there was parity of care between those patients who attended the department with a physical health need and those with a mental health need. We saw patients received the same level of care regardless of the reason for their attendance.

There were leaflets and information about supports groups for patients with mental health or people living with dementia that had been recently diagnosed. There was information available about anxiety and useful coping strategies.

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

Patients told us staff explained their care and treatment to them in a way they could understand. We observed staff communicating in a way that people could understand and was appropriate and respectful. Patients and relatives told us they were kept informed of what was happening and understood what tests or treatment they were waiting for.

Patients were made as comfortable as possible for example, if they were in the department for a long period of time a hospital bed was requested for the patient, which was more comfortable than the trolley.

We observed staff asked patients if they wanted them to inform their family that they were in accident and emergency. For example, a patient who was acutely unwell was admitted and staff telephoned their wife to inform them. This was done in a sensitive manner so as not to cause alarm.

Data supplied to us by the trust showed that between April 2017 and January 2018, 98% of patient records contained documentation that relatives/family had been informed of the situation. This confirmed that patients relatives and family were kept informed.

The hospital intervention team worked closely with family members to ensure discharge packages were appropriate, and they were comfortable with the arrangements.

Staff routinely involved patients in plans and decisions about their care and treatment. For example, we observed one nurse explained why a repeat blood test was required.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored worse than other trusts in 11 of the 24 questions relevant to caring. For the other 13 questions the trust scored about the same as other trusts.
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>3.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>7.4</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people

The department had acknowledged the mental health needs of the local population and had access to mental health services 24 hours a day seven days a week via the mental health liaison team. There was a separate room to assess patients with mental health needs.

The management team worked in collaboration with a local homeless charity. Staff were asked to donate a hat, scarf, socks or gloves for the homeless charity and in return, the management team gave them a cake.

Both staff and managers reported difficulties accessing child and adolescent mental health services, especially out of hours. Staff explained out of hours children under the age of 16 with mental health needs were admitted to the children’s ward and you people aged between 16 and 18 years old to the clinical decision unit. A referral to the child and adolescent service the following day. Managers and staff thought this group of patients were being disadvantaged by the system and lack of support in place. However, this problem was not limited to Conquest emergency department it was a countywide issue. Within the South East region, there was only 3.75 child and adolescent psychiatrists per 100, 00 children. Difficulty accessing child and adolescent services was highlighted on the departments risk register and measures in place to mitigate the risk. For example, one of the measures was availability of child and adolescent services liaison based on the paediatric inpatient ward between 9am and 5pm to Friday.

GP streaming was used in the department for patients that self-presented and were streamed to the GP on triage, if they were deemed suitable. Patients who were triaged and deemed unsuitable for GP streaming were either seen in the major’s or minor’s area, depending on their condition. Therefore, the most appropriate clinician could see all patients more quickly.

The department saw a significant number of patients with needs relating to frailty. To ensure they received appropriate care, a frailty lead and team of frailty practitioners were in post to support discharge packages and reduce the risk of readmission. This team also conducted virtual ward rounds with a geriatric consultant to ensure care pathways were appropriate.

The frailty team also worked with patients, relatives and other agencies to develop PEACE plans (or ‘Proactive Elderly Persons Advisory Care’ plan) which is a document to help health care professionals deliver the best care to frail, older people with life-limiting illnesses such as with Parkinson’s, advanced dementia and cancer who are anticipated to be in the last year of their life and reside in a care home. It records discussions between the older person and/or their representatives and the geriatric team about what that best care might look like in the future when the older person’s health starts to decline further.

A multidisciplinary crisis response team attached to the hospital worked to prevent unnecessary hospital admissions. Staff could refer patients to the team with a single telephone call who could escort patients home and provide support such as staying overnight with patients to ensure they were safe. The crisis response team prioritised frail patients in response to the increasing numbers of patients seen in the department who required support in their home.
At the time of our last inspection, the department had no permanent paediatric nurses, since then some had been recruited and a paediatric nurse was in the department for 12 hours a day. The paediatric waiting room had been refurbished however, it was suited to young children. In addition, there were two new paediatric cubicles.

There was a paediatric pathway, which ensured children attending were triaged, assessed and treated away from adult pathways.

Children with a learning disability were fast-tracked to the paediatric in-patient area, this ensured their needs could be met and distress minimised.

There was a standard operating procedure was in place between the air ambulance service and the department to provide rapid transfer of trauma and severely medically unwell patients by helicopter.

**Meeting people’s individual needs**

Urgent care services had a number of initiatives in place for patients living with dementia, these included; state-of-the-art digital reminiscence therapy system, twiddlemuffs and dementia rummage boxes.

The clinical decision unit had a state-of-the-art digital reminiscence therapy system, which helped patients with dementia and elderly patients to have a more comfortable stay by providing access to archives of historic photos, music, games and even by allowing patients to take their own photos.

The clinical decision unit also had a dementia box on the ward – with picture cards and twiddle muffs knitted by local volunteers for patients to use for comfort. Twiddlemuffs were knitted woollen muffs with items such as ribbons, large buttons or textured fabrics attached that patients with dementia can twiddle in their hands whilst on the unit. People living with dementia often have restless hands and twiddlemuffs help to keep them occupied. A butterfly symbol was added to patient records and to their wristband that helped clinical staff identify immediately if they were living dementia.

The department allowed for the specific needs of mental health patients to be met. For example, patients could be placed in a low stimuli environment.

The service took account of individual needs such as learning disabilities and dementia during triage and we saw they were noted in assessments. Carers, families and escorting mental health professionals were involved in information gathering to ensure patient needs were documented.

The trust learning disability nurse had attended a band seven away day to provide an update of the service provided by the trust for patients with a learning disability.

If people with a learning disability, dementia or mental health need required extra support or supervision whilst in the department additional, staff were resourced in from other wards to provide this support to ensure patient safety.

Community mental health teams, community learning disability teams and child and adolescent mental health services were copied into the patient’s discharge correspondence. This ensured all agencies involved in the patient’s care were kept informed of care and treatment provided by the emergency department.

There were dedicated disabled toilets available in both the adult and paediatric waiting areas. There was a hearing loop available for use by patients with a hearing impairment. A relatives’ room was available for private conversations.
The department had access to interpreting services for people whose first language was not English. Staff we spoke with told us that family members were never used for interpreting. Staff demonstrated to us how they would obtain access to translation services.

There were no leaflets displayed in languages other than English but staff told us they had access to leaflets in other languages if they were required.

The department did not have a viewing room for recently deceased patients. There were plans to locate a viewing room in the department but work had not yet started.

There was a box within the department, which contained resources to help provide emotional support to parents who had lost a child.

The department had link nurses that were used as a resource when caring for patients with individual needs, for example, there were link nurses for: alcohol, drugs and homelessness, dementia, diabetes, end of life, learning disability, and mental health. There were nurses from both adults and paediatrics.

Staff undertook and documented ‘intentional roundings’ for patients to ensure they could reach their call bell and had food and drink when needed.

There was dementia resource and information board for staff. This included information on recognising the condition and best practice guidance for effective and compassionate communication.

Patients had access to shower facilities within the clinical decision unit and basic personal care items were available.

**Emergency Department Survey 2016**

The trust scored worse than other trusts for one of the three Emergency Department Survey questions relevant to the responsive domain and about the same as other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>6.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Access and flow**

Staff told us that there had been a change in culture regarding the four hour target rates. Ownership of the target was now shared across the whole multidisciplinary team and was not just the responsibility of the emergency department. Staff told us that this had a positive impact and had improved staff morale and encouraged better communication teamwork.

At the time of our inspection, we spoke with senior staff about waiting times. They had introduced a number of measures in an attempt to improve patient waits. This included using streaming to direct patient to the most appropriate care setting and rapid assessment to make sure that any tests such as bloods or X-Rays were undertaken whilst the patient waited to see a doctor. There
were a variety of specific pathways in place, which streamed patients to other departments of specialist, for example to ambulatory care or medicine. Staff reported that this had a positive impact on waiting times and were hopeful that the number of patients waiting more than four hours would reduce.

The patient’s GP could request a direct referral to a specialist by telephoning ahead and writing a referral letter. This meant they did not have to wait for assessment by an emergency department doctor.

A consultant and matron undertook four hourly board rounds within the department. The board rounds not only assessed the quality of the care delivered in the department, but also helped alleviate bed pressures and flow issues. They assessed every patient and their records and where possible when they could identify patients who would benefit from an alternative treatment they would ensure that the plan for this patient was reviewed and treatment changed as necessary.

From our observations and discussions with patients and staff, patients were triaged and assessed quickly. There were boards in the waiting areas that clearly stated waiting times, this meant patients were kept informed of how long they expected to wait.

The department were backing the #Fit2Sit campaign, which encouraged frontline health professionals and paramedics to put an end to patients lying down on trolleys and stretchers if they were well enough to sit or stand. If patients who ended up on a hospital trolley the department very quickly became full. By encouraging and questioning those who were ‘fit to sit’ in designated areas flow could be increased and reduce ambulances queuing. We saw there were posters reminding staff to consider if their patient was ‘fit to sit’.

There was a television monitor within the department, which showed information on expected attendances, and expected conveyances (ambulances). It also showed what capacity was available within the department for example, how many cubicle spaces in the majors were available. It also showed how many four hour breaches had occurred and how many attendances and conveyances there had been since midnight. The escalation status of the department was also shown on the board. This helped to plan staffing and capacity through the day based on the expected attendances and conveyances.

Senior staff identified one of the busiest periods was between 5pm and 9pm, therefore an additional emergency nurse practitioner and nurse worked a twilight shift to meet the peak in demand.

Bed meetings took place three times a day at 09:30am,1pm and 4pm. We observed that they were attended by multidisciplinary staff and senior manangers including the chief operating officer. Waiting times were reviewed and breaches and potential breaches discussed. Escalation was efficient and action was taken to ensure there were beds made available for patients waiting to be admitted from the emergency department.

The risk of failing to meet the four hour target for 95% of patients was identified on the urgent care service’s risk register as the highest risk. This was mainly because of lack of capacity. To mitigate this risk, senior staff implemented bed meetings three times daily, daily board rounds and recruited additional locum staff and nurse practitioners. It was hoped when the primary care suite and rapid assessment and treatment was fully functioning the risk would be decreased further and performance improved.

The service manager, deputy head of nursing and head of nursing received a daily report on the previous day’s performance. All patients who had breached the four hour target were validated to
ensure they were in fact a breach and not excluded because of clinical exception. This also provided oversight of reasons for breaches and identified any trends to facilitate improvements.

If patients required transfer to Eastbourne hospital staff accessed a computer application on a telephone for example if a patient required specialist stroke services. A text was received back to confirm the message was received, read and responded to with details and approximate time frame. We observed staff using this during our inspection, staff were positive about it and did not report any problems.

There was a service level agreement between the emergency department and the mental health liaison team, which agreed that patients with mental health needs would be assessed within two hours. Staff said patients were always assessed by the mental health liaison team within two hours and this was sometimes quicker depending on the patient’s condition. The staff in the emergency department called the mental health liaison team when a patient was identified as needing an assessment. The mental health liaison team could see the emergency department patient list and could therefore triage the patient and plan for a new admission if required. Patients could request support from the mental health liaison team.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour.

The trust did not meet the standard for 10 of the 12 month over the time period from December 2016 to November 2017.

Performance against this standard showed a trend of improvement.

**Ambulance – Time to treatment from December 2016 to November 2017 at East Sussex Healthcare NHS Trust**

![Graph showing median time from arrival to treatment](image)

(Source: NHS Digital - A&E quality indicators)

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

The trust breached the standard in every month from January 2017 to December 2017.

From January 2017 to December 2017 performance against this metric showed a trend of improvement.
Board meeting minutes dated November 2017 showed us that the trust had continued to sustain improvements in meeting the four hour target from arrival to treatment within the emergency department despite a 6.6% increase in attendance. The data provided showed significant improvements from the preceding year with June 2016 showing 83% of patients were seen within 4 hours which had improved to 90% in June 2017. Similarly, in August 2017 the percentage of patients seen within four hours was 92% which was much better than the figure for August 2016 which was 79%. The trust was on target to meet the improvement trajectory for the four hour target.

**Four hour target performance - East Sussex Healthcare NHS Trust**

(Source: NHS England - A&E Waiting times)

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

From January to December 2017 East Sussex Healthcare NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was broadly similar to the England average.

From January to May 2017 the trust performed worse than the national average. However, from May to December 2017 the trust performed better than national average with the exception of September 2017 when the trust’s performance was similar to nationally.

Performance against this metric showed a trend of improvement.

(Source: NHS England - A&E Waiting times)
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from January to December 2017, no patients waited more than 12 hours from the decision to admit until being admitted.

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

From December 2016 to May 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average. However, it was better than the average for England in the most recent six months, June to November 2017.

Percentage of patient that left the trust without being seen - East Sussex Healthcare NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)
Median total time in A&E per patient (all patients)

From December 2016 to October 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average before showing an improvement in the most recent month, November 2017. In that month, the trust’s performance of 154 minutes was similar to the national average.

Median total time in A&E per patient - East Sussex Healthcare NHS Trust

(Source: NHS Digital - A&E quality indicators)

Learning from complaints and concerns

Summary of complaints

From November 2016 to October 2017 there were 102 complaints about urgent and emergency care services. The trust took an average of 34.9 working days to investigate and close these complaints which is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Twelve complaints remained open at the time of reporting and had been open for an average of 74.7 days.

The most common complaint themes were:

- Standard of care – 43 complaints
- Patient Pathway – 19 complaints
- Communication – 15 complaints
- Attitude – 13 complaints

At Conquest Hospital, there were 44 complaints, the most common themes from which were:

- Standard of care – 19 complaints
- Patient pathway – eight complaints
- Attitude – six complaints
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Complaints could be made via telephoning or emailing the trust the Patient Advocacy and Liaison Service. We did not see any information within the department, which informed patients on how to make a complaint. We raised this with the leadership team and later the same day we saw posters had been put up in the department.

Heads and deputy heads of nursing led weekly complaints meetings with the personal assistants to consultants and the hospital complaints lead. The leadership team received electronic notification of any complaints. The leadership team contacted the complainant themselves depending on the staff group/speciality it related to depended on who from the leadership team investigated the complaint. The leadership team offered to meet the complainant in person if that was preferred.

There was a whiteboard displayed outside the staffroom that had learning from complaints and incidents displayed and showed staff the action taken and whether there was a trend in complaints. The top three themes were identified, this meant staff were aware of the themes of complaints. Complaints feedback was also relayed during handovers and team meetings. We saw meeting minutes, which confirmed discussion of complaints was a standard agenda item. The ‘start of the week message’ also included information about complaints, this ensured staff were informed.

We were told that staff who had been the subject of a complaint would be spoken to, to pass on feedback and learning points. Staff who had been subject to positive feedback through a plaudit would also be given the positive feedback.

During the inspection, we reviewed six complaints five of which were not closed within 30 days in line with trust policy. All complaint responses showed a good understanding of the complaint and answered all points raised in the complaint and explanations given. Responses were written in plain English and did not contain any medical jargon, this meant complainants understood the response.

Each complaint response signposted the complainant to a SeAp (Support, Empower, Advocate, Promote). SeAp is an independent charity that provides free independent and confidential advocacy services. However, complaint responses did not signpost complainants to Parliamentary and Health Service Ombudsman. This meant patients and relatives might not know who to contact if they were not satisfied with the trust’s response to their complaint.

Staff told us they always tried to deal with complaints when they happened to avoid complaints being escalated to formal complaints. Staff had a good knowledge of hospital complaints procedures and addressed minor issues or informal complaints from patients or relatives at the time they occurred. Band seven matrons who usually addressed complaints during their shift had received training to help them handle complaints. Where this happened, they apologised to the patient and advised them of how to make a formal complaint if not satisfied with the response.

The noticeboard within the department which was accessible to all included a ‘you said we did’ section. This identified previous complaints or feedback raised by patients or visitors and the action taken. For example, we saw the paediatric waiting room had been refurbished after feedback from patients and visitors.
Is the service well-led?

Leadership
The leadership structure had changed since our last inspection, as had the directorate structure. Urgent care had been changed to a single directorate which included; the clinical decision unit, primary care, resuscitation unit. Majors and minors and the medical assessment unit were no longer in the same directorate.

A triumvirate made up of a head of nursing, lead medical consultant and a director of operations led the service. The head of nursing was supported by the deputy head of nursing. The head of nursing and deputy head of nursing were supported by a ‘matron's assistant’ they were responsible for the organisational and administration tasks. A team of band seven matrons managed by the deputy head of nursing, were responsible for the day-to-day running and coordination of the department. The band seven matrons managed band six nurses, band five nurses and health care assistants. The ‘matron's assistant’ role had been recently introduced and the role allowed them to drive the delivery of high quality patient care by releasing them from the burden of administration tasks. A service manager who was also a qualified nurse supported the director of operations by background. They were responsible for monitoring and managing the flow through the department and supporting clinical staff.

The nursing team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff.

Staff commented that the service manager was a dynamic leader and their background meant they understood both service delivery and patient care.

Staff said that the quality of care given to paediatric patients had improved since the paediatric nurses were part of the emergency care establishment. Staff felt the leadership team were committed to improving the service further and welcomed staff’s views on how this might be achieved.

The leadership team had a good knowledge of how services were provided and were quick to address any shortcomings that were identified. They accepted full responsibility and ownership of the quality of care and treatment within their department and encouraged their staff to have a similar sense of pride.

We saw strong leadership, commitment and support from the leadership team. They were responsive, accessible and available to support staff during challenging situations. They had introduced a clearer escalation process, which aimed to provide a consistent approach in times of pressure.

All staff told us clearly about their lines of reporting to the leadership team and told us they felt valued, supported and respected in their roles. Staff said that the organisation of the department and staff morale had improved dramatically since the new leadership team had been in post.

There was strong collaboration and support across all aspects of the service and there was a common focus on improving quality of care and people’s experiences. For example, the leadership team undertook prompt action to support the department during busy or challenging periods.

Staff told us that the leadership team were “responsive” and always willing to help out pushing beds, cleaning transferring patients to other wards and departments or undertaking any task, which supported the staff, and the care and treatment patients received.

Staff told us that the leadership team often came into the department out of hours and at the weekend to support the department.
Consultant leadership in the department was committed and consultants demonstrated clinical ownership of the patients in the department. Consultants had oversight of the patients in the department and had an awareness of who was the most unwell or had the potential to deteriorate.

The permanent locum doctors who worked in the department were appreciated by staff and provided stability for the gaps in the doctors rota. Doctors in training felt well supported by senior clinicians and felt they could approach them for advice and support.

Clinicians and the leadership team we spoke with were knowledgeable about their patient’s needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities.

The mental health liaison team had the expertise to lead the mental health service within the department.

A member of the senior executive team undertook weekly visits to the department and staff told us that senior managers were aware of the local challenges the department faced.

**Vision and Strategy**

The trust had East Sussex Hospital 2020 – Strategic priorities for improvement, it set out a framework of objectives and actions to be undertaken to make the organisation into the high performing organisation and outstanding by 2020. The outstanding by 2020 strategy had been developed using a structured planning process in collaboration with staff, people who use the services and external partners. The strategy was aligned to local plans in the wider health and social care economy, and services were planned to meet the needs on the local population. Trust board meetings monitored delivery and progress of the strategy. All staff we spoke to were aware of the strategic priorities, they also were part of the individuals personal objectives and were discussed at their appraisal.

The department did not have a specific vision or strategy but were committed and understood the outstanding by 2020 strategy and their role in achieving them.

A positive trajectory for improvement had been plotted to meet national standards, where targets were not currently being met. For example, a ‘deep dive’ was investigating the cause for ambulances to queue in the department and ensure patients were directed to the most appropriate service or agency.

The service had improved on many of the issues highlighted in the previous inspection.

**Culture**

There were high levels of staff satisfaction across all staff groups. Staff spoke highly of the culture. There was a common focus on improving quality of care and people’s experiences. Staff that we spoke to felt that they were valued and respected by their peers and leaders.

We observed positive working relationships between staff and a non-hierarchical culture where everyone felt comfortable to approach anyone for advice. We observed a health care assistant discussing a concern about a patient with a doctor, who listened to their concerns and acted upon them. In the 2017 staff survey 79% of staff said they knew who their senior managers were, this was slightly better than the 2016 survey (77%).

Staff told us that there had been a change in culture and pressures in the department were now seen as a site wide responsibility. We observed a bed meeting and there were executive team members and senior leaders in attendance, driving flow issues and looking for solutions.
There was a strong culture of openness and transparency, leaders actively encouraged staff to raise concerns.

Staff felt safe undertaking their role and felt there was a strong emphasis on the safety and well-being of staff.

The 2017 trust survey showed that 77% of staff agreed or strongly agreed that their immediate line manager encouraged them to work as a team, this was better than the 2016 survey (74%).

Patients attending the department with a mental health illness were treated exactly the same as patients attending with physical health needs. Improvements in the mental health provision had been made since our last inspection. For example, the refurbishment of the mental health assessment room, which ensured it, was safe for the patients who used it.

Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. For example, staff had been asked to sign up to the department’s value statement, which set out how the department worked together. Staff had to physically sign the poster, which outlined the value statement, which meant they endorsed it.

Staff felt supported in their work and there were opportunities to develop their skills and competencies, which were encouraged by senior staff. Staff also felt that they could raise ideas that could be potential solutions to the departments issues and they would be taken seriously and their ideas considered by the leadership team. For example, undertaking the rapid assessment and treatment of all patients by a senior decision maker at triage.

Staff we spoke to were aware of who the Freedom to Speak Up Guardian was, their role and how to contact them if required.

The 2017 staff survey showed that 87% of staff agreed that the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

The clinicians and leadership team promoted a culture of parity of care between patients who attended with either mental health or physical health needs.

Staff told us they were regularly praised and given positive feedback. One member of staff told us “they had a cracking job”.

Staff we met were all welcoming, friendly, and helpful, morale was good, one staff member told us “I work with a lovely team in a very challenging role”.

**Governance**

The department had governance, risk management and quality measures to improve patient care, safety and outcomes. The governance system supported the strategy and provided continuing assurance up to board level with the clear focus on patient safety.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

Governance and performance management arrangements were proactively reviewed and reflected best practice. There was a monthly urgent care governance meeting which was facilitated by the governance administrator. We reviewed meeting minutes which showed the meeting followed a set agenda which included review of incidents, complaints, serious incident reviews, risk register, friends and family tests and performance indicators.
There was regular engagement and communication with partners and third partner parties such as the local mental health trust who were responsible for providing mental health services.

**Management of risk, issues and performance**

There was a departmental risk register, which measured the impact and likelihood of the risk and documented the controls and mitigations in place to manage the risk. There were 10 risks on the risk register all of which had been reviewed within the last 12 months, two risks were categorised as extreme risk and the remainder high risk. All risks had a nominated person responsible for ensuring there was measures in place to mitigate the risk and to regularly re-assess the risk and update the risk register. The highest risks on the risk register were displayed for staff to familiarise themselves with and understand the key risks and issues for the department.

Managers told us that the escalation process was effective; issues were now escalated for action rather than for information and action was taken promptly to rectify the issue.

The clinical lead was responsible for quality measurement in the service to assess the quality of care and treatment provided.

During our inspection, despite the department being busy and utilising escalation plans the department was calm and well organised. Managers told us that the escalation process was effective; issues were now escalated for action and action was taken promptly to rectify the issue.

There was a nursing and medical lead in the department who oversaw sepsis management within the department.

Potential risks were taken into account when planning services or improvements to improve efficiency. For example, the primary care suite was not yet fully functioning, as the reception area was not suitable to ensure staff were kept safe.

**Information Management**

Staff were able to access patient information using an electronic system and paper records.

The department used an electronic system to track patients from presentation to discharge. This provided a visual overview of who was in the department at any one time and provided a breakdown of patients and waiting times. The system also provided reports to track any patients approaching a breach of four or 12 hours, which fed in to the daily bed meetings. Information collated was used to monitor, manage and report on quality via the quality dashboard.

The department used another system for requesting tests and diagnostics.

During our inspection we observed computer stations around the department were left locked, this meant that unauthorised persons could not gain access to patient records.

**Engagement**

Staff knew their role within the team and how this contributed to the cohesive organisation of the service.

The leadership team regularly bought pizza for the staff, buying it form a specific restaurant, which ensured the pizzas were Halal and therefore took account of staff’s different religious beliefs.

The leadership team encouraged staff to donate warm items of clothing to a local homeless charity and in exchange gave the staff cake.

Staff were offered a financial reward if they undertook a certain number of bank shifts a month.
There was a ‘staff shout out board’ where staff left messages for each other when they wanted recognition for a staff members or to thank them.

A trust welfare team provided support to the staff, often visiting the department offering staff food a drink especially in busy periods.

Staff had access to the on-site childcare coordinator who advised and assisted with childcare. On-site childcare facilities were available at Conquest Hospital and a holiday play scheme.

There were subsidised staff restaurants, on-site accommodation, other coffee shops, and Friends shops.

The trust ran a ‘star of the month’ award programme for staff who received a certificate, flowers, chocolates or wine as recognition for their contribution. We saw a member of the domestic staff within the emergency department had received the award.

In the 2018 staff survey 71% of staff said they were either satisfied or very satisfied with the support they got from their immediate manager. In the same survey 87% of staff said they were able to do their job to a standard they were personally pleased with.

The trust engaged in the #HelpMyA&E to save lives by using the right services campaign. Support and guidance was available on the website to assist patients in making the correct choice of where to seek health advice and treatment. For example, there was a guide to getting the most out of a General Practitioner appointment.

There were a number of ways patients and visitors could provide feedback. They could fill in an online patient survey, complete a ‘thank you’ form, raise a complaint or concern, rate the trust on the National Health Service choices website or complete the Friends and Family Survey.

We reviewed comments on the National Health Service choices website regarding the hospital, the hospital was rated as four and a half stars out of five by service users. There were many positive comments about the emergency department. For example, “A massive thank you to all your staff in A&E they are positively amazing, nothing was too much trouble even though they were run off their feet, they very quickly found out what my trouble was and watched me very carefully before I was allowed home in the evening.”

The trust interacted on social media via a variety of social media networks. Effective utilisation of social media can engage patients and was another way patients effectively communicated with the trust. This demonstrated that the trust was committed to communication and listening to feedback from social media users.

We saw information regarding the Friends and Family Survey throughout the department, feedback could be given in person, in writing or online.

Patients and visitors could nominate staff for a People’s Choice Award, to show their appreciation of the care and commitment shown to them by staff.

The trust had a patient experience strategy, which was launched in April 2013 and was based on eight commitments that emphasised that patient experience was everybody’s business without exception.

Members of the public could become a member of the trust, received quarterly newsletters, and were invited to events for example, a cardiology open day.

The trust had a team of volunteers who undertook a variety of roles in the hospital. Volunteers were not currently used within the emergency department however, the leadership team were exploring how they could be utilised within the department. A magazine was available for people
thinking of becoming a volunteer, which gave a description of what being a volunteer involved and how to apply.

Staff wore lanyards, which said what role they performed in the hospital for example, nurse or doctor. This meant members of the public and patients could easily identify staff roles.

A daily system wide call with stakeholders where the trust was open and transparent regarding the department’s performance.

The hospital and urgent and emergency care worked in collaboration with the local Healthwatch group. Healthwatch undertook a 24 hour observation of care delivered in the hospital which included the emergency department. Healthwatch gave feedback to the hospital and the department of their observations, which provided a useful insight. Feedback from patients given to Healthwatch staff during the observation was positive.

In addition, Healthwatch worked in conjunction with the hospital and undertook a night time unannounced observation to engage with and obtain feedback from hard to reach groups. Feedback from Healthwatch was taken seriously by the hospital and used to drive improvements.

Staff felt that the care they delivered co-ordinated care when patients had both physical and mental health needs, this was achieved by effective communication with the mental health liaison team. Patients who attended with mental health needs also had their physical health needs assessed.

**Learning, continuous improvement and innovation**

Staff were committed to making improvements for patients and felt they had been given the right resources to achieve this.

There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. For example, the ‘fit to sit’ campaign and primary care screening.

A room within the department had been identified to be a staff well-being room, providing a quiet calm place away from the department for staff.

If a service user in the emergency department died, a different consultant reviewed the case and medical notes. This meant an independent review was undertaken and any learning was fed directly back to the staff involved and shared in ‘board rounds’, staff meetings and ‘start of the week’ message. We saw evidence of this within the department’s communication folder. The department had a link with the local ambulance service, which meant any learning that involved them, could be fed back.

The introduction of the matron’s assistant role meant matrons could dedicate their time to improve safe high quality care, as their assistant undertook the majority of their administrative duties.
Medical care (including older people’s care)

Facts and data about this service

The trust had 45,580 medical admissions from October 2015 to September 2016. Emergency admissions accounted for 17,399 (38.2%), 1,563 (3.4%) were elective, and the remaining 26,618 (58.4%) were day cases.

Admissions for the top three medical specialties were:

- General Medicine: 13,181
- Gastroenterology: 9,878
- Clinical Oncology (Previously Radiotherapy): 6,136

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

In the majority of areas the medical department was meeting the trust target for mandatory training compliance.

The trust provided regular mandatory training for all staff. The training was delivered in a combination of classroom training and online training. Staff told us there were no barriers to attending mandatory training and there were adequate computers on the ward to complete the online training. The matrons’ assistant monitored training compliance on the ward. The matrons’ assistant told us they emailed staff reminding them when the training was due.

The trust collected mandatory training attendance figures centrally but staff told us this could be out of date by six weeks and they relied on their own records.

Examples of the training provided included health and safety, conflict resolution, information governance, infection control and prevention, resuscitation and moving and handling.

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for the completion of all mandatory training with the exception of information governance which had a training target 95%. No target was provided for training on the Mental Health Act.

A breakdown of compliance for mandatory courses from November 2016 to October 2017 for nursing staff in medicine at the hospital is shown below:
The overall completion rate for mandatory training modules by nursing staff in medicine at the hospital was 91.3%. Nursing staff met the mandatory training targets for five out of the seven modules. Four of the eight eligible nursing staff had completed Mental Health Act training, which had no trust target.

The ward teams exceeded the mandatory training targets in medicines management, fire safety, infection control, moving and handling, basic life support, intermediate life support, resuscitation. The targets for health and safety and information governance were not achieved but attendance was between 86.6% and 89.2%. Only 50% of eligible staff attended mental health act training but the trust had not set a target for this.

A breakdown of compliance for mandatory courses from November 2016 to October 2017 for medical and dental staff in medicine at the hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety</td>
<td>183</td>
<td>194</td>
<td>94.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>182</td>
<td>194</td>
<td>93.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>181</td>
<td>194</td>
<td>93.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>179</td>
<td>194</td>
<td>92.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>173</td>
<td>194</td>
<td>89.2%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>168</td>
<td>194</td>
<td>86.6%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by medical and dental staff in medicine at the hospital was 52.9%. Medical and dental staff did not meet the mandatory training targets for any of the six modules. One of the 91 eligible medical and dental staff (1.1%) had completed Mental Health Act training, which had no trust target.

We spoke to the medical director of the department about medical team not achieving compliance with any mandatory training. The medical director told us this was an area of concern and was being addressed with the medical team urgently.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

We found effective systems and processes to protect adults and children from the risk of abuse.

Staffs had a good knowledge of different types of abuse and could tell us the process for reporting a safeguarding concern. Some staff could name the safeguarding lead for adults and children and all staff we spoke to knew where to access this information on the internal intranet.
as needed. The medical department had reported 12 adult safeguarding concerns in the 12 months prior to inspection.

All areas we visited displayed laminated posters identifying the named safeguarding leads for adults and children. Phone numbers and contact details for the safeguarding leads were available on the computer system, on laminated posters, in staff rooms and offices.

There was a head of safeguarding, who was also the named nurse for safeguarding within the trust and reported to the deputy director of nursing. The lead for safeguarding adults and children on the trust board was the director of nursing.

### Safeguarding training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for the completion of safeguarding training.

A breakdown of compliance for safeguarding courses from November 2016 to October 2017 for nursing staff in medicine at the hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>194</td>
<td>194</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>194</td>
<td>194</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>180</td>
<td>194</td>
<td>92.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>178</td>
<td>193</td>
<td>92.2%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for nursing staff in medicine at the hospital was 96.3%. Nursing staff met all four safeguarding module targets.

A breakdown of compliance for safeguarding courses from November 2016 to October 2017 for medical/dental staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>69</td>
<td>69</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>69</td>
<td>69</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>44</td>
<td>69</td>
<td>63.8%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>44</td>
<td>69</td>
<td>63.8%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff in medicine at the hospital was 81.9%. Medical staff met the trust target for two out of four of the safeguarding modules.

We spoke to the medical director of the department about medical team not achieving compliance with two out of the four safeguarding modules. The medical director told us this was an area of concern and was being addressed with the medical team urgently.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Cleanliness, infection control and hygiene

Patients were almost always protected from the risk of acquiring health care associated infections.

The areas we visited were visibly clean, tidy and free from clutter. Ward domestics were allocated to a ward and took pride in maintaining their allocated area. They worked to a routine cleaning schedule. The cleaning was audited and the quality monitored. We saw cleaning occurring regularly during the inspection and colour-coded mops and clothes were used appropriately to the cleaning task.

The department had easily accessible infection prevention and control policies on the trust intranet. Staff told us they were aware of the policies and how to access them. We saw clinical and domestic waste bins were available throughout the ward area. The bins were clearly marked for designated waste. Waste was separated correctly and stored out of the ward area in a locked area. We noted each ward domestic stored the waste bags and soiled linen in the ward area prior to moving to a secure area. The meant there was a period of time where patients and visitors to the ward could have contact with the waste bags and soiled linen bags.

Each ward employed a ward orderly who was responsible for decontaminating the bed and surrounding area in between patient admission. We saw this happen several times during the inspection. When not on duty the ward nursing staff would complete this task. This reduced the risk of the spread of infection between patients.

All staff were bare below the elbows in the clinical areas. Bare Below the Elbows is an initiative aiming to improve the effectiveness of hand hygiene performed by health care workers. The effectiveness of hand hygiene is improved when: skin is intact, nails are natural, short and unvarnished; hands and forearms are free of jewellery and sleeves are above the elbow.

Antimicrobial hand rub dispensers were mounted on the wall at the entrance of each ward, outside each side room and bay of patients. There were also antimicrobial hand rub dispensers at the end of each patient bed. All hand rub dispensers were full and in working order. We observed sinks around the ward for staff to wash their hands.

We saw consistent hand decontamination when staff and visitors were entering and exiting the ward area. There were large posters instructing visitors to the ward to decontaminate their hands prior to entering the ward.

We saw many healthcare staff did not adhere completely to the ‘my five moments of hand hygiene’ despite posters prompting them to do this being displayed. We observed that staff missed decontaminating their hands prior to patient contact but did clean their hands at the other four key points.

The World Health Organisations ‘My 5 Moments for Hand Hygiene’ approach defines the key moments when health-care workers should perform hand hygiene.

This evidence-based, field-tested, user-centred approach is designed to be easy to learn, logical and applicable in a wide range of settings.

This approach recommends health-care workers to clean their hands

- before touching a patient,
- before clean/aseptic procedures,
- after body fluid exposure/risk,
- after touching a patient, and
- after touching patient surroundings.
We saw supplies of personal protective equipment such as aprons and gloves in dispensers on the walls. The domestic cleaner regularly checked and filled the dispensers. The staff used the aprons and gloves appropriately and disposed of them correctly.

We saw disposable curtains in place around the bed areas marked with the date changed. This complied with Hospital Building Note 00-09, infection control in the built environment. This also showed the staff regularly changed the curtains to minimise the risk of spreading infection.

Sharps boxes in each area we visited were assembled and disposed of in accordance with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 (The Sharps Regulations). We saw sharps boxes close to where medical sharps were used. Posters displaying guidance on actions for staff to take in the event of needle stick injury were present in the clinical and treatment rooms. Patients who needed isolating or presented a risk of infection to other patients could be nursed in individual rooms and had access to private washing and toileting facilities. These rooms were identified with clear signage, which informed staff and visitors of any special precautions needed when in contact with the patient.

While on a ward we saw actions taken by staff when a patient was identified as presenting an infection risk to others. The patient was immediately moved into a side room, signage put on the door and the staff rota divided to ensure staff nursing this patient did not nurse another patient who had been isolated as they had a low immunity to germs. The prompt actions taken showed risk of the spread of infection to other patients was minimised.

Each ward displayed their infection prevention and control audit results to ensure all patients, staff and visitors had current infection control information available.

**Environment and equipment**

The medical department had suitable premises and environment. Equipment was well maintained in line with trust guidelines.

There was access to emergency equipment. This included portable oxygen, suction and defibrillators and emergency drugs on purpose built trolleys. We saw records that showed they were checked according to the trust protocol. All patient bays and rooms we visited had piped oxygen and suction. All units we checked were in working order and ready to use in the event of an emergency.

Flooring, throughout the medical unit, was seamless and smooth, slip-resistant, easily cleaned. The hand washbasins in the ward areas were compliant with health building note HBN 00-09 - Infection control in the built environment. There were no plugs and no overflow. They had lever operated mixer taps.

The treatment room, on each ward, was locked when not in use and the punch lock code was only know to staff and was not displayed near the door. Each ward had a drug fridge, which displayed the current temperature. The staff monitored the temperature of the fridge once a day and this was recorded in a folder, which also contained actions to take if the temperature was not within normal limits.

Beds, furniture and equipment were labelled with asset numbers and labels showing service date. Medical equipment was readily available from a centralised medical equipment library, which was accessible 24 hours a day. We visited the medical equipment library and found good stocks of all equipment. Pressure relieving mattresses and equipment for bariatric patients were available on hire from specialist providers.
We saw fire exits were labelled clearly. Fire safety equipment was available throughout and we saw records that fire equipment safety checks had been completed by a specialist contractor.

Staff told us although the building was less than 25 years old, they felt it had not been well maintained and this let them down in their ward environment audits. We saw areas of peeling paint and staining in the walls and ceiling from water leaks.

**Assessing and responding to patient risk**

Patients always had all their risks identified and managed consistently.

We reviewed 20 sets of notes across the medical wards and saw comprehensive risk assessments were documented on each patient and stored within the notes in an integrated care pathway document. Each patient was assessed against their risk of falls, nutrition status, skin integrity and pain. We saw the risk assessments had be reviewed as per trust protocol and mitigating medical interventions commenced if needed.

The staff used a mobile electronic recording device to record and monitor patients’ vital signs. The data alerted staff to a patient who’s health was deteriorating and the need for medical intervention. One ward had an observation champion of the day who would prompt staff to do observations on their patients when they were due. The outreach team were automatically alerted to a patient with deteriorating health to enable them to provide early support for the nursing staff and patient.

When the observations indicated the patient may have sepsis the nurses used an acute adult sepsis screening and treatment tool to treat the patient. Sepsis is a rare but serious complication of an infection, which needs urgent medical intervention. The tool guided staff through a series of interventions that were needed to diagnose and treat patients with sepsis.

Staff told us there were two daily nursing handovers, one daily medical handover and a daily ward based multidisciplinary meeting to review each patient. We observed two multidisciplinary meeting and found them well attended by doctors, nurses, service managers, physiotherapists, occupational therapist and social workers from adult social care. We observed effective discussion and challenge during the meeting that promoted timely treatment and discharge.

The wards used a national early warning system to monitor patients’ health while in hospital. It is a simple scoring system in which a score is allocated to physiological measurements such as blood pressure and pulse. The scoring system enabled staff to identify patients who were becoming increasingly unwell and provide them with increased support.

**Patient moves per admission**

From November 2016 to October 2017, the proportions of patients who did not move ward and those who were moved ward once or more by site were as follows:

<table>
<thead>
<tr>
<th>Number of ward moves</th>
<th>Trust-wide</th>
<th>Conquest Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>No moves</td>
<td>12.9%</td>
<td>15.4%</td>
</tr>
<tr>
<td>One or more moves</td>
<td>87.1%</td>
<td>84.6%</td>
</tr>
</tbody>
</table>

This was based on the three medical wards with the highest numbers of ward moves: Baird, Folkington and Jevington.
Twice daily site management meetings were held to ensure that the best use of beds was made based on the clinical needs of patients. Senior staff from all areas of the hospital considered admission discharges and moves to ensure that all patients needing beds had one allocated. This did entail moving patients for non-clinical reasons to support the needs of other patients with higher levels of need.

(Source: Routine Provider Information Request (RPIR) P53 – Ward moves)

**Nurse staffing**

The medical department had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment.

Wards displayed the planned versus the actual staffing for the current shift. We saw on all wards that the actual staff on duty matched the planned staffing. Gaps in staffing were covered by internal bank staff if possible and then agency staff.

Staffing for each ward was monitored real time via the mobile electronic system. The staffing levels were assessed three times a day and staff moved to the ward with the higher acuity patients. Staff told us they were happy with this arrangement as it ensured they supported their colleagues to care for patients.

Recruitment was ongoing to fill the nursing vacancies within the department. Bank and agency nurses were block booked whenever possible to ensure continuity of care. Staff told us bank or agency staff were orientated to the ward and buddied up to work with a permanent member of staff. This gave us assurance bank and agency staff were monitored while working on the wards ensuring patient safety.

Staff told us of the arrangements for the handover of care between the nursing shifts. We saw the printed sheets they used to record patient information and found they contained the relevant information on the specific needs and risks of patients that supported the nursing staff to give safe care.

The trust has reported the following nursing staffing numbers in medicine by site as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>166</td>
<td>206</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

The following nurse staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 14% for nursing staff in medicine which was higher than the target of 10%:

- Conquest Hospital: 15%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Turnover rates
From November 2016 to October 2017, the trust reported a turnover rate of 7% for nursing staff in medicine which was lower than the target of 10%:

- Conquest Hospital: 7%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From November 2016 to October 2017, the trust reported a sickness rate of 4% for nursing staff in medicine which was higher than the target of 3.3%:

- Conquest Hospital: 6%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
From November 2016 to October 2017, the trust reported a bank and agency shift total of 40,069 in medicine (32,162 bank, 22.9% of which were registered nurse shifts; and 7,906 agency, 60.2% of which were registered nurse shifts). There were 7,078 shifts not filled by bank or agency staff.

Please note that we were unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and agency usage at Conquest Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/ agency</th>
<th>Healthcare Assistant</th>
<th>Registered nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Bank</td>
<td>9,204</td>
<td>2,765</td>
<td>11,970</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>1,192</td>
<td>1,414</td>
<td>2,606</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>1,396</td>
<td>1,645</td>
<td>3,041</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>1,954</td>
<td>3,346</td>
<td>5,300</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>1,780</td>
<td>2,257</td>
<td>4,037</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing
We found the numbers of doctors at appropriate grades were adequate to meet the patient needs.

Newly admitted patients received a review by a consultant trained in general medicine and we saw ward rounds taking place. The trust operated a consultant on-call system seven days a week. The majority of junior doctors told us they could access advice from a consultant and well supported.

Staff told us although there was high locum use there was an opportunity to provide two way feedback and any concerns about a colleagues work could be raised easily to ensure a high standard of care for patients.
The trust has reported the following medical staffing numbers in medicine as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>74</td>
<td>79</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

The following medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 13% for medical staff in medicine which was higher than the target of 10%:

- Conquest Hospital: 11%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 10% for medical staff in medicine which was the same as the target of 10%:

- Conquest Hospital: 10%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 1% for medical staff in medicine which was lower than the target of 3.3%:

- Conquest Hospital: 1%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

From November 2016 to October 2017, the trust reported a locum shift total of 4,732 in medicine. Over 60% of these shifts (3,034) were for consultants. There were no shifts that were filled by bank staff or shifts that were unfilled.

Please note that we were unable to calculate bank and locum usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of locum usage at both Conquest Hospital and Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>1,051</td>
<td>684</td>
<td>363</td>
<td>2,098</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)
Staffing skill mix

As of September 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the English average.

Staffing skill mix for the 148 whole time equivalent staff working in medicine at East Sussex Healthcare NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce statistics (01/09/2017 - 30/09/2017))

Records

Staff kept appropriate records of patients’ care and treatment.

The medical department used a used an integrated care pathway record which was shared by doctors, nurses and other healthcare professionals. Records were clear, up to date and available to all staff providing care for the patients.

We reviewed 20 sets of notes across the department and found a good standard of record keeping. The notes were stored safely in digital locking wheeled trollies. This ensured patient information was secure and private.

The notes contained admission details, a signature list and consent to treatment. Progress notes were documented clearly and always dated and signed. Patient risk assessments were complete and care plans were in place. Risks assessments were repeated as needed and actions taken to mitigate the risks identified.

Records were in the process of being moved from paper records to electronic records.

We observed whiteboards on each ward identifying the full name of each patient currently admitted to the ward. This meant the privacy of patients was not protected from observation by visitors or other patients.
Medicines

The medical department ensured the proper and safe storage and use of medicines.

The trust had medicines management policies, which were readily available to staff via the trust intranet. Prescribers had access to the relevant resources such as current copies of the British National Formulary.

Emergency medicines on the resuscitation trolley were stored in drawers with tamper evident tags. General medicines were stored in wall mounted lockable cabinets. Intravenous fluids were stored in a locked room. Mobile drug trollies were locked and kept in a locked room when not in use.

Controlled drugs were stored and given in line with current legislation on all wards. Spot checks on the recorded stock levels on controlled drugs matched the register.

We reviewed 15 prescription charts across the unit and found them legally valid and documented the any patient allergy. Patients on oxygen had this prescribed within the prescription chart. All medicines administered were documented correctly. The charts had been reviewed by a member of the pharmacy team.

The medicine fridge displayed the current temperature; records showed ward staff monitored this daily. Staff could describe the escalation process if the temperature was outside acceptable limits.

The trust had an antimicrobial policy, which was readily available to staff via the local intranet. Antibiotic prescriptions had a rational for prescribing and a review date. Nursing staff told us they if this wasn't in place they would challenge the prescriber to add this information.

Incidents

The service managed patient safety incidents well.

All staff we spoke to were confident in recognising and reporting incidents. The median time for reporting incidents was two days. This compares well to the NHS trust average, which was 24 days in the 12 months prior to inspection.

Staff had received trained to use the electronic reporting system linked to the staff intranet. They could ask a senior member of staff for support completing the web form if needed. Staff told us they received the outcome of investigation and could give us examples of learning from incidents.

Learning from incidents was shared across the department via departmental meetings, ward meetings and electronic communication. Urgent changes to practice were communicated to staff on duty via the regular staff safety huddle. Senior staff could give an example of when duty of candour was used after an incident.

Never Events

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for medicine.

Source: NHS Improvement - STEIS (01/12/2016 - 30/11/2017)
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident were:

- Slips/trips/falls meeting SI criteria – 11 incidents
- HCAI/infection control incident meeting SI criteria – three incidents
- Sub-optimal care of the deteriorating patient meeting SI criteria – two incidents
- Medication incident meeting SI criteria – one incident

Site specific information can be found below:

- Conquest Hospital: eight incidents

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

The entrance area to each ward displayed ‘green cross charts’ with current information gained from safety thermometer data. Information included key indicators such as falls and staffing levels. The displayed information enabled visitors to the ward to understand what the trust was monitoring and how the ward was performing against trust targets.

This trust had a positive focus on safety and was open about the levels of harm free care it had achieved.

Staff undertaking investigations did not have training to do so but are supported by the governance team.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported 48 new pressure ulcers, 10 falls with harm and 66 new catheter urinary tract infections from December 2016 to December 2017 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Sussex Healthcare NHS Trust**

<table>
<thead>
<tr>
<th>Total Pressure Ulcers (48)</th>
<th>Total Falls (10)</th>
<th>Total CUTIs (66)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.8</td>
<td>0.8</td>
<td>1.8</td>
</tr>
<tr>
<td>1.2</td>
<td>0.6</td>
<td>1.2</td>
</tr>
<tr>
<td>0.6</td>
<td>0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>0.0</td>
<td>0.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Dec-16 Jan-17 Mar-17 May-17 Jun-17 Aug-17 Oct-17 Nov-17 Dec-17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Safety thermometer - Safety Thermometer*

**Is the service effective?**

**Evidence-based care and treatment**

The medical department provided care and treatment based on national guidance and evidence of its effectiveness.

The integrated care pathways were based on current best practice and referenced National Institute for Health and Care Excellence quality standards. These included quality standard 161 sepsis and also quality standard 76 acute kidney injury. New and updated guidance was shared with staff.

Staff told us they were able to access national and local guidelines through the trust intranet. We reviewed a number of these and found them to be up to date, referenced and had hyperlinks to access national guidelines as needed. The intranet was simple to navigate and the policies straightforward to find.

The trust routinely reviewed the effectiveness of care and treatment by participating in local and national audits.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff had access to special feeding and hydration techniques if needed. The service made adjustments for patients’ cultural, religious and personal preferences.

The ward staff had a good relationship with the catering department and staff shared an example of a patient who was struggling to enjoy any food from the menu, the catering manager came and met them to develop a personal menu for their admission.

We reviewed notes that showed us the department used a national screen tool for nutrition and hydration. We saw that in all the notes this tool was completed and additional support from the dietician was available. The majority of fluid and food intake charts had been completed fully.

Patients’ dietary special needs were identified on a white board in the kitchen to ensure all staff serving food knew of any preferences and restrictions. While on the ward we observed patients being helped to eat and drink. Patients appeared well hydrated and had no complaints about the food.

Staff told us that patients who received nutrition through a nasogastric or parenteral feeding tube. Parenteral feeding is the process by which a patient receives nutrients intravenously by bypassing the normal process of eating and digesting. There were no patients’ receiving nutrition this way while we were on the ward.

Patients were offered three meals a day and snacks were available. A patient told us since moving from paediatric to adult services it was no longer possible to order toast on the wards. They would have liked to have some toast when they could not manage a full meal.

Pain relief

Patients had their pain assessed regularly and managed well during admission.

There was a pain management policy that staff could easily access via the trust intranet. There was a specialist pain management team that supported the ward staff to manage the patients pain. Staff we spoke to knew how to contact the team.

Patients had their pain assessed on a regular basis and we saw this recorded in the patient records. Patients told us they were given adequate pain relief medication and were not in pain. If they requested pain relief medication, the nursing staff brought it promptly.

Patient outcomes

Relative risk of readmission

Conquest Hospital

From September 2016 to August 2017, patients at Conquest Hospital had lower than expected risks of readmission for both elective and non-elective admissions when compared to the England averages.
Elective Admissions - Conquest Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in Clinical Oncology (Previously Radiotherapy) and Clinical Haematology had lower than expected risks of readmission for elective admissions
- Patients in Gastroenterology had a similar to expected risk of readmission for elective admissions

Non-Elective Admissions - Conquest Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in Geriatric Medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in General Medicine and Cardiology had similar to expected risks of readmission for non-elective admissions
Heart Failure Audit

In-hospital Care Scores

Results for Conquest Hospital in the 2015 Heart Failure Audit were better than the England and Wales average for two of the four standards relating to in-hospital care. The hospital’s performance relating to cardiology inpatients was worse than the national comparator while the proportion of patients receiving input from consultant cardiologists was similar.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Conquest Hospital</th>
<th>Eastbourne District General Hospital</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology inpatient (%)</td>
<td>40.4%</td>
<td>57.2%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Input from consultant cardiologist (%)</td>
<td>56.2%</td>
<td>78.8%</td>
<td>56.9%</td>
</tr>
<tr>
<td>Input from specialist (%)</td>
<td></td>
<td>99.6%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Received echo (%)</td>
<td></td>
<td>94.4%</td>
<td>90.1%</td>
</tr>
</tbody>
</table>
Discharge Scores

Results for Conquest Hospital were better than the England and Wales average for eight of the nine standards relating to discharge. For the remaining standard, relating to referrals to cardiac rehabilitation, the hospital scored 9.7% which was lower than the national average of 12.1%.

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement. The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

Conquest Hospital

The 2016 National Diabetes Inpatient Audit identified 58 inpatients with diabetes at Conquest Hospital, 81% of whom reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital. This placed the hospital in quartile 2.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).
Conquest Hospital

Between April 2015 and March 2016, 73.5% of nSTEMI patients were admitted to a cardiac unit or ward at Conquest Hospital and 98% were seen by a cardiologist. These proportions were both higher than England averages of 55.8% and 96.2%, respectively.

The proportion of nSTEMI patients who were referred for or had angiography at Conquest Hospital was 63.4% which was lower than the England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 39%, which was worse than the audit minimum standard of 90%. The 2015 figure was 73%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 20.7%, which was not significantly different from the national level. The 2015 figure was 14%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 68.8%, which was not significantly different from the national level. The 2015 figure was 64%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 57.1%. This was this is not significantly different from the national level and similar to the 2015 figure of 59%.

The one year relative survival rate for the trust in 2016 was 37.2% which was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Conquest Hospital

The hospital has a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 97% which was lower than the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 7%. This was lower than the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 52% which was lower than the national aspirational standard of 100%.

The metric relating to the crude proportion of patients with an appropriate mobility aid in reach was not applicable for this hospital.

(Source: Royal College of Physicians)
Competent staff

Staff had the necessary skills to meet peoples individual care needs.

The trust had robust recruitment policies and a job description for all grades of staff. Senior staff described the trust pre-employment checks carried out on new staff. This ensured new staff were qualified, competent and suitable for their post. All new staff attended a trust and local induction programme.

Registered nurses we spoke to told us the trust supported them in preparing for revalidation with their professional body. We saw this confirmed when reviewing appraisal documentation.

The trust used an appraisal system to identify their staffs training and learning needs. The appraisal was based on an assessment against the trust values, performance over the last year and a personal development plan for the next year. We reviewed five appraisals for staff of all grades and found them complete.

Nursing staff had monthly one to one meetings with their ward manager. Staff told us these meetings were rarely cancelled. Regular meetings ensured the staff felt supported in their role and any issues could be addressed.

We observed staff were very professional in their interactions with colleagues, patients and visitors to their ward.

Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Trust-wide

From April 2016 to March 2017, 76.1% of staff within medicine at the trust had received an appraisal compared to a trust target of 90%. In 2017/18 year to date, 87.6% of staff had received an appraisal. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>55</td>
<td>56</td>
<td>98.2%</td>
<td>36</td>
<td>40</td>
<td>90.0%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>212</td>
<td>272</td>
<td>77.9%</td>
<td>173</td>
<td>190</td>
<td>91.1%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>39</td>
<td>52</td>
<td>75.0%</td>
<td>28</td>
<td>36</td>
<td>77.8%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>271</td>
<td>362</td>
<td>74.9%</td>
<td>226</td>
<td>260</td>
<td>86.9%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>11</td>
<td>15</td>
<td>73.3%</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>25</td>
<td>41</td>
<td>61.0%</td>
<td>12</td>
<td>16</td>
<td>75.0%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>5</td>
<td>11</td>
<td>45.5%</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
<tr>
<td>Additional Professional</td>
<td>1</td>
<td>4</td>
<td>25.0%</td>
<td>-</td>
<td>-</td>
<td>n/a</td>
</tr>
<tr>
<td>Scientific and Technical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conquest Hospital

From April 2016 to March 2017, 70.2% of staff within medicine at the hospital had received an appraisal. In 2017/18 year to date, 87% of staff at the hospital had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>28</td>
<td>29</td>
<td>96.6%</td>
<td>18</td>
<td>21</td>
<td>85.7%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>90</td>
<td>123</td>
<td>73.2%</td>
<td>64</td>
<td>71</td>
<td>90.1%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>111</td>
<td>162</td>
<td>68.5%</td>
<td>93</td>
<td>109</td>
<td>85.3%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>20</td>
<td>31</td>
<td>64.5%</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>10</td>
<td>20</td>
<td>50.0%</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>6</td>
<td>16.7%</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

Across the medical department, we observed examples of good multidisciplinary working. This included effective working relations with speciality doctors, nurses, physiotherapists, occupational therapists and social workers. Medical and nursing staff and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

At meetings, we observed positive engagement and effective challenge between all members of the multidisciplinary team. We found the ward rounds were well organised and well attended by all members of the multidisciplinary team.

Medical, nursing and therapy staff of all grades described the good working relationships between staff and directorates.

The wards used integrated patient records, which were shared by clinical staff and therapists. This improved communication and meant that care was better co-ordinated between healthcare professionals.

Seven-day services

Seven-day cover included medical consultant cover, physiotherapy, radiology and pharmacy. The on call medical consultant was on site to do a ward round at 8.30am and again at 5.30pm on a Saturday and Sunday. The consultant was available for support and advice via the telephone at other times. This rota ensured a consultant reviewed patients seven days a week.

Diagnostic services were available throughout the week and staff did not report any issues with obtaining diagnostic results out of normal hours.

Discharge lounges were open during the day, from Monday to Friday between 8am and 8pm. This meant there was no discharge lounge support at the weekend for the medical wards.
Mental Capacity Act and Deprivation of Liberty training completion

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Across the medical directorate, staff demonstrated a good understanding of the legislation and best practice regarding consent, the mental capacity act and Deprivation of Liberty Safeguards. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment.

The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, the Mental Capacity Act, 2005 guidance and checklists for use when dealing with cases.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of Mental Capacity Act training. Deprivation of Liberty training completion was not reported by the trust.

Trust-wide

The trust reported that, from November 2016 October 2017, MCA training had been completed by 94.5% of all staff within medicine at the trust. The breakdown of training completion for nursing and medical staff at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>459</td>
<td>460</td>
<td>99.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>113</td>
<td>145</td>
<td>77.9%</td>
<td>No</td>
</tr>
</tbody>
</table>

Conquest Hospital

The trust reported that from November 2016 October 2017, MCA training had been completed by 92.8% of staff within medicine at Conquest Hospital. The breakdown of training completion for nursing and medical staff at the hospital is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>193</td>
<td>194</td>
<td>99.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>51</td>
<td>69</td>
<td>73.9%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We saw staff of all grades treating patients and visitors with kindness, compassion, courtesy and respect.

We were given many examples from patients of when the staff went above and beyond while caring for them.
Staff told us of two weddings they had organised on the ward for terminally ill patients. The staff had decorated the side room and the senior nurse had made a three-tear wedding cake for the occasion.

A staff member has purchased a freezer for the ward to allow for ice creams and frozen ice-lollies to be available to patients during hot days.

The frailty ward had organised a boredom cupboard with activities for patients’ with dementia. A member of staff who was also the dementia champion for the ward was responsible for this initiative.

Staff told us of how they moved furniture to allow a woman to spend the night in bed with her husband, who died the following day. She told them it meant the world to her as she had missed being physically close to him during his illness.

We saw displays showing key staff working in each ward or unit area as well as posters describing how to identify staff grades and specialities from their uniform colours. This meant patients and visitors could more easily identify who was attending them.

On one ward, the end of life champion had developed a practice where relatives of patients at the end of their life were offered comfort packs, which contained tissues, wet wipes, meal vouchers and parking vouchers.

Relatives of patients at the end of life were offered accommodation within the hospital or alternatively a bed on the ward if they preferred.

Staff introduced themselves to patients and relatives and we saw that patient privacy and dignity was maintained at all times. For example, curtains were used consistently in the bays and we saw staff knocking before entering bathrooms, side rooms and treatment rooms.

Our observations were supported by feedback from the patients we spoke to. They said they felt safe and were always treated kindly and respectfully. They told us there was no difference in the quality of care received during the day or at night. Patients said that staff asked them if they had everything they needed, were comfortable, pain free and had adequate hydration.

The units we visited comprised of side rooms with en suite facilities. The acute medical unit provided a combination of rooms and bays as well as a day unit with couches. Rooms were prioritised for patients presenting with infection risks, but were also used to avoid mixed sex breaches in the bays.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 37% which was better than the English average of 25% from December 2016 to November 2017.

The response rates at Conquest Hospital and Eastbourne District General Hospital were similar, at 36% and 39%, respectively.

A breakdown of FFT performance by ward for medical wards at the trust with total responses over 100 is below. All the wards had annual recommendation rates above 90%.
Friends and family Test – Response rate from December 2016 to November 2017

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Avg Response Rate</th>
<th>Percentage of patients recommending the service as a place to receive treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy EDGt</td>
<td>2507</td>
<td>37%</td>
<td>Dec-16 98%  Oct-17 95%  Aug-17 96%  Jul-17 96%  Jun-17 96%  May-17 96%  Apr-17 96%  Mar-17 96%  Feb-17 96%  Jan-17 96%</td>
</tr>
<tr>
<td>Entoscopy Conquest</td>
<td>1263</td>
<td>23%</td>
<td>Dec-16 100%  Oct-17 100%  Aug-17 100%  Jul-17 99%  Jun-17 100%  May-17 99%  Apr-17 99%  Mar-17 99%  Feb-17 99%  Jan-17 99%</td>
</tr>
<tr>
<td>Searford 1 (medical assessment) Unit</td>
<td>1103</td>
<td>42%</td>
<td>Dec-16 95%  Oct-17 97%  Aug-17 95%  Jul-17 96%  Jun-17 95%  May-17 95%  Apr-17 95%  Mar-17 95%  Feb-17 95%  Jan-17 95%</td>
</tr>
<tr>
<td>James (CCU) Ward</td>
<td>783</td>
<td>74%</td>
<td>Dec-16 100%  Oct-17 100%  Aug-17 100%  Jul-17 99%  Jun-17 100%  May-17 99%  Apr-17 99%  Mar-17 99%  Feb-17 99%  Jan-17 99%</td>
</tr>
<tr>
<td>Acute Admissions Unit (A&amp;U) Conquest</td>
<td>642</td>
<td>22%</td>
<td>Dec-16 97%  Oct-17 93%  Aug-17 94%  Jul-17 92%  Jun-17 94%  May-17 92%  Apr-17 94%  Mar-17 92%  Feb-17 94%  Jan-17 92%</td>
</tr>
<tr>
<td>Cardiology Unit Conquest</td>
<td>564</td>
<td>55%</td>
<td>Dec-16 97%  Oct-17 100%  Aug-17 96%  Jul-17 100%  Jun-17 97%  May-17 97%  Apr-17 97%  Mar-17 97%  Feb-17 97%  Jan-17 97%</td>
</tr>
<tr>
<td>Rand MAU Ward</td>
<td>474</td>
<td>46%</td>
<td>Dec-16 97%  Oct-17 100%  Aug-17 96%  Jul-17 97%  Jun-17 97%  May-17 97%  Apr-17 97%  Mar-17 97%  Feb-17 97%  Jan-17 97%</td>
</tr>
<tr>
<td>Jevnington Ward</td>
<td>300</td>
<td>49%</td>
<td>Dec-16 92%  Oct-17 92%  Aug-17 100%  Jul-17 97%  Jun-17 97%  May-17 97%  Apr-17 97%  Mar-17 97%  Feb-17 97%  Jan-17 97%</td>
</tr>
<tr>
<td>Folkington Ward</td>
<td>335</td>
<td>57%</td>
<td>Dec-16 100%  Oct-17 96%  Aug-17 96%  Jul-17 96%  Jun-17 96%  May-17 96%  Apr-17 96%  Mar-17 96%  Feb-17 96%  Jan-17 96%</td>
</tr>
<tr>
<td>Newington Ward</td>
<td>319</td>
<td>45%</td>
<td>Dec-16 100%  Oct-17 83%  Aug-17 83%  Jul-17 83%  Jun-17 83%  May-17 83%  Apr-17 83%  Mar-17 83%  Feb-17 83%  Jan-17 83%</td>
</tr>
<tr>
<td>Tressed Ward</td>
<td>307</td>
<td>46%</td>
<td>Dec-16 95%  Oct-17 95%  Aug-17 95%  Jul-17 95%  Jun-17 95%  May-17 95%  Apr-17 95%  Mar-17 95%  Feb-17 95%  Jan-17 95%</td>
</tr>
<tr>
<td>Wellington Ward</td>
<td>363</td>
<td>64%</td>
<td>Dec-16 100%  Oct-17 92%  Aug-17 92%  Jul-17 92%  Jun-17 92%  May-17 92%  Apr-17 92%  Mar-17 92%  Feb-17 92%  Jan-17 92%</td>
</tr>
<tr>
<td>Seafield 3 (Medical Short Stay/Day) Ward</td>
<td>260</td>
<td>55%</td>
<td>Dec-16 93%  Oct-17 97%  Aug-17 97%  Jul-17 97%  Jun-17 97%  May-17 97%  Apr-17 97%  Mar-17 97%  Feb-17 97%  Jan-17 97%</td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>275</td>
<td>71%</td>
<td>Dec-16 96%  Oct-17 94%  Aug-17 100%  Jul-17 100%  Jun-17 100%  May-17 100%  Apr-17 100%  Mar-17 100%  Feb-17 100%  Jan-17 100%</td>
</tr>
<tr>
<td>Macdonald Ward</td>
<td>271</td>
<td>56%</td>
<td>Dec-16 82%  Oct-17 80%  Aug-17 80%  Jul-17 80%  Jun-17 80%  May-17 80%  Apr-17 80%  Mar-17 80%  Feb-17 80%  Jan-17 80%</td>
</tr>
<tr>
<td>Stroke Unit EDGt</td>
<td>261</td>
<td>40%</td>
<td>Dec-16 100%  Oct-17 95%  Aug-17 95%  Jul-17 95%  Jun-17 95%  May-17 95%  Apr-17 95%  Mar-17 95%  Feb-17 95%  Jan-17 95%</td>
</tr>
<tr>
<td>Cardio Cath Lab EDGt</td>
<td>245</td>
<td>24%</td>
<td>Dec-16 100%  Oct-17 100%  Aug-17 100%  Jul-17 100%  Jun-17 100%  May-17 100%  Apr-17 100%  Mar-17 100%  Feb-17 100%  Jan-17 100%</td>
</tr>
<tr>
<td>Coronary Studded Unit CCU</td>
<td>244</td>
<td>23%</td>
<td>Dec-16 100%  Oct-17 100%  Aug-17 100%  Jul-17 100%  Jun-17 100%  May-17 100%  Apr-17 100%  Mar-17 100%  Feb-17 100%  Jan-17 100%</td>
</tr>
<tr>
<td>Codsline Ward</td>
<td>242</td>
<td>42%</td>
<td>Dec-16 94%  Oct-17 94%  Aug-17 81%  Jul-17 75%  Jun-17 65%  May-17 92%  Apr-17 92%  Mar-17 92%  Feb-17 92%  Jan-17 92%</td>
</tr>
<tr>
<td>Berwick Ward</td>
<td>211</td>
<td>33%</td>
<td>Dec-16 100%  Oct-17 92%  Aug-17 92%  Jul-17 92%  Jun-17 92%  May-17 92%  Apr-17 92%  Mar-17 92%  Feb-17 92%  Jan-17 92%</td>
</tr>
</tbody>
</table>

Highest score to Lowest score
Key 100% 50% 0%
Note: sorted by total response

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress. The hospital had arrangements in place to provide support when needed, which included help from specialists such as end of life, diabetes and dementia specialist nurses.

Patients also had access to physiotherapists and occupational therapists who provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.

We saw examples of thank you notes and cards written to staff expressing their gratitude and some of these had been placed on display in ward area.

There was a non-denominational hospital chaplaincy service, which provided pastoral support for patients and their relatives, carers and staff. The pastoral care team offered the following services:

- Help with understanding their experience of being in hospital
- Someone to talk to in confidence about anything which is bothering them
- Religious Support (guidance, prayers, Holy Communion, religious literature etc)
- Pastoral Care (from someone who is caring, compassionate and kind)
- Emotional support (time with someone who has a listening ear)
- A way of facing difficult news with professionals who have the time to listen
- To talk through life-threatening or ethical issues

Understanding and involvement of patients and those close to them
Staff involved patients and those close to them in decisions about their care and treatment. Patients we spoke to confirmed that staff explained care and treatment plans and they were provided with clear information.

We saw staff providing people with information about their medicines during their stay. Staff described examples of times they involved other specialists such as the end of life care team to ensure people had correct medicines prescribed and ready for discharge.

We saw the widespread use of pictograms on magnetic boards outside rooms and bays. This indicated the trust actively considered ways to inform and involve patients and relatives about who was providing care and how this was being provided.

**Is the service responsive?**

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

**Average length of stay**

**Conquest Hospital**

From October 2016 to September 2017 the average length of stay for medical elective patients at Conquest Hospital was 2.4 days, which was lower than the England average of 4.2 days.

Average length of stay for elective specialties:

- The average length of stay for elective patients in Respiratory Physiology was similar to the England average.
- The average length of stay for elective patients in Cardiology was lower than the England average.
- The average length of stay for elective patients in Gastroenterology was higher than the England average.

**Elective Average Length of Stay - Conquest Hospital**

![Bar chart showing average length of stay for different specialties at Conquest Hospital and comparison to England average.](chart)

*Note: Top three specialties for specific trust based on count of activity.*

For medical non-elective patients, the average length of stay at the hospital was 10.2 days, which was higher than the England average of 6.6 days.
Average length of stay for non-elective specialties:

- The average lengths of stay for non-elective patients in General Medicine was lower than the England average.
- The average length of stay for non-elective patients in Geriatric Medicine was higher than the England average.
- The average length of stay for non-elective patients in Cardiology was similar to the England average.

Non-Elective Average Length of Stay - Conquest Hospital

Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service took account of patients’ individual needs.

The trust employed specialist nurses to support the ward staff. This included dementia nurses and learning difficulty link nurses who provided support, training and had developed resource files for staff to reference. Wards also had ‘champions’ who acted as additional resources to promote best practice.

We saw that eating and drinking requirements were clearly displayed near each bed or room using signs.

We saw pictorial aides available for use with people with communication difficulties. Each bed had a call bell in place and within reach of the patient. We saw these being answered promptly by staff. Throughout the hospital we saw leaflets and useful information on display to help patients and their relatives understand their conditions and the treatment options available. The printed information was only available in English. Staff told us that an interpreter service was available for those patients who needed assistance.

The general environment had been designed to provide assistance for those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and manual handling equipment.

Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request. This meant that the hospital was able to care for patients with mobility difficulties.

Access and flow

People could access the service when they needed it. Overall, arrangements to admit, treat and discharge patients were in line with good practice.
Staff told us that patients were sometimes admitted to other parts of the hospital because of pressure on bed capacity. Outliers are patients admitted to wards outside of their speciality. This was a risk as the general environment was not always appropriate and staff did not always have the experience and expertise to manage the ‘outlying’ patients’ conditions.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The performance of the trust was consistently better than the England average from December 2016 to November 2017.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Five specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.3%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>96.8%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>93.2%</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

None of the specialties were below the England average for admitted RTT (percentage within 18 weeks).

(Source: NHS England)

**Learning from complaints and concerns**

**Summary of complaints**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. We saw advice leaflets readily available on the wards and departments we inspected. Patients had access to the Patient Liaison and Advice service (PALS), who supported patients with concerns and complaints and provided information about NHS services.

Staff confirmed that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings and briefings. We reviewed a sample of team meeting minutes and saw that complaints were discussed and monitored.
Staff could access the complaints policy on the trust’s intranet and knew how to direct patients to make a complaint. Medical and nursing staff told us that they received feedback from any complaint they had been involved in.

Patients we spoke with said they would raise any issues or concerns with the ward staff in the first instance and were aware that a complaints process existed.

From November 2016 to October 2017 there were 129 complaints about medicine. The trust took an average of 47.9 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 30 days.

Fifteen complaints remained open at the time of reporting and had been open for an average of 39.5 days.

The most common themes were:
- Standard of care – 59 complaints
- Communication – 28 complaints
- Discharge – 17 complaints

At Conquest Hospital, there were 50 complaints, the most common themes from which were:
- Standard of care – 22 complaints
- Communication – 12 complaints
- Discharge – seven complaints

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

We saw examples of strong local ward and department leadership. The trust had managers with the right skills and abilities to run a service providing high-quality sustainable care. Staff told us they felt well supported, valued and that that their opinions counted.

All ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their team faced in delivering good care.

Staff generally spoke in positive terms about the visibility of the senior management team. They told us they had met the new director of nursing and those who had not met were aware of their name and responsibilities. They said they felt free to raise any issues with them direct or through their line manager.

Vision and Strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

We saw poster displays and other publications about the vision and values as we visited the wards. These were readily available for staff, patients and the public to view. In addition to information published for staff on the trust intranet, the trust published information about its mission, values and vision on its public website.

The trust’s stated vision was ‘outstanding by 2020’. The staff were actively engaged in achieving this goal. The value ‘what matters to you, matters to us all’ was quoted by staff and embodied in their work ethic. Staff we spoke to were able to describe these statements and give examples that described an improving safety culture, better clinical leadership and governance.
Culture
Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke to confirmed this and described in positive terms how they felt appreciated, supported and enjoyed their work.

Staff spoke in positive terms about the team working with medical and specialist support to provide care.

Staff said they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an ‘open culture’ in which staff could raise concerns without fear.

Governance
The trust operated a divisional governance model and ‘Triumvirate working’. This was a structure, which ensured that both clinicians and managers were involved in the management and planning of hospital activities at every level. The Triumvirate model usually consisted of a lead clinician, a senior nurse and a manager. Each of the triumvirate leadership teams had responsibility for designated wards and departments.

We reviewed the minutes of meetings, which demonstrated that regular team and management meetings took place. The minutes documented how information on incidents and complaints were investigated and any learning shared and good practice promoted

Management of risk, issues and performance
The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

We found there were divisional risk registers in place. Managers we spoke with were aware of the risk registers and knew the main risks and the actions needed to reduce the risks.

Information Management
The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.

Engagement
The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys and complaints.

The management team told us that any good ideas put forward by staff were discussed at weekly ward meetings and monthly team meetings. Useful suggestions and good ideas were then passed on to the clinical and quality boards. All the staff we spoke with felt informed and involved with the day-to-day running of the service and its strategic direction.
Learning, continuous improvement and innovation

The department was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
The trust has 248 inpatient beds across 10 wards.

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

The trust had 28,846 surgical admissions from October 2016 to September 2017. Emergency admissions accounted for 6,632 (23%), 17,600 (61%) were day cases, and the remaining 4,614 (16%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The trust provided mandatory training to all permanent and temporary staff. Training was delivered through a combination of online and face-to-face learning. Each ward and theatre matron tracked the training needs of their teams. We reviewed three tracking tools and saw that staff were either compliant or had been booked for training in the near future. We were unable to see the training records for temporary staff as this was kept in a separate location by the bank coordinators.

Mandatory training covered topics such as infection control, information governance, moving and handling and basic life support. Surgical staff did not have intermediate life support training; however, the trust was in the process of rolling out a training programme. Most staff told us that the training was beneficial, however one member of staff said they would prefer written information to support the training.

The trust produced monthly mandatory training reports identifying each individual member of staff's compliance with all mandatory topics. These reports were sent to each department to follow up areas of non-compliance. Details of how to access the training was included in the emails and any shortfalls in training capacity were picked up and where necessary additional training courses were arranged. Managers received a notification when staff failed to attend training and were able to follow up with the member of staff.
Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for the completion of all mandatory training with the exception of information governance which had a training target 95%. No target was provided for training on the Mental Health Act.

Trust-wide

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>16</td>
<td>16</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>345</td>
<td>381</td>
<td>90.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>335</td>
<td>381</td>
<td>87.9%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>332</td>
<td>381</td>
<td>87.1%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>332</td>
<td>381</td>
<td>87.1%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>329</td>
<td>381</td>
<td>86.4%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>326</td>
<td>381</td>
<td>85.6%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>9</td>
<td>17</td>
<td>52.9%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The trust’s overall nursing mandatory training completion rate was 87.3%. The target was met for two of the seven mandatory training modules. Nine of the 17 eligible nursing staff had completed Mental Health Act training, which had no trust target.

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical and dental staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>169</td>
<td>210</td>
<td>80.5%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>165</td>
<td>210</td>
<td>78.6%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>149</td>
<td>210</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>147</td>
<td>210</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>134</td>
<td>210</td>
<td>63.8%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>97</td>
<td>208</td>
<td>46.6%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>14</td>
<td>271</td>
<td>5.2%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for medical and dental staff was 57.2%. The target was not met for any of the six mandatory training modules for medical staff. In addition, none of the 271 eligible medical staff had completed Mental Health Act training, which had no trust target.
Conquest Hospital

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing staff in surgery at the hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>167</td>
<td>188</td>
<td>88.8%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>162</td>
<td>188</td>
<td>86.2%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>162</td>
<td>188</td>
<td>86.2%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>161</td>
<td>188</td>
<td>85.6%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>159</td>
<td>188</td>
<td>84.6%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>159</td>
<td>188</td>
<td>84.6%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>6</td>
<td>10</td>
<td>60%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

Conquest Hospital’s overall mandatory training completion rate for nursing staff was 85.9%. The target was met for three of the seven mandatory training modules. Six of the 10 eligible nursing staff had completed Mental Health Act training, which had no trust target.

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical and dental staff in surgery at the hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>84</td>
<td>104</td>
<td>80.8%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>82</td>
<td>104</td>
<td>78.8%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>73</td>
<td>104</td>
<td>70.2%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>71</td>
<td>104</td>
<td>68.3%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>66</td>
<td>104</td>
<td>63.5%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>49</td>
<td>102</td>
<td>48%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>4</td>
<td>131</td>
<td>3.1%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

Conquest Hospital’s overall mandatory training completion rate for medical and dental staff was 57%. The target was met for none of the six mandatory training modules. In addition, four of the 131 eligible medical staff had completed Mental Health Act training, which had no trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

From November 2016 to October 2017, there were six safeguarding incidents reported relating to the surgery service.

The trust had safeguarding policies for adults and children. Staff were able to access polices on the trust intranet. The Director of Nursing led the trust’s safeguarding team. The team consisted of specialist nurses with expertise in nursing, midwifery, health visiting, paediatrics and education. Contact numbers for the safeguarding team were seen on the escalation flow charts displayed on information boards and staff told us the team were very responsive and provided the necessary support.
The Clinical Commissioning Groups (CCG) provided the trust with further safeguarding support. They had a designated doctor and nurse for safeguarding children, and a designated nurse for adults. East Sussex Healthcare NHS Trust’s safeguarding team had arrangements with their local CCG and other agencies to share information. This was to ensure that vulnerable individuals were protected whilst in hospital and when they returned to the community.

The trust had policies for Female Genital Mutilation (FGM). Training for female genital mutilation was included in the trust’s safeguarding training programme. Staff had a good understanding of the safeguarding policies and explained the referral process clearly.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of safeguarding training.

**Trust-wide**

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>381</td>
<td>381</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>381</td>
<td>381</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>364</td>
<td>381</td>
<td>95.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>347</td>
<td>381</td>
<td>91.1%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing staff at the trust was 96.7%. Nursing staff met the trust target for all four of the safeguarding modules.

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for medical staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>210</td>
<td>210</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>210</td>
<td>210</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>175</td>
<td>210</td>
<td>83.3%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>170</td>
<td>210</td>
<td>81%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff at the trust was 91.1%. Medical and dental staff met the trust target for two out of four of the safeguarding modules.

**Conquest Hospital**

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing staff in surgery at Conquest Hospital is shown below:
### A breakdown of compliance for safeguarding courses from November 2016 to October 2017 for medical and dental staff in surgery at the hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>188</td>
<td>188</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>188</td>
<td>188</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>177</td>
<td>188</td>
<td>94.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>170</td>
<td>188</td>
<td>90.4%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff in surgery at Conquest Hospital was 91.3%. Medical and dental staff met the trust target for two out of four of the safeguarding modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

### Cleanliness, infection control and hygiene

All areas we visited were visibly clean, tidy and free from dust. The trust had orderlies who were responsible for keeping ward and theatre areas clean. Patients told us the areas they had visited were cleaned to a high standard and they had seen cleaners, cleaning throughout the day. We saw that daily cleaning checklists were consistently completed on the wards and the theatres.

Disposable curtains used in patients areas, were clean and labelled to show dates of their last change. Curtains were changed every 3months.

Theatre changing room was very clean and tidy. Scrubs were stored neatly. It was unclear how often shoes were cleaned in theatres. Most staff had their own shoes so were responsible for the cleaning. We observed staff correctly dressed for theatres in line with the trust’s uniform policy. All staff wore scrubs, hair was secured above the shoulders and hats were worn in clinical areas.

All patients had pre-operative screening for Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile. Conquest hospital had not had an MRSA infection since 2008. Staff that we spoke to were aware of the infection control policy and were able to access it via the trust intranet.

We observed theatre staff cleaning theatre tables after the patients had been transferred to the recovery unit. A deep clean was conducted at the end of each working day. Theatres were
cleaned by the rapid response team if patient were positive for clostridium difficile and the theatre room was left to air dry for a minimum of an hour after cleaning.

Staff observed the “bare below the elbow” guidance. The theatres had a strict policy to ensure theatre staff wore protective coats over their scrubs and removed their theatre hats when leaving the theatres. Matrons reminded staff to check that they were bare below the elbow and that they wore a gown outside of the theatre. Staff were also encouraged to challenge any colleagues that breached these policies.

All ward areas we visited displayed up to date results of the hand hygiene and ward cleanliness audits on the information boards for all staff and visitors to see. The division had an overall hand hygiene rating of 99.04% over the last 12months. Ticehurst ward and Cookson Devas ward had both reported a score of 100% in the last audit. Although the service scored well on the hand hygiene audit, we observed on three occasions, theatre staff not complying with the World Health Organisation “Five moments for hand hygiene”. The guideline states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every point of contact or care. In January’s audit, theatres and Cookson Attenborough Short Stay ward reported compliance rates of 70% and 90% respectively.

We saw hand washing facilities and alcohol hand gel dispensers readily available throughout all clinical areas in theatres and on the wards. Personal protective equipment such as gloves and aprons were also readily available in sufficient quantities. Despite the availability of personal protective and hand sanitizing equipment, we observed three porters assisting with the transfer of a patient. No gloves were worn and none of the porters washed their hands afterwards, which increases the chance of being exposed to, and spreading germs.

The current annual report for Infection, Prevention and Control Annual Report showed the structure and reporting mechanism for the service. The Consultant Medical Microbiologist fulfilled the role of Director of Infection Prevention and control. Priorities for the current year included a review of all policies and a peer audit of hand hygiene standards. All wards visited had a link nurse for infection prevention and control who was responsible for disseminating finding of audit results, information and policies to colleagues within their clinical areas.

The surgery core service had completed a Prevention of Surgical Site Infection audit for knee replacement in July 2017. Conquest hospital recorded zero surgical site infections

**Environment and equipment**

Disposable curtains used in patients areas, were clean and labelled to show dates of their last change. Curtains were changed every 3months.

Theatre changing room was very clean and tidy. Scrubs were stored neatly. It was unclear how often shoes were cleaned in theatres. Most staff had their own shoes so were responsible for the cleaning. We observed staff correctly dressed for theatres in line with the trust’s uniform policy. All staff wore scrubs, hair was secured above the shoulders and hats were worn in clinical areas.

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All ward areas we visited displayed up to date results of the hand hygiene and ward cleanliness audits on the information boards for all staff and visitors to see. The division had an overall hand hygiene rating of 99.04% over the last 12months. Ticehurst ward and Cookson Devas ward had both reported a score of 100% in the last audit. Although the service scored well on the hand hygiene audit, during our inspection, we did not see staff consistently washing their hands or using hand gel in line with the World Health Organisation “Five moments for hand hygiene”. The guideline states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every point of contact or care. In January’s audit, theatres and Cookson Attenborough Short Stay ward reported compliance rates of 70% and 90% respectively.

We saw hand washing facilities and alcohol hand gel dispensers readily available throughout all clinical areas in theatres and on the wards. Personal protective equipment such as gloves and aprons were also readily available in sufficient quantities. Despite the availability of personal protective and hand sanitizing equipment, we observed three porters assisting with the transfer of a patient. No gloves were worn and none of the porters washed their hands afterwards, which increases the chance of being exposed to, and spreading germs.

In theatre two, the skirting board below the window had become loose and was coming away from the wall. There was a hole in the wall at the base of the floor, near the opening to the scrub room which was a trip hazard. There was also an increased chance of staff and patients coming into contact with contaminated sharp objects. This created an infection risk as these areas are difficult to clean and decontaminate which would allow microorganism to grow. We informed the theatre matrons, who were aware and had reported it to the estates department.

The current annual report for Infection, Prevention and Control Annual Report showed the structure and reporting mechanism for the service. The Consultant Medical Microbiologist fulfilled the role of Director of Infection Prevention and control. Priorities for the current year included a review of all policies and a peer audit of hand hygiene standards. All wards visited had current hand hygiene results displayed and date of last C.Diff, MRSA infection for example on Ticehurst ward. The latest audit for the ward’s cleanliness was 99% and hand hygiene 100%. There had been no MRSA infection reported by the ward since 2008.

**Assessing and responding to patient risk**

There were effective processes in place to assess and respond to patient risk. Elective patients attended a nurse led pre assessment clinic to ensure they were medically fit for surgery. Risk assessments for falls, malnutrition venous thromboembolism and pressure ulcers were undertaken. Nurses referred patients that presented with co-mobidities for an anaesthetic assessment prior to surgery.

Before and after surgery patients were continually assessed using the National Early Warning Score (NEWS). This system facilitates the early detection of deterioration by categorising the
severity of a patient’s illness. Nursing staff are prompted to request a medical review enabling a more timely response. We checked 12 sets of patient records and saw that not all risk assessments were documented. Staff assured us that the early warning scores were completed regularly however in most wards these were calculated on a handheld electronic observation system whilst other were on the paper record.

Staff in theatres were observed assessing patients and recording scores every 15 minutes. On the wards, staff monitored patients hourly and then the frequency of observations depended on the procedure and the patient’s history.

Staff in theatres were observed checking the venous thromboembolism status and patient pressure point areas. Detail was paid to positioning of the patient on the surgical table and during patient transfer from one bed to another. Pressure areas were checked and recorded in theatres and any special equipment used was noted in the patient care path booklet. Pressure areas were checked again in recovery. We saw that on the surgical assessment unit they had report zero pressure ulcers in last 300 days prior to our inspection.

The governance team had identified from incidents reports an increase in patient falls on the trauma ward Egerton. The governance team and ward staff worked together to redesign the falls assessment form. At the time of our inspection, the ward was trialling the new assessment. The matron spoke proudly of the new assessment stating there had been a significant decrease in the number of new falls per month. Previously eight to nine falls were reported per month. The introduction of the new form saw the average number of falls decreased to an average of 2 falls a month.

We inspected two sets of patient records on Egerton ward and saw the new form had been fully completed. The project was to be formally launched to other areas in the trust with the aim to reduce the number of falls in the hospital and ensure patients were safe during their hospital stay.

All surgical wards visited displayed on their quality and safety boards when they last had a patient fall for example on the surgical assessment unit (Ticehurst) they reported zero falls for the last 16 days prior to our inspection. The trust had up to date policies for major haemorrhage, anaphylaxis and adult advance life support. Staff had also completed the ALERT training, which enables staff to recognise deteriorating patients and act appropriately in order to treat acutely unwell patients. Members of staff we spoke to felt that they could confidently give the necessary care whilst waiting for assistance. The service did not carry out scenario training however, staff said the critical care outreach team were available to review any deteriorating patients. The team was described by staff as approachable and supportive to the ward teams.

The hospital used the five steps to safer surgery, which included the World Health Organisation (WHO) surgical safety checklist. The safety checklist is an international tool developed to help prevent the risk of avoidable harm and errors during and after surgery. We observed two safety checklist led by the consultant and all staff in the theatre participated. Monthly audits from September 2017 to February 2018 showed an overall compliance score of 100% for general surgery. In the same period, the trauma and orthopaedic area had scored 100% with the exception of the months of November 2017 and February 2018. There was a WHO- Post Anaesthetic Care Unit safety team debriefing every morning audited by the matrons. We reviewed the audit results and saw completed action plans when an issue was identified. This was addressed with staff in the team briefings and staff meetings.
Nurse staffing

The last inspection found that there was a heavy reliance on temporary staff and this was still the case during this inspection. Theatres were the only department in the trust that had an agreement for overtime to help the staffing situation.

The service used and met The Association for Perioperative Practice (AfPP) guidelines on staffing for patients in the perioperative setting. Staffing for the day was recorded daily and displayed on the staff board with up to date information.

During the first day of our inspection there were eight operating department practitioners (OPDs), 16 registered nurses, nine healthcare assistants (HCAs). Twelves of these were a mixture of agency OPDs and nurses.

Rotas were planned ten weeks in advance and the rosters were available to staff six week in advance. This allowed for adjustment to be made to ensure the correct skill mix and for the request of agency staff to be planned.

The high substantive vacancy rate and its resultant use of high numbers of agency staff was identified on the division’s risk register. Theatre matrons conducted daily micromanagement of staff and case mix on surgical lists to maintain the required activity rate and patient safety.

As well as the use of agency staff, the unit moved staff from Eastbourne District General Hospital’s main theatre or the Day Surgery units to Conquest hospital when available.

On the wards we saw the planned vs actual staffing levels displayed for patients and visitors to see. The ward always a band 6 (senior nurse) on duty. The staff were predominately permanent compared to that of the theatres. There was also a regular pool of agency staff used for the night shifts.

The trust has reported the following nurse staffing numbers in surgery by site as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>161</td>
<td>186</td>
</tr>
<tr>
<td>Eastbourne DGH</td>
<td>164</td>
<td>200</td>
</tr>
<tr>
<td>Total</td>
<td>325</td>
<td>386</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The following nurse staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate of 12% for nursing staff in surgery which was higher than the target of 10%:

- Conquest Hospital: 10%
- Eastbourne District General Hospital: 15%

There were 20 vacancies for theatres at this inspection for Conquest Hospital.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Turnover rates

From November 2016 to October 2017, the trust reported a turnover rate of 12% for nursing staff in surgery which was higher than the target of 10%:

- Conquest Hospital: 12%
- Eastbourne District General Hospital: 12%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, the trust reported a sickness rate of 4% for nursing staff in surgery which was higher than the target of 3.3%:

- Conquest Hospital: 5%
- Eastbourne District General Hospital: 3%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From November 2016 to October 2017, the trust reported a bank and agency shift total of 17,856 in surgery for healthcare assistants (9,489 bank and 1,445 agency) and registered nurses (4,869 bank and 2,053 agency). There were 4,125 shifts not filled by bank or agency staff.

Please note that we were unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and agency usage at Conquest Hospital and Eastbourne District General Hospital by whether the shift was for a healthcare assistant or registered nurse is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/ agency</th>
<th>Healthcare Assistant</th>
<th>Registered nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Bank</td>
<td>6,453</td>
<td>2,671</td>
<td>9,124</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>1,057</td>
<td>1,250</td>
<td>2,307</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>1,296</td>
<td>1,657</td>
<td>2,953</td>
</tr>
<tr>
<td>Eastbourne District General</td>
<td>Bank</td>
<td>3,036</td>
<td>2,198</td>
<td>5,234</td>
</tr>
<tr>
<td>Hospital</td>
<td>Agency</td>
<td>388</td>
<td>803</td>
<td>1,191</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>491</td>
<td>681</td>
<td>1,172</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Middle grade vacancies were on the risk register for medical staffing. Specialist registrars and specialist doctors predominately provided on call and ward cover for both Conquest and Eastbourne District General hospital. Agency staff covered the second on call where possible. The risk register stated there should be 17 middle grade doctors including one associate specialist for breast patients. The unit had recorded that there were normally seven middle grade doctors for both hospitals. This necessitated the use of agency doctors to maintain activity.

The service reviewed the its activities daily and weekly to ensure safe on call cover. When there
was no cover available from internal locums and external agencies, the unit reduced or cancelled elective activity to ensure safe on call and ward cover.

The trust were recruiting nationally. They also offered internal locums opportunities to maintain continuity. This risk was opended in 2015 and was reviewed regularly. There had been no changes to the risk and this reflected the national shortage of middle grade doctors.

The trust has reported the following medical staffing numbers in surgery as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>118</td>
<td>135</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>115</td>
<td>124</td>
</tr>
<tr>
<td>Total</td>
<td>233</td>
<td>259</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The following medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate of 9% for medical and dental staff in surgery which was the lower than the target of 10%:

- Conquest Hospital: 14%
- Eastbourne District General Hospital: 1%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, the trust reported a turnover rate of 11% for medical and dental staff in surgery which was higher than the target of 10%:

- Conquest Hospital: 12%
- Eastbourne District General Hospital: 11%

The Department currently has six vacancies at the time of our inspection.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, the trust reported a sickness rate of 1% for medical and dental staff in surgery which was lower than the target of 3.3%:

- Conquest Hospital: 1%
- Eastbourne District General Hospital: 1%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and locum staff usage

From November 2016 to October 2017, the trust reported a bank and locum shift total of 2,673 in surgery. Almost half of these shifts (1,283) were for middle grade doctors. There were 16 shifts that were not filled by bank or locum staff.

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/locum</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Bank</td>
<td>165</td>
<td>66</td>
<td>228</td>
<td>459</td>
</tr>
<tr>
<td></td>
<td>Locum</td>
<td>149</td>
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<tr>
<td></td>
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<td>144</td>
<td>0</td>
<td>563</td>
</tr>
<tr>
<td></td>
<td>Locum</td>
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<td>761</td>
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<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As of September 2017, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the whole time equivalent staff working at East Sussex Healthcare NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>18%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

In the surgical wards and theatres, we examined 12 patient's medical records. Staff kept records of patients' care and treatment in good order. Records were legible and up-to-date. We saw the surgical care plan was clearly filed into the main patient records and these were kept on the same unit the patient was having treatment. This meant that the records were available to all staff providing care and they were able to review the care, advice or medication given at each stage of the care pathway.
Records demonstrated a multidisciplinary collaborative approach to patient care. We saw that nursing and medical staff made entries on the same patient notes, and clearly signed their name, profession, and grade.

At discharge three copies of the summary were created which included one that was electronically sent to the patient’s GP, one for the patient and one to be kept in the patient’s hospital records. The summary notified the recipient of the procedure undertaken, the consultant in charge of care and medication prescribed.

The trust was in the process of transitioning from paper based records to electronic. We saw evidence of staff recording aspects of the patient care on an electronic handheld device. Nursing staff on Cookson Devas ward told us the electronic observation system had been trialled but had not been successful because of poor Wi-Fi coverage on the ward. This was to be corrected.

On all surgical wards patient records were stored in lockable trolleys. The trollies were locked away out of hours and required a digital code to access the storerooms. We were assured that only authorised staff we able to gain entry.

**Medicines**

The service prescribed, gave, recorded and stored medicines in line with national guidance. At the last inspection we found controlled drug records in theatres were incomplete with some staff block signing for drugs which contravened The Department of Health guideline, safer management of controlled drugs. This was no longer the case. We undertook a random check of controlled drugs in the anaesthetic room for theatre four. The controlled drugs book had been accurately completed with no block signatures. The medicines in the locked controlled drugs cupboard were reflected in the book. Staff told us the pharmacist undertook audits on the controlled drug entries. We reviewed the audits, which demonstrated that all drugs had been safely checked and administered.

The trust had implemented automated dispensing cabinets for the supply medicines in areas including in the recovery unit, and Ticehurst ward.

All fridges and cabinets were kept locked at all times. Authorised members of staff had access to the dispensary using their fingerprint. This created a data trail so records showed which member of staff accessed the cabinet, the date and time and what and how much had been dispensed. This ensured accurate record keeping. The pharmacy department were able to track and monitor stock levels for replenishment.

We were shown a demonstration of how the system worked in a live situation. Once the medicine had been selected on the automated screen, the dispensary flashed a light to indicate the location of the medicine. Staff had to turn the flashing light off to for the medicine to be deducted from the stock record. We were told of an incident where staff had forgotten to turn the light off, which resulted in the system stating it was fully stocked for a particular controlled drug, when the stock levels were insufficient. This resulted in a delay in restocking. We saw evidence of learning from this. Staff were reminded of their responsibilities when operating the system.

Medications that are required to be kept at a low temperature were stored in dedicated medicine fridges. Some but not all fridges were connected to the automated medicine cabinets. We checked the fridge monitoring records. We saw evidence that the maximum and minimum fridge temperatures were recorded as checked daily in the last month to ensure medication was being stored at the correct manufacturer’s recommended temperature.
The ambient temperatures on the wards and in theatres were also checked and completed daily in the last month. This gave assurance that medicines were stored at the correct temperature to maintain their function and safety. Staff were aware of what actions to take if room and fridge temperatures fell outside of the expected ranges.

We reviewed ten prescription charts. There were good recordings of patient allergies on medication records and patient records. Staff were heard asking patients of their allergy status before administering medication to reduce the risks of harm. Prescriptions were prescribed correctly and adhered to national guidelines. We saw a number of up to date British National Formulary books across the surgery service. The British National Formulary provides healthcare professionals with guidance on drug management of common conditions, cautions, contraindications, side effects and dosage.

We also saw a controlled drugs book on the surgical assessment unit for patients who had brought their own medication from home. Records were correctly completed in line with The Department of Health guideline, safer management of controlled drugs.

Incidents
The trust had an electronic reporting system to record safety incidents and near misses. Incidents were graded according to the severity and impact on the individual or the service. All staff spoken to were familiar with the reporting system and the policies of identifying when they needed to report an incident. Staff had a clear understanding of their responsibilities to report incidents in order to maintain safety within the service.

Staff told us that the culture around reporting of incidents had improved over the last four years. Managers encouraged and supported staff when reporting any incidents. Staff said they received feedback on incidents they had report through staff meetings, safety huddles and newsletters. Lessons were learned and improvements were made. For example, on the surgical assessment unit, a patient was given the wrong patient information. The unit made changes whereby only one set of notes were present in the room ensuring patient confidentiality was upheld.

The surgery division had a robust process for investigating incidents. We saw a detailed root cause analysis for a recent incident and the subsequent actions taken by the service. Staff in theatres were aware of the incident and demonstrated how the learnings had been implemented into the current practice. The incident related to an incorrect prosthesis being implanted. Theatre staff were now using an additional checklist in the patient care plan, details of the prosthesis were written on the white board in theatres for all staff to see and there was a read out of the equipment to be implanted.

In November 2014, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) was introduced for healthcare providers to comply with. The intention of the regulation was to ensure organisations were open and transparent with people who use the service. Staff of all levels were able to explain what was required from them under the regulation. We also saw evidence of a serious incident being shared with the patient involved via letter and minutes from a meeting held with the patient and their relatives.

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From December 2016 to November 2017, the trust reported one incidents classified as never event for surgery at Conquest hospital. The never event was classified as a surgical/invasive procedure incident meeting the serious incident criteria.

The never event occurred in September 2017. The patient re-attended hospital for a revision of total hip replacement due to post-operative infection. During this surgery, it was noted that the original prosthesis liner and head were different sizes. The prosthesis was subsequently replaced with correct size head and liner. An investigation of this incident was underway at the time of reporting.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents in surgery which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria – seven incidents
- Surgical/invasive procedure incident meeting SI criteria – three incidents
- Medical equipment/devices/disposables incident meeting SI criteria – one incident

Site specific information can be found below:

- Conquest Hospital: ten incidents
- Eastbourne District General Hospital: one incident

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 42 new pressure ulcers, 11 falls with harm and 25 new catheter urinary tract infections from December 2016 to December 2017 for surgery.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at East Sussex Healthcare NHS Trust

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

Care and treatment was delivered in line with current legislation and nationally recognised guidance. The trust had policies and guidelines readily available on their intranet. Staff told us it was easy to access the policies and procedures and they reflected current guidelines. We reviewed several policies and saw they were up-to-date including one on sepsis screening.

The trust had enhanced recovery programmes for patients undergoing bowel and breast surgeries. Enhanced recovery is an evidence-based approach that helps people recover more quickly after having major surgery. There was a team of enhanced recovery nurses who supported patients at all stages of their care. Once patients were discharged, the nurses arranged a follow-up call on the day of the discharge or the next working day so patient still had contact with the hospital.

The service ensured that care was managed in accordance with NICE guidelines through their clinical effectiveness team. The team reviewed all newly published NICE guidelines and distributed them to the relevant division. Action plans were produced and monthly meetings attended by the divisional governance team and the clinical effectiveness team were held to monitor the progress of compliance. The clinical effectiveness team were undertaking independent quality improvement reviews to be assured that all actions noted as completed had truly been
embedded in practice. At the time of our inspection, there were no outstanding guidelines for surgery.

Patients were assessed for risks of venous thromboembolism before surgery. We saw evidence that patients were given compression stockings and prescribed prophylaxis medication, which was in line with NICE guidance.

At the last inspection, we saw that theatre staff did not measure and record patients’ temperatures in accordance with inadvertent perioperative hypothermia, NICE guidance CG 65. There was a risk of patients becoming too hot or too cold and this would not be identified in a timely manner. The unit had made changes to ensure temperatures were regularly monitored. Staff said a fluid warmer (a device used to warm fluids before intravenous administration) and a warming blanket were provided for every patient. We saw staff measuring and documenting a patients’ temperature before leaving the surgical ward and upon arrival to theatres. The temperature was checked at 30-minute intervals whilst the patient was under the care of the surgery team. We saw consistent temperature recordings in the five patient records we reviewed in the surgery unit.

The trust had a local protocol for sepsis screening and treatment, which was an adaptation of the NICE guidance, NG51 Sepsis recognition, diagnosis and early management. Staff were trained in the management of sepsis. We saw a dedicated sepsis trolleys in the surgical assessment unit and in theatres.

**Nutrition and hydration**

Patients on the wards had their nutrition and hydration needs assessed using the Malnutrition Universal Screening Tool (MUST). The tool uses five steps to identify patients who are malnourished or at risk of becoming malnourished and categories them as being at low, medium or high risk. Patients had good access to the dieticians. Staff said they referred patients to a dietician for review by telephone or through an online system if required. Dieticians were part of a multidisciplinary team that provided cohesive patient care through daily ward rounds, safety huddles and multidisciplinary team meetings.

For patients who were able to have fluids, drinks were available on the bedside table and within reach. Patients in the recovery unit were offered a drink of water post surgery. Staff were seen refreshing water jugs. Staff on the wards offered patients drinks and light refreshments on their return to the ward and prior to discharge. Fluid charts were completed to monitor fluid intake for post-operative patients.

We reviewed the varied food menu, which catered for patients who followed a vegetarian and vegan diet. Most patients we spoke with were happy with the food they had been given, however one patient described the food as poor. Staff told us the kitchen staff were able to supply alternative meals if required.

We saw theatre and ward staff effectively managing nausea and vomiting. Staff asked patients about their appetites and offered medication for patients who reported feeling nauseous. Patients told us staff returned to ask whether the nausea had settled and if necessary offered alternative medication.
Pain relief

Pain relief was effectively assessed and managed across the surgery service. Concerns raised relating to pain were discussed at the red to green meetings. The purpose of the meeting was to add value and positive actions to the patient pathway therefore improving patient experience.

Patients we spoke with told us staff regularly checked if they were experiencing any pain and if they wanted medication to relieve it. Staff assessed pain using a zero to three scoring system. A score of zero meant there was no pain and three meaning extreme pain. We reviewed a number of patient records in theatre and saw evidence of pre anaesthetic medication prescribing and post-surgery monitoring of pain.

The trust used the Disability Distress Assessment Tool for patients with learning disabilities that impaired their communication skills. Staff were able to detect non-verbal ques caused by pain for example, which would otherwise go unrecognised.

Staff explained to us the different methods of delivering pain relief. Patients had a choice of oral medication, intramuscular injections, patient controlled analgesia or epidural infusion analgesia.

We observed a nurse giving discharge information. The patient was asked about their pain status and informed about of what to expect following discharge. The nurse advised the patient to ensure they had enough pain medication at home.

The trust had a consultant led pain management team. Ward staff told us upon request, the team reviewed patients within two hours of the referral.

Patient outcomes

The Mortality Review Group, which reports to clinical outcomes group, monitored the mortality indicators and conducted an in depth review of mortality data where a potential concern was identified. An example of a poor outcome within the last 12 months was the identification of orthopaedic post-surgical site infections which was unexpected from a specialty that had good outcomes for a sustained period. This resulted in a root cause analysis being undertaken he investigation was still ongoing at the time of our inspection.

The matron on the surgical assessment unit, was conducting a local audit assessing the route patients were admitted to the ward through and what the outcomes where. We saw evidence that the data collected was reviewed. This was to ensure patients were on the correct care path and whether there were lessons to be learnt to improve future care pathways.

Surgery audited mortality rates of hip fractures and the weekend effect. Short-term mortality after hip surgery was 5.7% and this was lower than the national average of 7.1%. Standards of care were no different whether admission or surgery took place over a weekday or weekend. Patients admitted over the weekend had surgery on average 1.4 hours earlier than those admitted over the week but this difference was not clinically significant.

Relative risk of readmission

Conquest Hospital

From September 2016 to August 2017, all patients at Conquest Hospital had lower than expected risks of readmission for both elective and non-elective admissions when compared to the England averages.
**Elective Admissions - Conquest Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in General Surgery had a lower than expected risk of readmission for elective admissions
- Patients in Trauma and Orthopaedics and ENT had higher than expected risks of readmission for elective admissions

**Non-Elective Admissions - Conquest Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in ENT had a higher than expected risk of readmission for non-elective admissions
- Patients in General Surgery and Trauma and Orthopaedics had lower than expected risks of readmission for non-elective admissions

(Source: Hospital Episode Statistics)

**Eastbourne District General Hospital**

From September 2016 to August 2017, all patients at Eastbourne District General Hospital had a similar to expected risk of readmission for elective admissions when compared to the England average and a lower than expected risk of readmission for non-elective patients.
Elective Admissions - *Eastbourne District General Hospital*

- Patients in General Surgery and Ophthalmology had lower than expected risks of readmission for elective admissions
- Patients in Urology had a higher than expected risk of readmission for elective admissions

Non-Elective Admissions - *Eastbourne District General Hospital*

- Patients in Urology had a lower than expected risk of readmission for non-elective admissions
- Patients in ENT and Maxillo-Facial Surgery had higher than expected risks of readmission for non-elective admissions

(Source: Hospital Episode Statistics)

**Hip Fracture Audit**

**Conquest Hospital**

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate at Conquest Hospital was 6.5% which was within the expected range. The 2016 figure was 8.7%.

The crude proportion of patients having surgery on the day of or day after admission was 80%. This was as expected when compared to other trusts but failed to meet the national standard of 85%. The 2016 figure was 85.9%.

The crude perioperative medical assessment rate was 93.3%, which was as expected when compared to other trusts but failed to meet the national standard of 100%. The 2016 figure was 90.8%.

The crude proportion of patients documented as not developing pressure ulcers was 93.8%, which fell in the bottom 25% of trusts and failed to meet the national standard of 100%. The 2016 figure was 96.1%. 
The crude overall length of stay at the trust was 25.7 days, which fell in the middle 50% of trusts. The 2016 figure was 22.2 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 76% of patients of East Sussex Healthcare NHS Trust undergoing a major resection had a crude post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 70.1%.

The risk-adjusted 90-day post-operative mortality rate was 1% which was within the expected range. The 2015 figure was 5.3%.

The risk-adjusted 2-year post-operative mortality rate was 27.9% which was worse than expected. The 2015 figure was 20.7%.

The risk-adjusted 30-day unplanned readmission rate was 5.1% which was within the expected range. The rate was not reported in 2015.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 47.9% which was within the expected range. The 2015 figure was 50.6%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not participate in this audit.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), East Sussex Healthcare NHS Trust provided poor quality data for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The trust was not eligible for the metric relating to 90-day post-operative mortality.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 40%, which was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)
National Emergency Laparotomy Audit

Conquest Hospital

In the 2016 National Emergency Laparotomy Audit (NELA), Conquest Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of the risk of death. This was based on 167 cases.

Conquest Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 116 cases.

The hospital also achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 92 cases.

Conquest Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 57 cases.

The risk-adjusted 30-day mortality for Conquest Hospital was within expectations, based on 167 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on the EQ-5D index for groin hernias was slightly better than the national average regarding improvements while performance on the EQ VAS index was similar to nationally.
No information was provided on the trust’s performance in surgery for varicose veins. For hip and knee replacements, performance was about the same as the England average.

(Source: NHS Digital)

**Competent staff**

All new staff including agency workers undertook the trust’s induction and their competency was assessed locally before working unsupervised. Overseas staff had an additional induction to support their transition into the community and Conquest hospital.

Theatres had a high usage of agency staff. The matron told us most agency staff had worked there long term and they tried to use those who had previously worked there before to reduce the burden of retraining agency staff who were new to the service.

The matrons in theatres facilitated a journal club on the last Friday of each month. Staff were encouraged to reflect on learning from the sessions and could use this for revalidation purposes. Students were able to attend education and training during audit afternoons to supplement their training.

The service had practice educators who worked closely with the university’s link lecturer and were responsible for supporting both staff and students. Practice educators kept a record of staff development which included courses and conferences attended. They supported staff to complete their revalidation for both the Health and Care professions council and the Nursing and Midwifery Council.

Nursing staff told us there were plenty of development opportunities within theatres. Band 5 staff completed a preceptorship and had a band 6 workbook to complete before they were deemed ready for a promotion.

Junior doctors spoke positively about the support they received in theatres. Each had a specific learning development plan and good contact with consultants. Surgery registrars had voted Conquest Hospital and the surgical assessment unit as the best place to train.

A high proportion of staff were registered mentors with Nursing and Midwifery Council. This was also a requirement of the university. Students were allocated and rostered with their mentor throughout their placement. They were also allocated an associate mentor to ensure the student always had support even when the main mentor was unavailable. Junior staff and students told us they benefitted from direct training and mentoring from other staff within the team.

We spoke to students undertaking training for different surgical professions including student nurses and operating department practitioners. All spoke of the second year student on their eight week placement. Student was thinking theatres may be somewhere he would like to work. The student felt well supported.

**Appraisal rates**

Staff we spoke with said they had an annual appraisal. Appraisals enable staff and managers to identify training needs, track progress and enhance clinical practice. We saw appraisal trackers in theatres and on Egerton and Ticehurst wards. We were assured that staff had had their appraisals or it had been booked. Completed appraisals were sent to the trust’s learning development team. Staff told us there was an application process for external courses that required the completion of
all mandatory training, approval from the matron, head of nursing and the learning development team.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From April 2016 to March 2017, 86.9% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%. In 2017/18 year to date, 89% of staff within surgery at the trust had received an appraisal. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Professional Scientific and Technical</td>
<td>60</td>
<td>63</td>
<td>95.2%</td>
<td>37</td>
<td>43</td>
<td>86.0%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>114</td>
<td>122</td>
<td>93.4%</td>
<td>94</td>
<td>98</td>
<td>95.9%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>45</td>
<td>51</td>
<td>88.2%</td>
<td>29</td>
<td>32</td>
<td>90.6%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>155</td>
<td>176</td>
<td>88.1%</td>
<td>119</td>
<td>135</td>
<td>88.1%</td>
</tr>
<tr>
<td>Nursing</td>
<td>313</td>
<td>360</td>
<td>86.9%</td>
<td>197</td>
<td>226</td>
<td>87.2%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>3</td>
<td>4</td>
<td>75%</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>50</td>
<td>76</td>
<td>65.8%</td>
<td>14</td>
<td>17</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

Conquest Hospital

From April 2016 to March 2017, 88.9% of staff within medicine at the hospital had received an appraisal. In 2017/18 year to date, 87.4% of staff at the hospital had received an appraisal. This was lower than the previous year and did not meet the trust target of 90%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>97</td>
<td>102</td>
<td>95.1%</td>
<td>56</td>
<td>64</td>
<td>87.5%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>49</td>
<td>52</td>
<td>94.2%</td>
<td>43</td>
<td>44</td>
<td>97.7%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>12</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>Additional Professional Scientific and Technical</td>
<td>27</td>
<td>29</td>
<td>93.1%</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>5</td>
<td>5</td>
<td>100%</td>
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<tr>
<td>Nursing Registered</td>
<td>147</td>
<td>177</td>
<td>83.1%</td>
<td>76</td>
<td>91</td>
<td>83.5%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
Multidisciplinary working

Collaborative working was evident within the surgery service. Staff credited this as one of the reasons they were able to deliver an efficient service and better patient care. Staff told us they attended multidisciplinary meetings where the care of patients was discussed at length to ensure the appropriate support was in place. Evidence of this was seen on all surgical wards and in theatre and each area held there meetings at regular time.

We observed good forward planning for example, a routine laparoscopic procedure became complex. This increased the planned surgery time, so staff immediately contacted the theatre coordinator to warn them of the prolonged procedure. The theatre coordinator was responsible for informing the ward staff of any delays so they could provide those patients waiting for surgery with the adequate fluids and nutrition if time permitted.

Once the procedure was complete, theatre staff notified the recovery unit of the imminent arrival of the patient. A patient handover was carried out between the two teams to facilitate the safe recovery from anaesthesia.

Nursing and operating department practitioners spoke of good working relationships with doctors. Staff of all levels were seen interacting positively with each other.

There was multidisciplinary participation in all patient care. Patient records demonstrated input from physiotherapist, the medical team, surgical nurses, occupational therapists and specialist nurses.

We saw strong multidisciplinary working on Cookson Devas ward. This is an orthopaedic ward. Staff discussed all patients and which member of staff was reviewing which patient. The team included a social worker, physiotherapist and occupational therapists who were attached to the ward and also supported patients when they returned to the community.

Seven-day services

Staff rotas in theatres showed sufficient levels of staffing and appropriate skill mix.

The surgery kept three theatres open 24 hours a day 7 days a week. CEPOD and obstetric units were always open. There were staff available to cover emergency operations at all times, including weekends and out of hours. Trauma theatre was open from 8 am to 6 pm, 7 days a week.

Surgery consultants and their teams conducted ward rounds 7 days a week between 9am and 10.30am.

Patients had access to consultant and anaesthetic cover 24 hours a day. The shift arrangements were from 8 am to 6pm and 6pm to 8 am. Consultants were supported by a registrar, senior house officer and a foundation doctor.

Occupational therapist delivered a five-day service, from Monday to Friday.

The pharmacy department provided cover Monday to Friday from 9am to 5.30pm and on Saturday from 9 am to 12 pm. There were arrangements to support surgery out of hours via an on call system.

The radiology department provided diagnostic services Monday to Friday from 8 am to 8 pm. There were arrangements for out of hours cover and a limited Saturday service.
Health Promotion

Patients on the enhanced recovery programmes were seen by a nurse specialist with the aim to encourage patients to have an active role in their recovery. Patients were given pre-operative advice relating to eating and drinking well and exercise. Written information with guidance on site-specific enhanced recovery programmes were also given to patients at pre assessment. These leaflets were also available on the wards.

Staff told us they encouraged patients to be mobile as soon as possible after surgery to reduce the risk developing deep vein thrombosis and improve wound healing. On Cookson Devas ward (elective orthopaedic), we observed two physiotherapists assisting a patient with their walking and tackling obstacles such as stairs. Staff said patients who had had a hip or knee replacement were given a personalised Zimmer frame to encourage independency when they were not with a member of staff.

Staff advised patients to give up or cut down on smoking and alcohol consumption to help speed up the recovery process and reduce complications. The trust did not provide a stop smoking service. Patients were referred to their GP or practice nurse for smoking cessation support.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Patients we spoke with told us they had received information regarding the procedures they were undergoing verbally and in written form before surgery. Staff discussed all aspects of the treatments, including medication to be taken and the possible risks and benefits before delivering care. We saw fully completed consent forms signed by and dated by both the patient or guardian and consultant. Consent forms were available in the patient records for staff to review before starting treatment.

At the pre assessment appointment, the nurse identified those patients with a learning disability. Doctor’s responsible for the care of the patient used the Department of Health consent form 4, and others used the functional analysis of care environment (FACE) document. Both documents contained the legal assessment of the two stage test — the diagnostic test and the functional test. The forms provided information on how to hold a ‘best interests’ meeting, prompts for Independent Mental Capacity Advocate (IMCA) referrals, Advance Decisions and Lasting Powers of Attorneys.

The service referred the patients to the trust’s learning disability specialist nurse. The nurse supported patients through the consenting process, admission, surgery and discharge. This ensured that barriers stopping patients from receiving adequate care were removed.

Although medical staff did not meet the trust target for Mental Capacity Act training, they were able to explain the process of gaining consent for patients with learning disabilities, living with dementia or mental health illnesses. Nursing and medical staff told us, when a patient lacked capacity, they sought consent from their relatives or carers. If this was not possible staff referred to an independent mental capacity advocate in line with the requirements of the Mental Capacity Act 2005.

Mental Capacity Act and Deprivation of Liberty training completion

The following training information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of Mental Capacity Act training. Deprivation of Liberty training completion was not reported by the trust.
Trust-wide

The trust reported that, from November 2016 October 2017, MCA training had been completed by 95.9% of all staff within surgery at the trust. The breakdown of training completion for nursing and medical staff at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>381</td>
<td>381</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>186</td>
<td>210</td>
<td>88.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

Conquest Hospital

The trust reported that from November 2016 October 2017, MCA training had been completed by 95.9% of staff within surgery at Conquest Hospital. The breakdown of training completion for nursing and medical staff at the hospital is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>188</td>
<td>188</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>92</td>
<td>104</td>
<td>88.5%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Is the service caring?

Compassionate care

Staff throughout the surgery service treated patients with compassion, dignity and respect. We observed staff speaking to patients with kindness. To gain an understanding of the service users’ view of the service and experience, we spoke with 12 patients and their relatives. The feedback was consistently positive and complimentary. Patients commented that the care was “excellent from the point of referral to post surgery”, “outstanding” and “could not recommend the service enough”.

Patients also said the staff were “professional yet personable” and felt they were receiving the best care. On the wards, staff were observed drawing curtains for privacy when giving personal care and asking for permission to enter side rooms.

The atmosphere in theatres was calm. Staff were noticeably busy but exhibited a cheery and relaxed demeanour. Patients told us the staff were approachable and there was always someone available speak to about any concerns or queries they had.

We observed staff being respectful of patient who were under general anaesthetic. Staff maintained patient dignity when positioning the patients on the theatre table. However, the doors leading out of theatre four had clear glass windows. It was possible to see into the opposite theatre and anyone passing through the corridor could look into theatre four, which posed a privacy and dignity issue.
Friends and Family test performance

The Friends and Family Test response rate for surgery at East Sussex Healthcare NHS Trust was 35% which was better than the England average of 29% between December 2016 and November 2017.

The response rates at Conquest Hospital and Eastbourne District General Hospital were similar, at 37% and 38%, respectively.

A breakdown of FFT performance by ward for surgical wards at the trust with total responses over 100 is shown below. All the wards had annual recommendation rates above 90%.

![Ward performance table]

(Source: NHS England Friends and Family Test)

Emotional support

Conquest Hospital had a chaplaincy centre on the same level as theatres and the surgical wards. The trust had made provision for spaces in the centre for a Christian Chapel of the Holy Spirit and a multi faith/ quiet room, which was open 24 hours a day.

The surgical unit considered each patients religious and spiritual needs. The patient pathway booklet asked patients of their religious beliefs and if they wished to have a visit from the chaplaincy team.

Staff regularly assessed the emotional state of patients and discussed any concerns they had at the team huddles. Staff told us they referred patients to the link specialist, be it the mental health nurse, dementia nurse or a member of the chaplaincy.

Written information was available for patients and relatives in the chapel and on the surgery wards, allowing them to take the leaflets away and read the information in their own time.

Understanding and involvement of patients and those close to them

Communication between staff and patients was good. Discharge and post operation care was considered pre operatively. Patient and their relatives were involved in the discussions to ensure...
the appropriate arrangements were in place to support recovery. Staff told us all questions from patients and relatives were answered and plans were put in place to ensure the admission and hospital stay was as stress free as possible. This included allocating a learning disability or dementia nurse as appropriate. Patients told us the staff listened to their concerns and adjusted the care plan to benefit the patient.

In the recovery unit, we saw that both parents were encouraged to visit their child after surgery despite the lack of space. The parents told us theatre staff helped ease their anxieties by keeping them up to date during the surgery and they were able to see their child as he recovered from the anaesthetic.

One patient had unexpectedly been admitted overnight. The patient said the doctor explained at the earliest stage the reason for not discharging and the appropriate support had been given. Staff contacted the patient’s husband, to explain the situation and made provisions for discharge the following day that suited the patient and family.

Staff addressed the psychological, physical and emotional needs of patients. On Egerton ward, staff showed an understanding and a non-judgemental approach towards patients living with dementia and mental health diagnoses. We saw how staff took the time to sit with a patient who was exhibiting signs of distress. The ward was very busy and staff were able to give one to one attention to ensure the patient did not put themselves in danger.

Is the service responsive?

Service delivery to meet the needs of the local people

Patients who required communication assistance or physical support to navigate to areas in the hospital, were identified at pre assessment. Arrangements were made prior to admission to ease the process. We saw written information in English, however, staff assured us all patient information documents were provided upon request in other languages as well as in alternative formats including easy read, braille, audio and large print.

Discharge expectations were discussed at pre admission for planned admissions or at the time of admission for emergency cases. Discharge pathway co-ordinators worked with the ward staff and community services. For patients with learning disabilities and those living with dementia, there were regular patient and family liaison meetings to support patients and their families with the transition towards discharge. The Joint Community Rehabilitation service team attended multidisciplinary meetings to support and identify patients for discharge to community.

The trust had various initiatives to allow patients to feel included and supported whilst in hospital such as, the butterfly scheme and “This is me passport”. Staff said the trust had made environmental improvements for example, contrasting toilets/bathroom fittings, adaptations for sleeping preferences, and dietary needs where possible.

There was a dedicated Dementia Care Team supported by an orthogeriatrician in charge of assessing and planning of care. The team had good links with the psychiatric team for complex patients who required psychiatric input. The psychiatric team was consultant lead and worked together with the learning disability liaison nurse to ensure the service was well designed for these patients. For example, they assured that the relevant information had been given in a format that suited the patients prior to admission.
Average length of stay

Conquest Hospital

From November 2016 to October 2017 the average length of stay for all surgery elective patients at Conquest Hospital was 3.7 days, which was higher than the England average of 3.3 days.

Average length of stay for elective specialties:

- The average length of stay for elective patients in Trauma & Orthopaedics was similar to the England average.
- The average length of stay for General Surgery elective patients was higher than the England average.
- The average length of stay for ENT elective patients was lower than the England average.

**Elective Average Length of Stay - Conquest Hospital**

Note: Top three specialties for specific trust based on count of activity.

The average length of stay for all surgical non-elective patients at Conquest Hospital was 7.6 days, which was higher than the England average of 5.0 days.

Average length of stay for non-elective specialties:

- The average lengths of stay for General Surgery, Trauma & Orthopaedics and Urology non-elective patients were higher than the England averages.

**Non-Elective Average Length of Stay - Conquest Hospital**

Note: Top three specialties for specific trust based on count of activity.

Meeting people’s individual needs

All patients requiring elective surgery had a pre-operative assessment. Specific needs were identified and referrals to the appropriate teams or specialist nurses were made. This meant that individualised care plans were developed and reasonable adjustments were made to facilitate
admission. For example the orthopaedic trauma ward had a specialist nurse newly in post who supported the patients pathway and supported staff in their knowledge and training to care for patients.

Patients with learning disabilities were referred to the Learning Disability Liaison Nurse, anaesthetic and surgical teams as appropriate. The trust had a dedicated dementia team were patients living with dementia were referred to. Staff said patients were included in planning their own care using forms of communication suitable for their needs. This was clearly documented in the patients plan of care.

A bariatric link nurse was available in recovery. Pre assessment staff liaised with theatre staff to pre advise of bariatric patients. The nurses assisted in the pre and post-operative management of bariatric patients. The trust were looking to employ a bariatric link nurse to support the theatres. The theatres also had a hover mattress which mattress is used to safely transfers and reposition patients, without lifting or straining.

The service had developed a number of information leaflets for patients. For patients on the enhanced recovery programmes, they had leaflets about the surgery, what to expect each day and a progression diary for patients to fill.

An ortho-geriatrician provided junior doctors with support on the orthopaedic ward. Junior doctors told us, the patients they cared for tend to have complex needs. They said it was easy to contact the clinician and discuss the patients need to make sure they were met.

Social workers were actively involved in the multidisciplinary meetings and the discharge planning of patients with mental health and or learning disabilities. They assessed patients For example, on Cookson Devas ward; we reviewed a report in the patient records, which set out the requirements for safe discharge.

**Access and flow**

The surgery unit had nine theatres. During our inspection eight of the nine theatres were running in accordance with demand. Theatre two being used for training. The matron for surgery told us theatre two was available if there were any delays or emergencies.

The surgery team was divided into four team, which consisted of:

- general surgery and gynaecology,
- ear, nose and throat,
- orthopaedics,
- recovery unit.

During our inspection, the theatre lists ran on time. There were no concerns relating to the admission or discharge of patients from the wards or theatres. Delayed discharge rates were low, for example on Cookson Attenborough ward, there were 3380 total discharges (between December 2016 to November 2017) and 12 delayed discharges.

Ward staff on Cookson Devas told us it was uncommon to have medical patients on the ward. Their first priority was to accommodate surgical patients from other wards if there were free beds. In contrast, staff on Cookson Attenborough ward said it was common to have medical patients due
to the lack of beds on the medical ward. We saw medical patients on Benson ward as well as Cookson Attenborough. Cookson Devas ward had strict admission criteria. The matron told us patients were screened for admission and patients living with dementia or who had leaking wounds were not permitted onto the ward because of the level of care they required.

Referral to treatment (percentage within 18 weeks) - admitted performance

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for admitted pathways in surgery was consistently below or similar to the average for England.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, all three specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.6%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>45.7%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>61.9%</td>
<td>72.8%</td>
</tr>
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</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust where the patient was not treated within 28 days was consistently better than the England average.
Percentage of patients whose operation was cancelled and were not treated within 28 days - East Sussex Healthcare NHS Trust

Over the two years, the percentage of cancelled operations as a percentage of elective admissions at the trust showed a trend of decline, and was generally lower than the average for England, with the exception of Q4 2015/16 in which the trust's performance was similar to the average for England.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

Cancelled Operations as a percentage of elective admissions - East Sussex Healthcare NHS Trust

(Source: NHS England)

Cancellation rates for the service were low including the winter months. The surgical unit proactively monitored the cancellation of operations. A list of cancelled procedures was printed and senior staff conducted an investigation to identify the reason for cancellation. Ward matrons micro managed bed occupancy by safely discharging patients to the surgery patient lounge if necessary. Where there was capacity at other hospital sites, for instance Boxhill and Uckfield hospitals, patients were moved accordingly.

Learning from complaints and concerns

The trust had a policy to monitor, report and investigate complaints and concerns. Staff told us they addressed any concerns immediately and directed patients to the patient advice and liaison service (PALS) if patients were not satisfied. PALS provided support for patients and relatives who wished to make a complaint. Information on how to make a complaint was accessible to patients and visitors. We saw posters and leaflets on how to complain or leave feedback displayed in theatres, surgical wards and in the pre assessment unit.

Staff said
on the wards. In theatres, the matrons told us, they would share information about concerns and complaints to each individual theatre team ensuring learning was received by all members of staff. Some of the surgical wards and theatres found it difficult to hold regular meeting. To ensure the latest information was shared with everyone the units had a communication book. We reviewed a communication book on Ticehurst ward and in the theatres and saw that evidence of shared learning. The matrons said the book was effective as staff were able to read it in their free time, she asked that they signed to say they had read.

Summary of complaints

From November 2016 to October 2017 there were 91 complaints about surgery. The trust took an average of 39.9 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 30 days.

Eight complaints remained open at the time of reporting and had been open for an average of 29.3 days.

The most common causes for complaints throughout the trust were:
- Standard of Care – 38 complaints
- Communication – 16 complaints
- Patient Pathway – 11 complaints

At Conquest Hospital, there were 54 complaints, the most common themes from which were:
- Standard of Care – 20 complaints
- Communication – nine complaints
- Patient Pathway – seven complaints

At Eastbourne District General Hospital there were 34 complaints. The most common themes were:
- Standard of Care – 16 complaints
- Communication – seven complaints
- Patient pathway – four complaints
- Discharges – four complaints

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

Is the service well-led?

Leadership

A team of three senior staff led the surgical directorate. The team consisted of the head of nursing, deputy head of nursing and a medical lead that were each responsible for a specific area of the division. The team worked closely with each other to ensure the unit delivered high quality, accessible care. The medical lead described the division as clinically lead and well supported by the managers.

Staff told us they were listened to and that the senior managers understood their concerns because they had the relative experience, skills and knowledge to support them.

The leadership team were visible and made time to speak to staff. Staff we asked told us they felt comfortable to raise any concerns and were confident that their concerns would be considered and actions taken if necessary. For example, one member of staff said they requested a change in
their shift pattern for personal reasons. The matron was understanding and approved the request. The member of staff felt they were a valued member of the team.

We observed that senior managers were not segregated from the team. Staff on the wards and in theatres said the matrons were very involved in the safety huddles. Senior staff were aware of the daily events be it staffing issues or the management of patient care. Administration staff also said their managers were visible and they always knew where to find them if they needed advice.

Senior managers spoke proudly about their teams. The service had low patient cancellation rates throughout a busy winter period. Managers were proud of the dedication staff showed by continuing to provide a comprehensive and effective service despite being affected by the bad weather.

All the staff we spoke with knew who the Chief Executive was and often saw him walking around the hospital speaking to staff and patients. Staff in theatres and on the surgical wards said the chief executive had visited the unit and spoke to staff working that day. Staff said they felt comfortable asking questions about the trust because of the chief executive’s friendly approachable demeanour.

**Vision and strategy**

The trust’s vision is to combine community and hospital services to provide safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex. This was displayed on the information boards on the wards we visited and in theatres.

The surgical directorate had its own vision, which was to be the best provider of surgery. Their strategies to achieve this were to work more as a network, succession planning, and to utilise automated systems to drive improvements. They told us that their business plan was under development and they were looking at examples of successful care pathways used by other trusts.

Trust’s value were embedded into everyday activities. Staff of all levels said the values were discussed at the appraisal meetings. We were shown six examples of completed appraisals. The objectives were set according to the values. This meant that staff understood the values and used them for professional development.

The values were also embedded in the risk register. Each risk was categorised alongside a value. Areas within the division had their own aims and goals. For example, on Cookson Devas ward, their goals were to be polite, caring, respectful to patients and carers, to provide safe care to a high standard and to promote individualised care. This was dated within the last year and the ward manager told us they reviewed this annually as a team.

Staff we spoke with were aware of the trust’s on-going “Outstanding by 2020” strategy. There was a sense that the hospital was moving in the right direction and that the staff were in unison with the trust to achieve this.

**Culture**

We spoke to five members of staff who had worked at the trust for at least 8 years. They told us the culture had improved over the last few years and said the trust was moving in the right direction.

All staff we spoke with were enthusiastic about working for the trust. Staff spoke of good teamwork and were proud of the service they delivered. The surgery team had invited the newly appointed
Chief of Nursing to visit the unit, to showcase the work they were doing. The matrons described how staff of all levels supported each other and that this was embedded into the culture of the service. For example, the students travelled together to reduce the cost of long distance travel to their placement site.

The trust had a number of awards to recognise staff for their efforts within the division. A member of the surgery team had recently won the first DAS (Diagnostic Anaesthetic & Surgery) award. Nominees were also congratulated and this was reported in the quarterly DAS newsletter. We also saw messages of congratulations, best wishes and condolences. Staff said morale was high and they felt valued by colleagues and senior managers.

In theatres, staff made suggestions for “quote of the week” and this was displayed on the information board to give staff a positive boost.

Matrons said they were open and honest with staff and addressed behaviour issues at the earliest point. We saw on the appraisal form a statement stating that poor performance must be addressed before the meeting so staff were not surprised with poor feedback. Addressing issues at an early stage gave the individual the opportunity to make the necessary improvements.

All staff we spoke to were happy with the level of support they received from their managers. The matrons said they were well supported by the head of nursing.

The trust had recruited overseas staff from places such as the Philippines and Europe. We were told the service tried to remove any barriers that overseas staff faced when settling into a new environment. Staff had created a welcome board, with greetings in their native language and information about the trust, the UK and the local area. The new staff were allocated a buddy to support them in and outside the working environment.

**Governance**

Surgery was part of the Diagnostic, Anaesthetic and Surgery (DAS) division. The governance arrangements for the division were well established. There were clear two way processes of sharing information throughout the structure. Regular meetings at all stages of the hierarchy allowed for information to be passed on and dealt with in a timely manner. Staff were clear on what their responsibilities were and maintained accountability.

Ward and theatres sisters told us they had daily meetings with matrons. Discussions focussed on daily issues such as staffing levels and patient safety management. Senior nurses also had weekly meetings with the Chief Operating officer.

The trust had monthly matron meetings. Agenda items included but were not limited to incidents, risk register, complaints and policies. Matrons from all wards attended to share concerns, ideas and learnings with their peers from their areas of responsibility.

Minutes from the meeting in November 2017, showed a concern was raised relating to the differences in the processes in place to support overseas staff in passing the International English Language Testing System test (IETS). IETS is an English language proficiency test used to prove that overseas staff have the necessary English language skills to effectively communicate with patients and colleagues. In 2016, The Nursing and Midwifery Council (NMC) made this a requirement to become a register member of the council.

It was recognised that staff from the Philippines had a clear pathway and support if they failed the test. The trust did not have any processes in place for European nurses. We saw that an action plan was put in place, which shows that the trust was proactive in ensuring staff were well supported and they could retain nursing staff.
There was a monthly governance meeting attended by consultants, clinical leads for each speciality and clinical nurse specialists. Governance meetings were well attended. The service managers of each speciality presented highlights from their area from the previous month. There was also a financial update informing attendees of the current and expected budget deficit as well as the savings target for the division.

We reviewed minutes from the last three clinical governance meetings. Agenda items discussed at the meetings included updates from the last meeting, policies for ratification and incidents. Minutes showed that incidents were discussed.

The governance lead had randomly selected five incidents reported at the last meeting and contacted staff involved to check whether they had received any feedback relating to the incident. It was reported that the majority of staff received feedback. This gave the governance team assurance that actions from incidents were discussed with theatre and ward staff, particularly with the staff involved.

We saw that the divisional risk facilitators and divisional governance officers were present at both matrons and clinical governance meetings. This allowed information to be escalated up to senior managers from one or two sources. Similarly, information was passed down to the matrons who were responsible for feeding back to their own teams.

Every month the divisional leads met and reported key issues to the executive team. Issues surrounding financial control, quality, safety, leadership, and culture were discussed.

Morbidity and mortality meetings were part of division’s governance structure. All surgical specialties were requested to meet monthly and report to the general surgery mortality and morbidity meeting. This meeting fed into the divisional clinical governance meeting. During a previous inspection, we noted the lack of morbidity and mortality meetings as a concern and at the last inspection there had been improvements. We discussed and agreed with the trust that there were still further improvements to be made. We reviewed the mortality and morbidity minutes from the December 2017 to February 2018. Each case was discussed at length and actions taken were recorded for example, when a patient was removed from a course of treatment and put onto end of life care and if relatives were informed. The quality of care was rated and any learning from the case was also noted.

Management of risk, issues and performance

Surgery reported its risks to the diagnostic anaesthetic and surgery risk register. Risks were categorized in order of priority from extra high to moderate. At the time of our inspection, there were 41 open risks for surgery.

The oldest risk had been open since September 2012 and was last reviewed in February 2018. We saw that the clinical governance team had also discussed the risk in the meeting minutes.

The risk affected the safety of staff and patients due to the use of latex gloves in theatres. Controls were in place to mitigate the risk and included an ongoing monitoring of staff with current latex allergies, possible redeployment of staff to latex free areas and establishing the allergy status of patients as soon as possible. Staff were to wear the appropriate gloves when caring for patients with a latex allergy. Due to the financial constraints within the trust, the financial implications of changing to non-latex sterile surgical gloves were reviewed often. Although there had been no incidents relating to the use of latex gloves, the risk remained high on the register.
Divisional risk meetings were held monthly, risks were reported to and discussed at the monthly clinical governance meeting. Therefore, risks were reviewed twice a month. We saw evidence of discussions in the minutes from the governance meeting. Risks from both Conquest and Eastbourne District General Hospitals were included. At the time of our inspection, all risks had been reviewed and had an action plan in place.

The trust were in the process of developing Local Safety Standards for Invasive Procedures (LocSSIPs) using the National Safety Standards for Invasive Procedures (NatSSIPs). Work on the policy was on hold pending authorisation to fill the vacant post.

Information management

The trust had invested in a number of systems to improve the sharing and monitoring of information to drive improvements. There was an electronic system and paper records that staff showed us they could access.

An electronic rostering system was used to access staffing levels and where and how best to utilise staff. Matrons updated the system multiple times a day so the information was as close to real time as possible. Ward matrons were able to release or ask for more staff to maintain patient safety accordingly.

The unit monitored data from the friend and family test. At the matrons meeting in November 2017, the rising trend in low response rates for the friends and family test was recognised. Matrons shared their ideas on how to improve this and one suggestion that received positive feedback was to have a healthcare assistant champion on each ward to make sure patients/relatives were filling the survey.

Theatres used a management computer system detailing the timeliness of theatres. Receptionist was aware of theatre lists running times and could give other areas an update to effectively manage any delays. Adjustments were made in regards to moving patients from one theatre list to another if it was appropriate.

Engagement

Staff said they were encouraged to share their views at team meetings and safety huddles. A new initiative had been introduced on the surgical assessment unit where the deputy head of nursing led the huddle every Thursday. Staff were also able to share their views, news or nominate their colleagues for awards via the division’s newsletter.

There were health and wellbeing pop up events for all East Sussex Healthcare NHS trust staff. The event offered a range of staff wellbeing interventions such as hand and arm massages, occupational health checks and self-help information.

The assistant head of nursing for the surgery division held monthly staff engagement meetings. Staff could book a 10-minute appointment to discuss nursing issues. The service was looking do the same for service issues. This meant that senior staff wanted to hear about the experiences of the frontline staff, to make the appropriate adjustments for improvement. We did not speak to any staff who had accessed this service.

The trust had a freedom to speak up guardian whose role was to raise staff concerns with the trust. Staff were aware of who the guardian and how to make contact. None of the staff we spoke with had made contact with the guardian.
Patients and their relatives were encouraged to give their views on the service provided. All patient information leaflets we saw had the contact details for the Patient Advice and Liaison Service. We also saw patient satisfactory questionnaires were available on each ward. These forums gave patients and their relatives the opportunity to give the service feedback to improve the quality of care given.

**Learning, continuous improvement and innovation**

Recruitment was one of the top risks on the risk register for surgery. The trust had initiatives to “grown their own” staff in order to tackle the issue.

Senior staff commented that the wards were more successful at recruiting compared to the theatres. The service had introduced a scheme to encourage the secondment of nurses from the wards into theatres. This gave nursing staff the opportunity to try a different career path, with the assurance of retaining their original role if they decided against this. We spoke with one member of staff who had been recruited on the scheme. They told us they had enjoyed the experience and were hoping to become a permanent theatre nurse. Staff we spoke to believed the plan was positive enabling the service to increase their staffing levels without having an impact on the overall trust retention.

Theatres had a development plan to support up to 10 healthcare assistants to complete a foundation degree. This would allow the assistants to become theatre practitioners who would be able to scrub for minor procedures. Some of the senior theatre staff had started in similar roles with the trust, which showed that there were opportunities to rise through the ranks.

The trust recognised and rewarded its staff for the work they did to improve quality. During our inspection, the hospital's chairman attended theatres to present an award to a theatre member of staff in recognition of the work they had done in anticipation of the winter period. The staff member received a certificate and free parking for one month. Staff had told us parking at the hospital was expensive, therefore, this was a significant benefit.

The trust used the red, amber, green status system to track performance. Areas of improvement highlighted at the last inspection and additional issues that had arisen since our visit were tracked using the tool. Red denoted that there were significant issues for immediate action. Amber meant that there was still work to be done to improve the issue and green meant no further actions were required.

This tracking tool was discussed at staff meetings so they were aware of how the unit was performing and how many issues had achieved a green status. There was also a display board in theatres showing all the problems identified at the last inspection. The majority of problems were now in the green zone.
Facts and data about this service

The East Sussex Healthcare NHS Trust has 56 maternity beds across two sites. Of these beds, 49 beds are at Conquest Hospital, 10 of which are rooms. There are seven beds at Eastbourne District General Hospital.

The trust provides the following services: antenatal, postnatal, early pregnancy unit and obstetrics.

From July 2016 to June 2017 there were 2,992 deliveries at the trust.

A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below.

**Number of babies delivered at East Sussex Healthcare NHS Trust – Comparison with other trusts in England**

(Source: Hospital Episode Statistics)
A profile of all deliveries from July 2016 to June 2017 can be viewed below. The profile at the trust was similar to the national profile:

### Profile of all deliveries (July 2016 to June 2017)

<table>
<thead>
<tr>
<th>East Sussex Healthcare NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2,954</td>
</tr>
<tr>
<td>Multiple</td>
<td>38</td>
</tr>
<tr>
<td><strong>Mother's age</strong></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>146</td>
</tr>
<tr>
<td>20-34</td>
<td>2,273</td>
</tr>
<tr>
<td>35-39</td>
<td>460</td>
</tr>
<tr>
<td>40+</td>
<td>113</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,992</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

The trust also had a similar profile of deliveries by gestation period when compared to the national proportions:

### Gestation periods (July 2016 to June 2017)

<table>
<thead>
<tr>
<th>East Sussex Healthcare NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Gestation period</strong></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>182</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>2,746</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,934</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics

Notes: For reasons of confidentiality, numbers below six and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)
Trends by quarter for the last two years can be seen in the graph below:

**Number of deliveries at East Sussex Healthcare NHS Trust by quarter**

![Bar chart showing delivery numbers per quarter](image)

(Source: HES - Deliveries (July 2015 - June 2017))

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory Training**

The service provided mandatory training in key skills to all staff and made efforts to ensure everyone completed it.

Mandatory training included fire safety, infection control, mental health, safeguarding adults at risk, safeguarding children level one to three, equality and diversity, blood transfusion, health and safety, information governance, and basic life support. The trust set targets of 90% for all mandatory training.

Staff also received mandatory training in specific maternity safety systems, including responding to childbirth emergencies such as post-partum haemorrhage (excessive bleeding following delivery) and umbilical cord prolapse, a condition where the umbilical cord comes out of the uterus with or before the presenting part of the foetus. There was also additional safeguarding level three competencies that were new to the department used to check midwives knowledge and training needs every year.

Mandatory training records showed that targets were almost met across the unit. The department had a thermometer style display showing how they were trying to meet training targets. Improvements had been made since the last inspection and although 90% was not completed universally for mandatory training, efforts were being made to address this.

Safeguarding training for medical staff had been an issue with only 60% of staff having had level three safeguarding training six months ago. The specialist midwife had worked hard to ensure the...
target of 90% was now met. Training data forms part of the six monthly risk meeting to ensure compliance and address issues arising from non-completion.

Staff were given four days to complete training a year and training was primarily by e-learning or booked training courses. Staff reported this was enough time and they felt generally supported to complete training though some staffing issues within the unit had inhibited this.

The midwife practitioner told us all staff were given advance warning of training days and she ensured all staff coming back to work after long term sick leave or maternity leave completed training before they returned to work. We were told that if staff did not complete mandatory training in a timely way that it would be reported to their manager and would be bought up at one-to-one meetings or reviews.

Practical Obstetric Multi-Professional Training was incorporated into mandatory training. Four staff members had attended a course to become trainers in Practical Obstetric Multi-Professional Training and now they offered monthly sessions. There was now a multidisciplinary faculty of trainers including consultants and anaesthetists as well as midwives.

**Mandatory training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of all mandatory training with the exception of information governance which had a training target 95%. No target was provided for training on the Mental Health Act.

We were unable to identify the number of staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore the following analysis includes staff from both maternity and gynaecology.

**Trust-wide**

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing and midwifery staff in maternity and gynaecology at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>144</td>
<td>154</td>
<td>93.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>141</td>
<td>154</td>
<td>91.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>136</td>
<td>154</td>
<td>88.3%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>136</td>
<td>154</td>
<td>88.3%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>135</td>
<td>154</td>
<td>87.7%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>134</td>
<td>154</td>
<td>87.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by nursing and midwifery staff in maternity and gynaecology at the trust was 89.4%. Nursing and midwifery staff met the trust targets for three out of seven of the mandatory training modules.
A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical staff in maternity and gynaecology at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>21</td>
<td>27</td>
<td>77.8%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>17</td>
<td>27</td>
<td>63.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>15</td>
<td>27</td>
<td>55.6%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>15</td>
<td>27</td>
<td>55.6%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>14</td>
<td>27</td>
<td>51.9%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>8</td>
<td>27</td>
<td>29.6%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>35</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by medical staff in maternity and gynaecology at the trust was 45.7%. Medical staff did not meet the trust targets for any of the six mandatory training modules. In addition, none of the 35 eligible medical staff had completed Mental Health Act training, which had no trust target.

**Conquest Hospital**

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing and midwifery staff in maternity and gynaecology at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>100</td>
<td>109</td>
<td>91.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>99</td>
<td>109</td>
<td>90.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>96</td>
<td>109</td>
<td>88.1%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>96</td>
<td>109</td>
<td>88.1%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>95</td>
<td>109</td>
<td>87.2%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>94</td>
<td>109</td>
<td>86.2%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by nursing and midwifery staff in maternity and gynaecology at Conquest Hospital was 88.7%. Nursing and midwifery staff met the trust targets for three out of seven of the mandatory training modules.

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical staff in maternity and gynaecology at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>16</td>
<td>21</td>
<td>76.2%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>14</td>
<td>21</td>
<td>66.7%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>11</td>
<td>21</td>
<td>52.4%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>11</td>
<td>21</td>
<td>52.4%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>10</td>
<td>21</td>
<td>47.6%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>8</td>
<td>21</td>
<td>38.1%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>29</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by medical staff in maternity and gynaecology at Conquest Hospital was 45.2%. Medical staff did not meet the trust targets for any of the six mandatory training modules. In addition, none of the 29 eligible medical staff had completed Mental Health Act training, which had no trust target.
Eastbourne District General Hospital

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing and midwifery staff in maternity and gynaecology at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>44</td>
<td>45</td>
<td>97.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>42</td>
<td>45</td>
<td>93.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>42</td>
<td>45</td>
<td>93.3%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>40</td>
<td>45</td>
<td>88.9%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>40</td>
<td>45</td>
<td>88.9%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>38</td>
<td>45</td>
<td>84.4%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>44</td>
<td>45</td>
<td>97.8%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by nursing and midwifery staff in maternity and gynaecology at Eastbourne District General Hospital was 91.1%. Nursing and midwifery staff met the trust targets for two out of seven of the mandatory training modules.

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical staff in maternity and gynaecology at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>0</td>
<td>6</td>
<td>0.0%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>6</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by medical staff in maternity and gynaecology at Eastbourne District General Hospital was 47.6%. Medical staff did not meet the trust targets for any of the six mandatory training modules. In addition, none of the six eligible medical staff had completed Mental Health Act training, which had no trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The maternity service had two safeguarding midwives. The safeguarding specialist and midwives interviewed worked in keeping with safeguarding and child protection policies.

There was a single system for communicating safeguarding concerns between the safeguarding team, midwives and medical staff. Concerns were flagged on the electronic reporting system and Additional Support Forms (ASF) forms were used to report safeguarding issues. We saw examples were these were clearly logged for patients who were deemed to be at risk or have particular social or domestic circumstances needing additional monitoring. These forms were electronic and shared between community midwives and hospital midwives. This information was...
then highlighted in code on the display boards so staff knew at a glance when there were issues requiring added vigilance.

The safeguarding team had huddles with ward and community midwives to highlight any new referrals. They would discuss and pre plan for any admissions into the hospital to ensure the woman’s additional needs were met on their admission.

There were plans to introduce a system that nationally monitors and logs safeguarding concerns for patients so that people who attended from another geographical area became instantly known to the team. The child protection information sharing (CP-IS) project was not yet available but training had been planned on this system.

Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had Female Genital Mutilation (FGM) or who have a family history of female genital mutilation. In addition, where this was identified in NHS patients, it was mandatory to record this in the patient’s health record. We saw a clear process in place to facilitate this reporting requirement and clear guidelines on female genital mutilation including recognising and supporting women who may have experienced this.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of safeguarding training.

We were unable to identify the number of staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore the following analysis includes staff from both maternity and gynaecology.

**Trust-wide**

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing and midwifery staff in maternity and gynaecology at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children L1</td>
<td>154</td>
<td>154</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults L1</td>
<td>154</td>
<td>154</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>152</td>
<td>154</td>
<td>98.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>151</td>
<td>154</td>
<td>98.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>119</td>
<td>133</td>
<td>89.5%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing and midwifery staff in maternity and gynaecology at the trust was 97.5%. Nursing and midwifery staff met the trust target for four out of five of the safeguarding modules.
A breakdown of compliance for safeguarding courses from November 2016 October 2017 for medical staff in maternity and gynaecology at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>27</td>
<td>27</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>27</td>
<td>27</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>16</td>
<td>27</td>
<td>59.3%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>16</td>
<td>27</td>
<td>59.3%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>3</td>
<td>10</td>
<td>30.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical staff in maternity and gynaecology at the trust was 75.4%. Medical staff met the trust target for two out of five of the safeguarding modules.

**Conquest Hospital**

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing and midwifery staff in maternity and gynaecology at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>109</td>
<td>109</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>109</td>
<td>109</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>107</td>
<td>109</td>
<td>98.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>107</td>
<td>109</td>
<td>98.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>79</td>
<td>91</td>
<td>86.8%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing and midwifery staff in maternity and gynaecology at the hospital was 97.0%. Nursing and midwifery staff met the trust target for four out of five of the safeguarding modules.

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for medical staff in maternity and gynaecology at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>21</td>
<td>21</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>21</td>
<td>21</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>13</td>
<td>21</td>
<td>61.9%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>13</td>
<td>21</td>
<td>61.9%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>2</td>
<td>6</td>
<td>33.3%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical staff in maternity and gynaecology at the hospital was 77.8%. Medical staff met the trust target for two out of five of the safeguarding modules.

Since this data was published, we have been told that 95.2% of medical staff had completed level three safeguarding children training.
Eastbourne District General Hospital

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing and midwifery staff in maternity and gynaecology at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children L1</td>
<td>45</td>
<td>45</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults L1</td>
<td>45</td>
<td>45</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>45</td>
<td>45</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>44</td>
<td>45</td>
<td>97.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing and midwifery staff in maternity and gynaecology at the hospital was 98.6%. Nursing and midwifery staff met the trust target for all five of the safeguarding modules.

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for medical staff in maternity and gynaecology at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>1</td>
<td>4</td>
<td>25.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical staff in maternity and gynaecology at the hospital was 67.9%. Medical staff met the trust target for two out of five of the safeguarding modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Although we found most areas to be clean and tidy there were inconsistencies with cleaning practice. There were several areas that did not meet cleanliness standards. We noted dust on patient televisions and on the oxygen cylinders in the antenatal ward. The kitchen on Murray ward was dirty on the first day of inspection and the door into this kitchen was wedged open constituting a fire risk. This kitchen was used to heat up patient hospital food and housed a fridge used by patients for food storage. We were told that no patient was allowed in the kitchen but we observed patients using the kitchen on several occasions. We saw dirty cups, dirty jugs and juice bottles, toast crumbs and an unclean fridge. The floor was also wet and dirty which was a health and safety hazard as well as an infection risk.

The assessment room on Murray ward had a paper checklist to indicate when bedding had been changed and the examination couch cleaned after use. The paperwork indicated that this had not
been done for six days. When asked, staff said that the cleaning had occurred but staff forgot to sign the checklist meaning there was no assurance that the area had been cleaned.

At the last inspection we noted that in the delivery suites there was wallpaper on walls. This was not best practice following the Health Building Note (HBN) 00-09:3.119 Infection control in the built environment which suggests ‘Smooth cleanable impervious surfaces are recommended in clinical areas. Design should ensure that surfaces are easily accessed, will not be physically affected by detergents and disinfectants, and will dry quickly.’ There were no specific risk assessments in place to address this issue although it was planned to refurbish all delivery suites. The head of midwifery was aware that this was an ongoing issue and knew it needed to be removed.

We saw evidence that domestic staff followed guidance in regard to the required cleaning standards, practices and frequency of cleaning. Cleaning schedules and monthly cleaning scores were on display. On the delivery suite, dedicated cleaners were available during the working day. Outside these times maternity staff would carry out the cleaning schedules. Compliance for cleaning was at 91.6% for February 2018.

All staff we met were ‘bare below the elbows’ to allow effective handwashing and staff with long hair had it tied back. Delivery rooms had dedicated hand hygiene sinks for staff to wash their hands before and after direct patient care. Gloves were available to protect staff and patients against infection and we saw that staff adhered to use of gloves where clinically indicated.

Sanitising hand gel dispensers were available at the entrances to and within wards. Signs above gel dispensers encouraged staff and visitors to use the gel to clean their hands. The hand hygiene audit tool was used to measure compliance with hand hygiene before and after contact with patients. The data for February 2018 and March 2018 showed 100% compliance across a range of staff groups. We saw most staff use hand gel, however, we observed two doctors who did not clean hands between patients seen on both the antenatal and postnatal ward. This constituted an infection risk of transferring unnecessary germs between patients and contravened trust policy and National Institute of Care and Excellence guidance, QS61 statement 3: ‘People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.’

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

Side rooms were available for women who had infection and needed isolation on the antenatal ward and within the postnatal and labour wards.
Environment and equipment

The service had suitable premises and equipment and mainly looked after them well.

The maternity and gynaecology department consisted of antenatal clinic rooms, a day assessment unit, an antenatal ward (Murray ward) and a post-natal ward (Frank Shaw) as well as the delivery suite. There was also the gynaecology ward (Mirrlees) which we did not inspect, one theatre and an annex theatre which was used if a second theatre space was needed, for example, in emergencies. This meant that patients had direct access to theatres in an emergency without having to leave the maternity unit. An emergency buzzer was audible throughout the unit when assistance was needed to attend to someone promptly.

The postnatal ward and special care baby unit (SCBU) are also located on the same floor within a short distance from each other. This allowed mothers on postnatal ward recovering from birth to visit and spend time with their babies and to enable breastfeeding. Frank Shaw and Murray wards were open and with enough space to manoeuvre beds between bays and other areas. There was the correct emergency equipment on the delivery suite including drug boxes for specific emergencies such as sepsis. We saw the resuscitation trolley was fully equipped, with drugs in date, and staff checks were signed and dated on all but two days that we looked at.

The special care baby unit was opposite the delivery suite via the sluice. This meant that potentially vulnerable babies needed to be wheeled through a utility room used for disposable of fluids, dirty linen and other unclean items to reach the special care ward. Although the sluice was tidy and clean and the route was secure, this was not an ideal path for neonatal transfer.

The delivery suite did not have a high dependency unit (HDU). In the event that a woman unexpectedly needed high dependency care at Conquest, staff transferred the woman to the main critical care unit.

Flooring throughout Murray ward and Frank Shaw ward was old and had permanent stains which made the area look unclean. There were several areas on the walls of both wards that had markings and were in need of repair or painting. In particular, there was a partially filled in hole on the wall outside the assessment room on Murray Ward that looked unsightly and posed an infection control risk.

We saw some areas where the environment was not welcoming or safe. The chairs in the day assessment waiting area did not look comfortable for pregnant women and were very basic. We also saw the kitchen in Murray ward as well as being unclean was in a state of disrepair. There were kickboards missing from under cupboards and fronts of drawers absent from the units. We entered an unlocked sluice room on Murray with dusty high surfaces, stored disinfectant including chlorine based tablets in an unlocked cupboard that posed a safety risk.

Medicines

There was a detailed policy for storing and administering medication. We saw that medicines, including intravenous fluids, were stored correctly.

However, on Murray ward, ampoules of water for injection, an anaesthetic gel and ampoules of sodium chloride for injection were unsecured on a vaginal examination trolley on the date of inspection. They were removed when staff were alerted and staff were aware of why this was not acceptable practice when challenged.

Medicines requiring refrigeration were stored within the correct temperature, and daily checks were made.
We reviewed the medication records of four patients. These records were completed correctly including information about allergies.

Controlled medication was stored securely and had proper checks in place. The controlled drug entry log on the antenatal unit indicated that this medication was checked by two qualified staff at the change-over of each shift and before administration.

**Records**

We looked at six sets of postnatal records for women who had used maternity services at Conquest Hospital. The overall quality was good. Notes were legible; entries were signed, dated and timed in line with best practice guidance. There was adequate use of the venous thromboembolism (VTE) score checklist, partogram (a composite graphical record of key maternal and foetal data during labour), World Health Organisation (WHO) checklist used in theatres, charts for growth and early warning scores. Only one set of notes in those scrutinised did not have a venous thromboembolism check.

Records were complete and showed that each woman had individualised care plans for pregnancy and labour, each had received antenatal screening and assessment of risk to promote safe treatment. The trust ensured the allocation of named midwives or consultants to women.

We saw notes stored securely although they were readily accessible to staff. The notes were stored in locked trolleys that required a number key to access. The notes, however, were disorganised because the ward had insufficient clerks for filing them and midwives were too busy to reorganise them but there were more clerks being recruited to help this.

We reviewed a set of notes after witnessing a patient complaining on a ward and noted that all information about the issues was documented correctly and accurately. The complaint was about a perceived piece of information about a baby’s treatment. The notes recorded the complainant’s concerns succinctly, factually and detailed the explanation given to those involved. We were told there was no routine audit of maternity notes to monitor whether all key elements were included, in line with good practice. However, when an issue was identified, we were told that a manager would discuss this with the individual at supervision.

Mothers were given a Personal Child Health Record (commonly known as the Red book). Health professionals used the red books to record information on baby’s birth and health, including feeding assessments, new-born checks and new-born hearing screening.

**Assessing and responding to patient risk**

Patients were continuously risk assessed using the Modified Early Obstetric Warning Score (MEOWS). Patient notes we reviewed showed comprehensive completion and evidence of escalation if a patient was seen to be deteriorating.

The service followed the ‘Five Steps to Safer Surgery’ World Health Organisation (WHO) checklist which included a sign in, time out and sign out checks. Patients had a copy of the ‘Five Steps to Safer Surgery’ WHO checklist in their notes and is recorded on the theatre database. Where required, this had been fully completed in notes we reviewed. We did not see staff introduce themselves in theatre though as a small unit all staff knew each other.
The matron ensured that employees who are involved in the performance of invasive procedures develop shared understanding and are educated in good safety practice. We saw the department had produced local Safety Standards for Invasive Procedures using the national Safety Standards for Invasive Procedures. This included all surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms and other procedural areas within an organisation. For example surgical repair of episiotomy or genital tract trauma associated with vaginal delivery.

All patients received a venous thromboembolism assessment on arrival this was repeated 24 hours later to check for any increased risk.

The department uses a system of ‘fresh eyes’ on all cardiotocography monitoring (CTG). This is a system where a review of the cardiotocography printout is undertaken by another midwife or medical staff to check there is agreement in its interpretation. This system helps identify possible misinterpretation. To also address issues around challenging and interpreting cardiotocography data, ‘CTG huddles’ were called. At these huddles, staff requesting more clarity on cardiotocography readings or challenging opinion were able to discuss findings with several staff. This was another checking mechanism to counteract previous cardiotocography reading failures that had been a problem for the department and was noted at the last inspection.

Some staff spoke of wanting central monitoring of CTG. This is where all interpretations are sent to a central monitor for continuous review by staff and open discussion around interpretation. There was no plan for central monitoring to be used at the time of our inspection but an application for funding of this was on the trust’s risk register.

**Nurse and midwifery staffing**

The trust reported that staff numbers fell below their target for 2016 to 2017, reporting that nurse staffing levels were not compliant with trust targets. For example on the Frank Shaw ward, Murray ward and the delivery suite the target whole time equivalent (WTE) 90 was not met with the number of midwives and nurses in post at 82. However, recent recruitment meant that new appointments had been made that would bring the staffing levels to establishment requirement.

The department had identified staffing on the trust wide risk register. Throughout our visit staffing levels were often mentioned as a challenge across the department. The unit was funded for 1:25 and worked at 1:28 (that was 1 midwife to every 28 patients). Midwifery staffing was frequently below plan and had the potential to compromise safety. There was no formal mechanism of reporting staffing issues to the board although six monthly reporting was planned but this had not started.

The trust used a nationally recognised acuity tool to calculate the required number of midwives to maintain one to one care for women in labour. Trust data showed that in June 2017, the midwifery-led service had a planned ratio of one midwife to every 28 women across the trust. This was in-line with evidence-based guidance set out in the intercollegiate document, Safer Childbirth (2007): Minimum Standards for the Organisation and Delivery of Care in Labour. The intercollegiate guidance suggested this ratio was sufficient for the acuity level of the service provided at Conquest Hospital to ensure the capacity to achieve one-to-one care during labour.

We were told one to one care was provided most of the time and the trust used a commercial acuity tool to monitor one to one care for women in labour. The trust had just invested in the most recent version of the tool which was due to be implemented shortly.
There was an escalation policy that all staff were aware of to manage staffing when numbers were compromised. Matrons, specialist midwives and community midwives were used in times of heightened activity and staff flexed between antenatal, post-natal and delivery suite. The labour ward coordinator was able to explain how staff were redeployed at times of high acuity in line with this policy. Staff reported unsafe staffing levels (sometimes down to six rather than the agreed ten) via the electronic risk reporting tool. However, some staff stated that they did not always do this due to being too tired at the end of the shift.

All midwives had an allocated named supervisor for clinical support. Changes were made nationally in 2017 to the way midwives were regulated which removed supervision from regulatory legislation. Within this trust, an application had been made to Health Education England Kent Surrey Sussex to fund a research study to support the implementation of a new ‘Professional Midwifery Partner’ role for midwives. This was proposed after a local maternity service review identified that maternity staff wanted greater clinical support. This was to be started in April 2018. In the interim, maternity staff had safeguarding supervision and ‘lessons learned and reflection’ supervision. Newly qualified midwives had six one hour sessions at the start of employment.

The trust provided some specialist services for maternity in-line with National Institute of Care and Excellence guidance, including, Practice Development Midwife, Project Lead Midwife, Perinatal Mental Health Midwife, Infant Nutrition Midwife, Bereavement Midwife, Midwifery Preceptorship Facilitator, Maternity Practice Education Facilitator and two Safeguarding midwives. A young parents midwife had also been recently been appointed to support a population of young teenage mothers who needed one to one care.

The trust has reported their nursing and midwifery staffing numbers in maternity by site as of October 2017 below:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>82</td>
<td>90</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>126</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

The following nurse and midwifery staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

We were unable to identify the number of staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore the following analysis includes both maternity and gynaecology nursing and midwifery staff.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 6% for nursing and midwifery staff in maternity and gynaecology which was lower than the target of 10%:

- Conquest Hospital: 6%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Turnover rates

From November 2016 to October 2017, the trust reported a turnover rate of 11% for nursing and midwifery staff in maternity and gynaecology which was higher than the target of 10%: The rate at Conquest hospital was on target.

- Conquest Hospital: 10%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, the trust reported a sickness rate of 5% for nursing and midwifery staff in maternity and gynaecology which was higher than the target of 3.3%:

- Conquest Hospital: 5%
- Eastbourne District General Hospital: 8%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From November 2016 to October 2017, the trust reported a bank and agency shift total of 2,810 in maternity and gynaecology (1,877 bank and 933 agency). There were 1,006 shifts not filled by bank or agency staff.

Please note that we were unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and agency usage at both Conquest Hospital and Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/agency</th>
<th>Healthcare assistant</th>
<th>Maternity care assistant</th>
<th>Registered midwife</th>
<th>Registered nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Bank</td>
<td>859</td>
<td>0</td>
<td>521</td>
<td>232</td>
<td>1,612</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>41</td>
<td>0</td>
<td>206</td>
<td>685</td>
<td>932</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>171</td>
<td>0</td>
<td>613</td>
<td>187</td>
<td>971</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Bank</td>
<td>4</td>
<td>15</td>
<td>234</td>
<td>2</td>
<td>255</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>2</td>
<td>1</td>
<td>28</td>
<td>0</td>
<td>31</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Midwife to birth ratio

As of September 2017 the trust had a ratio of one midwife to every 25.1 women, which was better compared to the national average of 26.8 and better than the recommended ratio.

(Source: Electronic Staff Records – EST Data Warehouse)
Medical staffing

Consultants were available 24 hours seven days a week. Consultant obstetricians provided 72 hour presence on delivery suite to support junior staff. This is better than the recommended Safer Childbirth and RCOG guidelines of 60 hours of consultant presence for 6000 births a year or greater.

The on-call Consultant was present on the labour ward from 08.30am to 20.30pm Monday to Friday and 08.30am to 2.30pm Saturday and Sunday. Outside of these hours they were on call from home within 30 minutes of the hospital. A registrar and senior house officer (SHO) was on call and on-site 24 hours a day, in addition to a dedicated additional registrar and SHO available on site from 8:30am to 5 pm. The department used a ‘hot’ weeks system where a consultant was allocated periods in advance to provide continuous care over one week at a time. This offered a rota system of continuity for both patients and trainees.

The service used locums to provide cover as recently some consultants had left the service. Currently locums work within the service with consultants posts being advertised. There were difficulties recruiting middle grade doctors to obstetrics and gynaecology posts but the leadership team were addressing this by bolstering recruitment. They believed attracting these doctors to be a problem as the unit was not a specialist maternity centre and there were national vacancies at this level.

The trust has reported their medical staffing numbers in maternity as of October 2017 below.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>27</td>
<td>29</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The following medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

We were unable to identify the number of staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore the following analysis includes both maternity and gynaecology medical staff.

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate of 3% for medical staff in maternity and gynaecology which was lower than the target of 10%:

- Conquest Hospital: 6%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Turnover rates

From November 2016 to October 2017, the trust reported a turnover rate of 6% for medical staff in maternity and gynaecology which was lower than the target of 10%:

- Conquest Hospital: 8%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, the trust reported a sickness rate of 2% for medical staff in maternity and gynaecology which was lower than the target of 3.3%:

- Conquest Hospital: 2%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

From November 2016 to October 2017, the trust reported a bank and locum shift total of 477 in maternity and gynaecology. There were no shifts that were not filled by bank or locum staff.

Please note that we were unable to calculate bank and locum usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and locum usage at both Conquest Hospital and Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/locum</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Bank</td>
<td>51</td>
<td>127</td>
<td>0</td>
<td>178</td>
</tr>
<tr>
<td></td>
<td>Locum</td>
<td>39</td>
<td>220</td>
<td>38</td>
<td>297</td>
</tr>
<tr>
<td>Eastbourne DGH</td>
<td>Bank</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Locum</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

In September 2017, the proportions of consultant staff and junior staff reported to be working at the trust were lower than the England averages.

Staffing skill mix for the 34.1 whole time equivalent staff working in maternity at East Sussex Healthcare NHS Trust
Incidents

There was a clear process for reporting incidents through an electronic incident recording system. The policy on how to report incidents was available through the trust’s intranet site. Midwives, support workers and doctors told us the system was easy to use and that they felt comfortable completing incident reports. Detailed guidance was available to support staff using the system. Midwives and maternity leaders were able to articulate changes resulting from incidents, for example there was an incident with a patient and a particular blood pressure medication that had caused her to become unwell. Staff learning from this was discussed at handovers, risk meetings, emails and via Maternity Matters (a newsletter for staff).

Incidents were dealt with by the governance lead as a full time role. There was a plan to appoint six risk champions to share the workload, develop staff and disseminate learning and themes to colleagues. We saw that learning was shared via a folder in the staff room which included whole root cause analysis reports. However, staff said that these were lengthy and preferred to have a synopsis given there was little time for reading at work.

The trust reported that safety briefings before handover, monthly mortality meetings and updates on the intranet were used to share the lessons learnt from investigations with staff. We saw evidence of this in a shared staff file and staff could give examples of where they had learned from previous incidents.

We looked at the escalation process for incidents and incidents graded as level 3 and we reviewed two root cause analysis reports following incidents and found them to be detailed, complete and had clear actions for learning.

The trust confirmed that all serious incidents regarding still births were forwarded to the new Health and Safety Executive Health Investigation Branch (HSIB) in line with national guidance. This independent body reviewed all still births so that lessons were learnt and improvements embedded in practice. All cases of still birth were discussed with the bereavement midwife and obstetric lead to highlight any practice issues or trends in health or clinical practice. All outcomes of investigations are recorded within the electronic reporting system.

There were daily risk meetings Monday to Friday, from 1pm-2pm which involved multidisciplinary staff members including anaesthetists, junior doctors, senior midwives and clinical leads. The aim of these meetings was to discuss any incidents from the day before (or weekend if a Monday), and ascertain if the correct protocol had been followed and report any learning that could be implemented. During these risk meetings, time allowing, any recent emergency caesarean sections were also discussed and reviewed to gain consensus on whether they were needed. This involved going over case notes and reviewing tracings allowing for further learning. Midwives we spoke to stated that being released from shift to attend was difficult due to staffing issues despite it being part of their learning and development needs.
We reviewed the trust's major incident response plan which established the framework for the trust's response in the event of any major emergency, regardless of cause. We spoke with a matron that was aware of their duty in respect to a major incident and a midwifery support worker who was also able to articulate what they would do in the event of an emergency or disaster.

All new staff received duty of candour training as part of their Induction training. For existing staff duty of candour training was also provided trust wide and featured in the learning and development training brochure with sessions provided by the patient safety team. Duty of candour training was also included in the mandatory risk training sessions (patient safety and health and safety training), incident reporting training and introduction to root cause analysis (amber) investigation training. Newsletter bulletins had also been circulated trust wide and a screen saver had been created for use for all staff using trust computers. We reviewed incident data for the service and actions staff took following incidents and saw evidence staff applied duty of candour.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents which were classified as never events for maternity.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from December 2016 to November 2017.

The three incidents reported were maternity/obstetric incidents meeting SI criteria relating to the baby only (this includes a foetus, neonate and infant). All three incidents occurred at Conquest hospital.

*(Source: Strategic Executive Information System (STEIS))*

**Safety Thermometer**

The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. There are different topics to review depending on the specialism. The trust had developed a system which provided monthly data about obstetric and neonatal outcomes compared against national averages. The information about safety was not available or displayed in a format which was accessible to patients and the public.

The trust recorded all birth information on the maternity dashboard. This covered organisational aspects, such as closures, activity, workforce and clinical indicators. The dashboard was reviewed at the monthly quality meetings and also reviewed monthly at board level during executive meetings.
It was reported that the total number of women with a blood loss of over 2000mls was in line with the target set by the trust for eight out of eight months from May 2017 to December 2017. It was also reported that the total number of women with a third or fourth degree perineal was in line with the target set by the trust for from May 2017 to December 2017.

**Is the service effective?**

**Evidence-based care and treatment**

We found from discussions with staff and patients as well as our observations that care was being provided in line with The National Institute for Health and Care Excellence (NICE) quality standard 22. This standard covers the care of all women up to 42 weeks of pregnancy. It covers all areas of ante-natal care including community and hospital settings.

Data provided showed that standardised caesarean section rates and models of delivery were all similar to expected rates and the proportion of deliveries recorded for instrumental deliveries, non-interventional deliveries and other methods were in line with other trusts in England.

There was evidence to indicate that NICE Quality Standard 37 was being adhered to in respect to post-natal care. Examples included staff discharging patients with checks and with correct medicines. All patients we spoke with had been given infant feeding advice and support.

The National Institute for Health and Care Excellence (NICE) quality standard seven on skin to skin contact was adhered to in post-natal care. Skin-to-skin contact with babies soon after birth had been shown to promote the initiation of breastfeeding and protect against the negative effects of mother–baby separation. There was information about this on the wards, this was promoted heavily in theatre and all staff encouraged women to do this. An audit was planned in May 2018 to measure the success of this.

The National Institute for Health and Care Excellence (NICE) guideline quality statement six on intrapartum care on delayed cord clamping was evidenced in theatres. Delayed cord clamping meant more blood reached the baby immediately after birth and may help to prevent anaemia. This had been introduced and implemented by a specialist nurse for caesarean sections over the previous 12 months. We observed this happen in theatre and we asked a parent if it had occurred. They affirmed it had and were able to tell us why this was important to the health of their baby.

There were two antenatal screening midwives in post and there was a joint paediatric and antenatal clinic for all foetal abnormalities that linked with the local hospice. A 'New-born Infant Physical Examination (NIPE) smart' system had been introduced and was working well to ensure that neonatal screening and referral pathways existed. This included a mechanism that meant that babies not screened within 72 hours of birth would be identified. Growth was monitored from 24 weeks by measuring and recording the symphysis fundal height as highlighted by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries.

The service undertook a series of audits to ensure they regularly reviewed the effectiveness of care and treatment of patients. These included an audit of postnatal readmissions, a reaudit of perineal tear management and the national pregnancy in diabetes audit.

A communication tool ‘Situation, Background, Assessment and recommendation’ (SBAR) had been introduced for staff handovers and advice calls between midwives and doctors at the last inspection. Staff reported this new system had improved handovers and we saw this in handover notes. SBAR stickers used to act as prompts for communicating critical information about patients were not yet in use.
Insertion of a double balloon catheter for induction of labour in pregnant women was used on the antenatal ward. NICE evidence stated that this had the benefit of spontaneous vaginal delivery within 24 hours in 69 per cent of women and offered a positive birth experience in almost 90 per cent of cases.

The use of transcutaneous electrical nerve stimulation (TENs) as pain relief in labour was being considered. The National Institute for Health and Care Excellence (NICE) suggest that this is probably most effective during the early stages of labour, when many women experience lower back pain. It showed that the department was looking at a multitude of ways to help women have a positive birthing experience. Similarly, the unit was considering intradermal sterile water for injections as an alternative analgesia for women experiencing severe lower back pain in labour.

At the last inspection, we had some concerns about completion of the correct documentation pertinent to termination of pregnancies. We reviewed and knew from talking to staff that the service now adhered to The Abortion Act 1967 and the Abortion Regulations 1991. We saw the correct completion of HSA1 form which were signed by two doctors before admission. Staff were able to show the documentation and process after the initial paperwork was submitted. No termination of pregnancy occurred for social reasons within the department. Terminations were performed for foetal abnormalities only.

We saw the policy and procedures for pool evacuation in the event of an emergency and were told that drills had been performed to make sure everyone knew how to use the evacuation equipment. The lack of pool evacuation procedure had also been an issue at the last inspection but had been rectified and staff were able to tell us how to use the equipment for evacuation if needed.

The trust holds a gap analysis of all NICE guidelines to ensure new recommendations are included. A Guideline Group (GIG) met bi-monthly, led by a consultant obstetrician. The group reviewed latest guidelines and implemented any applicable policy changes. We reviewed three months of meeting notes and minutes and found the actions dealt with in a timely manner.

**Nutrition and hydration**

Patients were offered a choice of menu options and dietary requirements were taken into consideration. Patients we spoke with reported the food was good and options were available. Patients were invited to help themselves to a variety of breakfast items from a trolley on wards; if a woman was not mobile then staff helped her choose and delivered it to the bedside. Hot drinks were available for patients and visitors at all times from a trolley in ward areas. There were snack bags available for women who had a planned caesarean section so that they had food handy dependent on operating times.

A specialist infant feeding midwife was employed on a part time basis to offer extra advice, support and guidance to women experiencing difficulties with breastfeeding. This specialist midwife taught staff how to assist women with feeding their babies using aids for a ‘hands-off’ approach. The unit did not have Baby Friendly Initiative (BFI) accreditation but were keen to work towards this. The UNICEF UK Baby Friendly Initiative was launched in the United Kingdom in 1995 to work with the NHS to ensure a high standard of care for pregnant women and breastfeeding mothers and babies in hospitals and community health settings. Mothers with babies on the neonatal unit were encouraged and supported to express milk for their babies. If women wished to bottle feed sterilisers were readily available and they were advised to supply their own formula milk as a cost saving measure.

The department offered breastfeeding workshops which were held twice a week. These aimed to help women struggling to breastfeed and support them to do it. All patients we spoke to said they
had received support to breastfeed soon after birth, and that this had continued on the post-natal ward. Patient information of breastfeeding support was seen throughout the department. We also saw information on the drop in feeding service in Eastbourne.

### Pain relief

Women had access to a range of pain relief methods following NICE guidance CG190. This included Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour.

Epidurals were available 24 hours seven days a week. Women generally received epidurals within 30 minutes of request.

We spoke to several women over the two days of our inspection and all reported their pain was managed well. A woman we spoke to had recently had a caesarean section she reported that she was advised of her pain relief options before surgery and that her pain had been monitored well. We were told women requesting an induced abortion are routinely offered pain relief in-line with The Royal College of Obstetricians and Gynaecologists (RCOG) guidance the care of women requesting induced abortion. Guidance from Best Practice in Comprehensive Abortion Care 2015 recommended that women should routinely be offered pain relief such as non-steroidal anti-inflammatory drugs (NSAIDs) during surgical abortion. However, only paracetamol and codeine was routinely available at the Conquest site.

### Patient outcomes

#### National Neonatal Audit Programme

**Conquest Hospital**

In the 2016 National Neonatal Audit Conquest Hospital’s performance was as follows:

**Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?**

There were 17 babies born at less than 32 weeks included in this audit measure, 94% of which had their temperature measured within an hour of birth. This was below the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

**Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 69 eligible mothers identified for inclusion in this audit measure, 78% of which were given a complete or incomplete course of antenatal steroids. This was below the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

**What proportion of babies at less than 33 weeks gestation at birth was receiving any of their own mother’s milk at discharge to home from a neonatal unit?**

There were seven babies born at less than 33 weeks who met the criteria for inclusion, 86% of which were receiving mother’s milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit. This was above the national average, where 59% of eligible babies were receiving any mother’s milk at the time of their discharge from neonatal care (please note that only babies who had a final neonatal discharge to ‘home’ at the end of their first episode of neonatal care were included in this analysis. Babies who were transferred between neonatal units at any point were excluded).
Eastbourne District General Hospital

Eastbourne District General Hospital did not submit data to this audit.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised Caesarean section rates and modes of delivery

From July 2016 to June 2017 the standardised elective, emergency and total numbers of caesarean sections at the trust were all similar to expected:

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England Caesarean rate</th>
<th>Caesareans (n)</th>
<th>East Sussex Healthcare NHS Trust Caesarean rate</th>
<th>Standardised Ratio</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective caesareans</td>
<td>12.1%</td>
<td>354</td>
<td>11.8%</td>
<td>103.8 (z=0.3)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.4%</td>
<td>389</td>
<td>13.0%</td>
<td>85.5 (z=-1.2)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.5%</td>
<td>743</td>
<td>24.8%</td>
<td>93.4 (z=-0.9)</td>
<td>Similar to expected</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

In relation to other modes of delivery, the table below shows the proportions of deliveries recorded by method in comparison to the England averages from July 2016 to June 2017. The profile of deliveries by delivery method at the trust was similar to the national profile:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>East Sussex Healthcare NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>743</td>
<td>24.8%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>423</td>
<td>14.1%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>1,806</td>
<td>60.4%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>20</td>
<td>0.7%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>2,992</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of October 2017 the trust had one maternity outlier, which will be taken to the Maternity Outlier Panel meeting in March 2018 for consideration:

<table>
<thead>
<tr>
<th>Date received</th>
<th>Trust aware</th>
<th>Alert source</th>
<th>Indicator</th>
<th>Patient group</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2017</td>
<td>No</td>
<td>CQC</td>
<td>Maternity</td>
<td>Maternal readmissions (excluding Z codes)</td>
<td>New case - pending consideration</td>
</tr>
</tbody>
</table>

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.1 compared to 4.7 for the comparator group, indicating that performance was ‘worse than expected’.

When compared to other trusts with similar service provision, the trust’s rate was in the amber band indicating that it was up to 10% higher than the average for the comparator group.

However, the overall trust figure was below the national average for still births at 3.2 stillbirths per 1,000 births in 2017. Every stillbirth was reviewed and discussed in depth at daily risk meetings and again at a Weekly Patient Safety Summit (WPSS).

There had been one maternal death reported by the trust since May 2013 which was a patient who was subsequently found to be pregnant after she had died.

(Source: MBRRACE UK)

Competent staff

Staff had the right skills and knowledge to assess patient’s needs, preferences and choices. The department had a dedicated preceptorship midwife who was identified training needs and supported staff. We saw clinical support and supervision for newly qualified midwives, junior doctors and students.

Appraisals are benchmarked against the visions and values of the trust. We saw examples of in depth well written appraisals and appraisals achieved with the trusts visions and values in mind. There were clear objectives, aims and training needs documented.

There was a matrix system to ensure that all staff are up to date with appraisals on the shared drive. A traffic light system displaying red, amber and green prompts when appraisals were pending or overdue.

Appraisal training was available for ESHT staff on a monthly basis and ad hoc sessions were available for those areas where compliance in completion of appraisals was below what was expected.

Not all staff had had an appraisal with their line manager. This was due to staffing issues within the unit and reporting issues with the computer systems. There had been a slight delay from time of appraisal to when it was reported but improvements had been made with the arrival of the new matrix system. There had been an improvement in completed appraisal rates at the time of inspection.

Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

We were unable to identify the number of staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore the following analysis includes both maternity and gynaecology staff.
**Trust-wide**

From April 2016 to March 2017, 63% of staff within maternity and gynaecology at the trust had received an appraisal compared to a trust target of 90%. In 2017/18 year to date, 85.6% of staff within maternity and gynaecology at the trust had received an appraisal. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>25</td>
<td>38</td>
<td>65.8%</td>
<td>16</td>
<td>21</td>
<td>76.2%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>71</td>
<td>119</td>
<td>59.7%</td>
<td>76</td>
<td>87</td>
<td>87.4%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Conquest Hospital**

From April 2016 to March 2017, 58.5% of staff within maternity and gynaecology at the hospital had received an appraisal compared to a trust target of 90%. In 2017/18 year to date, 80.2% of staff at the hospital had received an appraisal. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>19</td>
<td>28</td>
<td>67.9%</td>
<td>11</td>
<td>16</td>
<td>68.8%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>45</td>
<td>86</td>
<td>52.3%</td>
<td>44</td>
<td>54</td>
<td>81.5%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Eastbourne District General Hospital**

From April 2016 to March 2017, 74.5% of staff within maternity and gynaecology at the hospital had received an appraisal compared to a trust target of 90%. In 2017/18 year to date, 95.5% of staff at the hospital had received an appraisal. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>26</td>
<td>33</td>
<td>78.8%</td>
<td>32</td>
<td>33</td>
<td>97.0%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>2</td>
<td>4</td>
<td>50.0%</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
**Multidisciplinary working**
Staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. Care was delivered and reviewed in a coordinated way when different teams were involved in patients care. Staff we spoke to reported good multidisciplinary working relations between midwives, midwifery support workers, doctors in the maternity day unit, and other staff. Midwives told us they contacted consultants if they needed advice, for example, around risk assessments, and found consultants approachable.

The daily risk meetings were well attended by staff across the whole women and children’s department including paediatricians, anaesthetists, junior doctors, lead clinicians, ward clerks, midwives, pharmacists and department leaders. However, due to poor staffing levels, some midwives were not able to attend these meeting despite this being part of their mandatory training requirements to do this yearly.

We saw several examples of good multidisciplinary team working within the department. We attended a risk meeting which had representatives from several disciplines discussing complications following a caesarean birth. Staff contributed freely and collaboratively with opinion and suggestion.

**Seven-day services**
Consultants and anaesthetists were available on site from 8:30am to 8:30pm and on call outside of these times on a rotation basis. On call meant that they were no more than 30 minutes away from the hospital. This ensured women had access to consultant advice at all times. This was in-line with The Association of Anaesthetists of Great Britain and Ireland, Obstetric Anaesthetic Guidance: An anaesthetist must be immediately available for emergency work on the delivery suite 24 hours seven days a week, and National Health Service, Seven Days a Week, Priority Clinical Standards.

Foetal anomaly screening was available Monday to Friday and routine ultrasounds examinations were available on the day assessment units at all times.

There was an onsite pharmacy which was accessible at all times of the day and night.

The day assessment unit accepted patients at all times. We were told that this often resulted in long waits for patients as at certain times there were less consultants and doctors around to see women.

**Health promotion**

There was information displayed on boards throughout the unit for patients and visitors to read promoting, for example, smoking cessation, infant feeding, dietary advice and diabetes in pregnancy. The trust championed the health promotion initiative Make Every Contact Count (MECC) and staff on the maternity unit were aware of this. This meant they used the everyday interactions they had with women and families to promote health and healthy living.

The focus, however, was not to offer leaflets to women but staff encouraged them to access online material. Women were given an information sheet on discharge detailing all relevant websites. It was deemed a more useful and user-friendly way of asking patients and families to look at information.
Consent, Mental Capacity Act and Deprivation of Liberty safeguards

For significant interventions and procedures requiring written consent as per department of health recommendations the trust used a standard set of NHS consent forms to record a person’s consent.

For general care that required verbal consent, healthcare professionals were required to document this in the relevant area of the person’s notes. The trust monitored this process through regular audit of consent forms and the healthcare record. All staff were required to follow the trust policy and procedure for consent which is updated regularly and based on the department of health model consent policy. Multidisciplinary training on consent was provided regularly throughout the year as classroom based sessions and online induction.

We spoke with staff members about the Mental Capacity Act 2005 and staff demonstrated a good awareness of consent procedures. One midwife explained she had recently had concerns about a patient in her care and had escalated to the consultant who was going to see the women with the perinatal mental health specialist.

We saw staff verbally gaining consent before commencing any treatment. Staff were seen fully explaining procedures and the associated risks of accepting the treatment or not.

Mental Capacity Act and Deprivation of Liberty training completion

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of Mental Capacity Act training. Deprivation of Liberty training completion was not reported by the trust.

We were unable to identify the number of staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore the following analysis includes both maternity and gynaecology staff.

Trust-wide

The trust reported that, MCA training had been completed by 96.0% of all staff within maternity and gynaecology at the trust from November 2016 October 2017. The breakdown of training completion for nursing/midwifery and medical staff at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery staff</td>
<td>154</td>
<td>154</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>22</td>
<td>27</td>
<td>81.5%</td>
<td>No</td>
</tr>
</tbody>
</table>

Conquest Hospital

The trust reported that, MCA training had been completed by 95.0% of staff within maternity and gynaecology at Conquest Hospital from November 2016 October 2017. The breakdown of training completion for nursing/midwifery and medical staff at the hospital is shown below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery staff</td>
<td>109</td>
<td>109</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>17</td>
<td>21</td>
<td>81.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Is the service caring?

Compassionate care

We saw staff introducing themselves to patients and explaining their roles within the department in line with National Institute for Clinical Excellence guideline QS15. This statement 3 states that ‘patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team’. We saw staff taking time to interact with patients and saw examples where staff demonstrated the importance of gaining the trust of women they were treating. When asked, patients were able to tell us the midwife that was in charge of their care on that day along with the named consultant. Positive comments included: “they have been brilliant,” and “can’t fault the care I have been given.”

Team working ‘compassion in practice’ was part of mandatory training and included a section on feedback from patients and recent complaints. Staff pulled curtains around patients before undertaking examinations or providing care maintaining patient’s privacy and dignity. During the inspection patients were observed with curtains closed around their beds in bays for privacy and staff knocked on doors before entering patient side rooms.

We saw photographs of all staff displayed within the department. This helped patients to identify staff members during their stay. All ward area display board featured thank you cards from patients and families for the care they had received.

Friends and Family test performance

Friends and family test performance (antenatal), East Sussex Healthcare NHS Trust

![Graph showing Friends and Family test performance (antenatal)]
From November 2016 to October 2017 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average. The trust’s latest month performance was 100% compared to the England average 96%. The trust did not report any figures for August 2017.

**Friends and family test performance (birth), East Sussex Healthcare NHS Trust**

![Graph showing Friends and family test performance (birth)]

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

**Friends and family test performance (postnatal ward), East Sussex Healthcare NHS Trust**

![Graph showing Friends and family test performance (postnatal ward)]

From October 2016 to October 2017 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average. For 11 out of 13 months the trust performed slightly better than the England averages.

**Friends and family test performance (postnatal community), East Sussex Healthcare NHS Trust**

![Graph showing Friends and family test performance (postnatal community)]

From October 2016 to October 2017 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. However, the trust’s performance dropped in May 2017 to 78%.

The trust’s latest month’s performance was 100% compared to the England average 98%. The trust did not report any figures for November 2016.

(Source: NHS England Friends and Family Test)
### Labour and birth

<table>
<thead>
<tr>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the very start of your labour, did you feel that you were given</td>
<td>About the same</td>
<td>8.7</td>
</tr>
<tr>
<td>appropriate advice and support when you contacted a midwife or the hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During your labour, were you able to move around and choose the position</td>
<td>About the same</td>
<td>7.8</td>
</tr>
<tr>
<td>that made you most comfortable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your partner or someone else close to you was involved in your care</td>
<td>About the same</td>
<td>9.7</td>
</tr>
<tr>
<td>during labour and birth, were they able to be involved as much as they wanted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you have skin to skin contact (baby naked, directly on your chest or</td>
<td>About the same</td>
<td>9.2</td>
</tr>
<tr>
<td>tummy) with your baby shortly after the birth?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Staff during labour and birth

<table>
<thead>
<tr>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.2</td>
</tr>
<tr>
<td>Were you and/or your partner or a companion left alone by midwives or</td>
<td>About the same</td>
<td>7.6</td>
</tr>
<tr>
<td>doctors at a time when it worried you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you raised a concern during labour and birth, did you feel that it</td>
<td>About the same</td>
<td>8.4</td>
</tr>
<tr>
<td>was taken seriously?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in</td>
<td>About the same</td>
<td>9.3</td>
</tr>
<tr>
<td>a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If attention was needed during labour and birth, a member of staff</td>
<td>About the same</td>
<td>8.6</td>
</tr>
<tr>
<td>helped them within a reasonable amount of time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved</td>
<td>About the same</td>
<td>8.8</td>
</tr>
<tr>
<td>enough in decisions about your care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated</td>
<td>About the same</td>
<td>9.4</td>
</tr>
<tr>
<td>with respect and dignity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during</td>
<td>About the same</td>
<td>9.2</td>
</tr>
<tr>
<td>your labour and birth?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Care in hospital after the birth

<table>
<thead>
<tr>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital</td>
<td>About the same</td>
<td>7.2</td>
</tr>
<tr>
<td>after the birth was appropriate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your</td>
<td>About the same</td>
<td>8.0</td>
</tr>
<tr>
<td>baby, were you given the information or explanations you needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room</td>
<td>About the same</td>
<td>8.9</td>
</tr>
<tr>
<td>or ward you were in?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your</td>
<td>About the same</td>
<td>8.5</td>
</tr>
<tr>
<td>baby, were you treated with kindness and understanding?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your discharge from hospital</td>
<td>About the same</td>
<td>5.3</td>
</tr>
<tr>
<td>delayed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, If attention was needed after the</td>
<td>About the Same</td>
<td>7.9</td>
</tr>
<tr>
<td>birth, a member of staff helped within a reasonable amount of time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, that their partner who was involved</td>
<td>About the Same</td>
<td>4.8</td>
</tr>
<tr>
<td>in their care was able to stay with them as much as they wanted</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

**Emotional support**

Women we spoke with confirmed that staff explained processes in detail, spent time with them and provided reassurance. Women using maternity service could access support for specific health
related issues including diabetes or mental health needs. Midwives assessed women for anxiety and depression during their initial antenatal appointment and then they were given continuous support as required once admitted. Women had access to counselling and could be referred to by consultants, if needed. We saw patient information on these services and advice to women about support services available.

The trust had named bereavement midwives who supported women and their families following stillbirth or neonatal death. All midwives undertook bereavement training as part of their mandatory training. A bereavement midwife was responsible for speaking with women and families who had been bereaved during or after childbirth or had a late miscarriage or termination for medical reasons. Women undergoing termination of pregnancy were offered support and counselling before and after procedures. There were three scheduled appointments per month arranged for each affected patient and referrals were made in the community and by hospital midwives. After the appointments had ended, women were given email details to ensure advice and support was available as required. A bereavement midwife met with the Still Birth and Neo-natal Death (SANDS) team six weekly to review the service and feedback any concerns raised.

There was a debriefing service for women and their partners who wished to talk about their birthing experiences. The trust wide spiritual care and chaplaincy team were available to women, their families and supported staff. The chaplaincy service offered emotional support to women and their families as requested.

We spoke with a patient who had a complicated pregnancy requiring multiple admissions; she was positive about the advice, care and said all staff were kind and caring. “Absolutely everything was well explained” She said that she received breastfeeding support immediately and that this continued once on the ward.

There was a Facebook page for mothers to get support from peers and meet new people. Staff and patients said this had been a useful tool in helping new mothers feel more prepared and supported.

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

Staff communicated with women and their families and care partners making sure they understood the treatment they were to receive and the risks associated with this. We witnessed a staff member explaining the risks of induction to a lady who had been admitted with reduced foetal movements. They outlined both the positive and negative aspects of the care plan and allowed time for the patient to ask questions.

We asked women across this service if they felt well informed and involved in decisions about their care and treatment. All confirmed that midwifery, nursing and medical staff informed them of their choices of treatment before proceeding with any care and they felt they were able to ask if more detail was required if they did not understand anything.

Our review of care records showed women were advised of their options at every stage of their pregnancy including when complications occurred. Staff recorded consent was obtained before carrying out procedures in line with women’s care.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. People’s individual needs and preferences were central to the delivery of tailored services. We saw several innovative approaches to providing integrated person centred pathways of care that involved other service providers.

The trusts maternity dashboard showed an average of 89.8% of women receiving antenatal care at Conquest saw a midwife by 12 weeks and six days of pregnancy between September 2017 and December 2017. This was just below the trust’s target of 90% agreed with the strategic health authority.

A Triage system operated at the Eastbourne site and patients were directed from there. Once this service ended then calls would divert to the antenatal ward at Conquest. Women we spoke with had found this service worked well and reported no issues with being unable to speak with a midwife. However, when staffing numbers were low, midwives told us that the lack of a dedicated triage person had the potential to compromise patient care.

The service aimed to send women home promptly (24 hours) after having a caesarean section. Women were given the date of discharge in advance to enable planning. A specialist midwife dedicated to caesarean section care saw women at a pre-assessment clinic and was in theatre with them on the day of delivery. This demonstrated good continuity of care and meant that women were aware of what to expect. Women we spoke to felt they had received good informed care before and after caesarean section.

There was a lack of space to discuss difficult situations with women in the antenatal ward which doubled as a day assessment unit. Rooms were found and used on an ad hoc basis dependent on occupancy. A clinical scanning room doubled up as a room for staff handovers. We saw one patient attend following a home birth for an appointment in the post-natal ward and she was seated in a corridor whilst waiting to see a physician. This was an uncomfortable and awkward place for a nursing mother to sit and wait.

At the last inspection, it was recognised that a pathway of care for women in the latent phase (early labour) was needed and mentioned that there was a designated room. During this inspection we were shown a room that was in the process of being converted into a latent phase room, however, women were still not able to use this room. This meant that women and their partners who preferred to be in hospital rather than travel home in the early stages of labour were not accommodated.

Bed Occupancy

From quarter 1 2016/17 to quarter 2 2017/18 (April 2016 to September 2017) the bed occupancy levels for maternity at the trust were consistently higher than the England average, with the trust having 69% occupancy in Quarter 2 2017/18 (July to September 2017) compared to the England average of 61%.
The chart below shows the bed occupancy levels at the trust compared to the England averages over the time period:

(Source: NHS England)

Meeting people’s individual needs

People could access the service when they needed it. Waiting times from treatment were satisfactory and arrangements to admit, treat and discharge patients were in line with good practice.

Safer childbirth standard 2.2.20 states ‘Women have the right to choose where to give birth. If a woman chooses to give birth at home or in a midwifery unit contrary to advice from midwives and obstetricians, there needs to be clear documentation of the information given. Women we spoke with had been given options and were aware of available choices.

Maternity matters guidelines suggest ‘All birth environments should be designed to offer a home-like comfortable environment with en suite facilities, including equipment such as comfortable chairs, beanbags, mats, balls, baths and birth pools. There were many such facilities available on the wards and the delivery suite consisted of ten single rooms with en suite facilities. One of these was a home from home room with a large birthing pool which had a much less clinical feel. However, women on the antenatal ward had no shower facilities. A new bath had been installed but without a shower. Women needed go to a neighbouring ward to shower which impacted on their dignity and was inconvenient as the wards were locked requiring a swipe system for access.

Women were given a named midwife and contact number on booking. There was a welcome pack which contained information about mealtimes, visiting information, infection control, use of mobile phones and use of curtains around beds.

Community midwives identified patients who would need translation services at booking and a telephone interpreting service was used for people who did not have English as a first language. Telephone interpretation was part of a trust wide policy as there were local difficulties in obtaining face-to-face translation in this geographical area.
Bariatric patients could be found a suitable bed from other areas of the hospital if needed and all the newly purchased beds in treatment areas and delivery suite were suitable for bariatric use. The department had pathways of care for patients with learning disabilities and two rooms which were wheelchair accessible.

There was a smoking cessation lead midwife who followed public health guideline 26 (PH26) to identify women who needed help to quit smoking. All women who attended the early pregnancy unit who were diagnosed with a viable pregnancy, that smoked were referred to the smoking cessation service.

Patients with mental health issues were on a care pathway and in contact with a perinatal mental health midwife. This meant that women with a variety of mental health needs had good management of care which improved their quality of life in pregnancy. We spoke with the midwife who had a busy caseload and she gave us several recent examples of her complex workload.

We saw how NICE clinical guideline 110 which had recommendations for pregnant women who have complex social factors was followed. We saw an available specialist midwife attend a home visit for an unwell woman who had called threatening to harm her 15 week old baby. Help was provided and the woman brought to the emergency department for treatment.

The trust had employed a young parents midwife to deal with young pregnant women aged under 20 who may feel uncomfortable using antenatal services in which the majority of service users are in older age groups.

There was visiting from 9am to 9pm for partners of patients and women but not facility for overnight stay. Most people were happy with this though one gentleman we spoke with said it ‘would have been nice’ to stay overnight with his partner and new born child.

There was limited but available patient car parking near delivery suite for maternity patients and there was easy access for ambulances bringing women into this part of the hospital.

As a result of comments about noise levels on the unit, foam ear plugs were available in a dispenser. In addition, noise levels were detected by an ‘EAR ‘ which was a neon sign that illuminated as noise on the unit increased so that staff then took action to make the area as peaceful as possible.

The bereavement facilities, however, needed upgrading and this was planned to be undertaken urgently. The poor facilities were highlighted in the CQC report published in January 2017. Over one year later and this had still not been completed. The room was cold and clinical. There was a ‘cuddle cot’ (a chilled cot for the deceased infant) that had been made and gifted to the hospital but that aside the room was an inadequate environment for grieving families. We were told that money had been raised and work was to be done with SANDS (Stillbirth And Neonatal Death charity) to redesign this space.

The white patient information display board on Murray ward had potentially confidential information in public view. Staff were conscious of this but names, details of patient status and medical jargon were obvious for everyone to see. There were plans to obtain a board which could conceal this information.
**Access and flow**

People could access the service when they needed it. Access to care was managed to take account of people’s needs including those with urgent needs.

Women had 24 hour access to the triage phone line for advice or if they were in labour or experienced any immediate problems, such as bleeding. The triage system for all women went through a dedicated triage midwife at Eastbourne Midwife Led Unit. This system was in place from 8:30 am until 7pm Monday to Friday. Outside of this time the calls were diverted to Conquest and women were brought into the day assessment unit or directly to labour ward depending on their needs. Patients were then advised or asked to attend.

Triage happened on the day unit within Murray Ward and dependent on risk the patient might be transferred to the delivery suite. At night women went to the labour ward for triage. This meant mixing emergency and elective care and midwives told us also that the workload was sometimes confusing. This triage service seemed rather fragmented and we read about an incident that supported this. A member of staff had moved women overnight from the wards to beds nearer to the delivery suite because of poor staffing that. The maternity review also identified that this system was putting a strain on staff particularly out of hours when midwives were attending to patients and also expected to cover the triage calls.

The department had one main theatre and a annex theatre with a separate scrub area for busy times. The hospital planned for two caesarean sections a day on weekdays, except Thursdays when only emergency surgery would be undertaken.

Patients were discharged with a contact number to call for any issues which arose after leaving hospital. We saw a midwife explaining to a patient they were available 24/7 and to call if she had any worries. Discharge planning included information packs for women outlining medication needs, doctor’s appointment and follow up, and women’s contraception methods. We saw all of this discussed with patients before departure and advice was given on cot death risks, smoking cessation and sleeping positions for the baby. Patients were given an opportunity to offer feedback about the care received.

The day assessment unit waiting room was a large but un-inviting area. This was highlighted in our last inspection report. It was an old six bedded bay converted into a waiting area that was filled with basic seating. We did not see any chairs suitable for bariatric patients and the area was sterile and unwelcoming. The day assessment unit was on the antenatal ward near to inpatient beds. Staff used a screen to partition the area when clinics were occurring. This had an impact on flow, privacy, security and space on this ward. Staff on the day assessment unit told us it was often very busy. The day assessment unit reported seeing upwards of 30 women a day. The unit ran booked appointments but also saw women who required urgent review, such as women who experienced low foetal movement. The day assessment unit was on the risk register as women who may be suffering pregnancy loss had to wait close to services occupied by obviously pregnant women. This impacted potentially on the mental well-being and anxiety levels of distressed women and families.

**Learning from complaints and concerns**

Complaints were reported to the Trust Board on a monthly basis in the integrated performance report with additional commentary on any trends and themes. There was a patient experience and public engagement group that met on a bi monthly basis where the complaints data and themes were included within the patient experience report. In addition the patient experience report was reviewed and discussed at the patient safety and quality group.
Complaints about maternity services were reviewed at the monthly risk meetings and the information from complaints was also included in the governance report for the division. Actions from complaints were recorded on the datix electronic reporting system to ensure they were followed up and completed. The complaints policy stated that complaints were acknowledged within three to seven days. This contact was, where possible, by phone. If this was not possible a letter was sent outlining what exactly will be investigated and complainants were asked to confirm they were happy with this process.

Staff we spoke with explained how they would deal with a patient’s concerns immediately and, wherever possible, as they arose, then they would escalate to their ward sister or manager, when necessary. Staff were able to signpost patients to the Patient Advice and Liaison Service department where appropriate. Staff at all levels told us complaints were discussed at meetings. We saw actions from these that were shared with staff via various mediums including newsletters and staff told us that complaints were discussed at ward meetings. Records of complaints and action plans were held in staff information files with audit reports and action plans, which were available in the communal staff room. Staff were able to give examples of complaints that had happened in their area and were aware of the findings from investigations and any actions that were needed.

We reviewed four complaints which were all signed by the chief executive for the trust and had a detailed summary of the issues presented by the complainant with a comprehensive response to the concern. All complaints we read were suitably apologetic, written without medical jargon so they were easy to understand and offered clear explanations of events.

The local Healthwatch had completed a review of the maternity services and the report was being finalised but results were positive overall. Mothers felt happy with the care received, and were surprised by the quality of the service. All the mums had received one-to-one care during labour and felt staff were supportive when asked for help. They felt there was good levels of information prior to discharge, for example information for mothers with diabetes and special dietary requirements and described much improved breastfeeding support for new mums.

The wards displayed a ‘you said, we did’ board. We saw examples of this that included the bobble hat scheme which was launched in September 2017. Babies with additional needs wore a red hat to indicate that they needed more input. There was a red hat sticker on the display board to highlight vulnerable babies also. This was in response to feedback and learning from a baby being prematurely discharged.

Another example was there had been feedback about mothers feeling separated from their babies on transfer to or from Eastbourne. The ambulance service agreed to take babies in car seats. These were purchased by the local midwifery unit and had improved patient experience when being moved to another hospital.
Summary of complaints
From November 2016 to October 2017 there were 20 complaints about maternity. The trust took an average of 49.1 days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 30 days.

Four complaints remained open at the time of reporting and had been open for an average of 40.3 days.

The most common themes from the 20 complaints were:
- Communication – nine complaints
- Standard of care – four complaints
- Attitude – three complaints

At Conquest Hospital, there were 19 complaints, the most common themes from the 19 complaints were:
- Communication – eight complaints
- Standard of care – four complaints
- Attitude – three complaints

At Eastbourne District General Hospital there was one complaint related to communication.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership
The directorate was made up of women’s, children’s and sexual health services. There had been leadership changes with the appointment of a new head of midwifery. This had improved leadership visibility and accountability we were told. The head of midwifery recognised that the structure of this directorate was diverse and vast given it included children’s’ services, gynaecology, sexual health, audiology, health visiting, paediatric community services as well as maternity. We were told that there was good synergy amongst the leaders though they were clearly different in style.

All staff we spoke to felt supported by their line manager. Midwifery staff spoke positively about the leadership of the department and the support they were offered. Positive comments included “we all pull together”, ‘it’s a great place to work” and “Staff want to support each other, as we know how hard this job can be”.

The department had direct access to the chief executive every month through a performance meeting; he chaired the meeting and discussed quality with the clinical leadership teams. It was through engagement at these meeting that the maternity review had been launched. All staff, when asked, were able to tell us the names of the chief executive and the head of midwifery.

Non-executive directors (NEDs) took part in four or five quality walks per month throughout the trust. When asked, the non-executive directors were aware of the staffing issues within the maternity department and familiar with the concerns on the maternity risk register.

Vision and Strategy
The values and vision for the department were displayed in ward areas. This was to provide efficient and effective service to women and their families, to be friendly and supportive to each other, in a calm, stress-free, productive dynamic, tidy well organised environment. There were also
displays titled ‘what we are proud of. There was a clear vision for the service and a strategy already in progress. This included the maternity service review which had surveyed 121 women who had given birth at the trust in January and February 2017. This national survey on maternity services undertaken on behalf of the Care Quality Commission (CQC), found that maternity care at East Sussex Healthcare NHS Trust had improved across a number of areas. This had shown an improvement from the previous survey in 2015 which suggested that leaders were investing in a value led maternity department.

Staff were able to tell us about upcoming improvements and talked enthusiastically about recent changes in the department. This was also articulated in monthly staff newsletters, weekly staff forums and via the intranet and emails. The maternity team had their own ‘top ten values’ displayed on posters. These values were collated by canvassing staff on their opinions via social media and email and staff felt proud of having meaningful values to heed.

There was a strategy to change the way services were led and configured with other departments but no formal documentation of this was available on the day of inspection. Whilst changes had been made to the structure, there was more work to do to complete this. The head of midwifery planned to have two deputy heads of midwifery and midwife practitioners. However, the piece of work to advance these strategic changes was dependent on Birthrate Plus data which was incomplete. Birthrate Plus is a national tool and midwifery model designed to inform decision making about safe and sustainable services.

The head of midwifery looked forward to introducing ‘Better Births’ to help the maternity service plan and deploy continuity of carer models as recommended by NHS England to improve one-to-one care for women in labour.

**Culture**

We received consistent views and feedback about the culture of the unit and the culture of the wider trust. Staff felt that they worked in a positive environment with friendly colleagues. Staff across many services reported a positive, open culture and were passionate, committed and proud to work as part of the trust. Across many services, particularly inpatient maternity and neonatal services we saw staff worked with a demanding caseload, however staff demonstrated they were genuinely happy when providing care to women and their babies.

Staff reported that it was a different place to work than a year ago and that positive changes to leadership had been the driving force behind the changes. Staff said they “Felt involved and like our opinions mattered” and they welcomed new management appointments. Staff stated that following the last inspection, senior managers took actions and supported them with any concerns and the open door style was mentioned by four staff members.

The inspection team were welcomed into the unit by all staff members. Staff were willing to talk to us and be open about what the service was like. This showed an open work force who welcomed review.

However, we were told that there had been reported ‘low level bullying’ within the department that was being investigated but no conclusion had been reached on its legitimacy.

**Governance**

Midwives and maternity support workers (MSWs) reported to the ward sisters who then reported into the matrons. The matrons reported to the clinical services managers who reported to the head of midwifery. Clinical services managers and the head of midwifery sat on the trust’s internal accountability and governance committee for women’s, children’s and sexual health services. The
committee met monthly and provided quality and safety assurances to the trust board. We saw that matrons received copies of the minutes and disseminated any learning points or changes of practice to all relevant staff. We heard from staff that they were informed about any changes in ward meetings or via e-mail.

Maternity services also held a trust-wide daily maternity risk meeting at Conquest Hospital. Matrons and clinical services managers attended these meetings, as well as the head of midwifery. Risk meetings were open for all staff to attend if they wanted to. Midwives said they were often too busy to attend, but that they always received learning feedback from these meetings. A newsletter had been produced named Maternity News which was a clinical governance and risk newsletter. This publication commenced in January 2018 and focused on incidents and trends.

We spoke to the midwife leading on patient risk, we found there were reliable risk management processes in place including systems for learning from incidents and implementing change. When action plans were developed following incidents we saw the changes were tracked at trust level to ensure completion.

**Management of risk, issues and performance**

There was a demonstrated commitment to best practice performance and risk management. Risk was reviewed through a series of local and trust wide meetings. We saw there were comprehensive assurance systems, and performance issues were escalated through clear structures and processes.

The department took part in the Trust Mortality Review Group Meetings which occurred monthly. The meetings reviewed mortality statistics including crude mortality and Summary Hospital-level Mortality Indicator (SHMI) Mortality. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average. They also had clear actions and who should undertake them, and any future strategy and changes in practice in regards to mortality.

We reviewed the Maternity risk register and saw the top risks included interpretation and escalation of cardiotocography monitoring, Birthrate Plus planning, staffing and staff training and the early pregnancy unit waiting areas in acute sites being insensitive to women’s emotional needs.

We saw evidence of the clinical and internal audit processes working well. The department were aware of the impact of audit and how audit can be used to further the development of better systems within the department.

**Information Management**

There were effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. Staff told us there was good access to information at the trust. The head of midwifery told us they received an updated maternity dashboard every month and could access a range of data from the trusts intranet facilities.

Relevant information was displayed on notice boards within the maternity unit. We saw posters about training opportunities, development opportunities for staff, infection control, parenting advice and educational material for new parents. However, not all the information was dated so we did not know what was current or out of date.
Guidelines were stored on an electronic resource on the intranet. There was a focus on not printing off copies so that the most up to date policy was always accessed. All but one policy we looked at were in date and had a review date published. The out of date policy was a trust policy on complaint management and not specific to maternity. Staff told us they could access policies, protocols and other information they needed to do their job through the trust intranet. They also had internet access to evidence-based guidance from bodies such as NICE and the Nursing & Midwifery Council (NMC). We saw computers available to allow them to do this.

**Engagement**

A closed Facebook group called ‘make it happen’ had been set up for staff to engage in service changes. This group included midwives, student midwives, nurses, maternity support workers and ward clerks. It also enabled staff to get shifts covered and find support when needed. After the success of this a similar Facebook group started for local women to share experiences, insights and ideas about how to make midwifery services better. Both groups had been involved in choosing wall art at the maternity entrance.

Staff had access to a staff room which they were really proud of. They had sourced money from the trust to improve facilities and now had a decent kitchen area and sofa. There was also a large information board displaying staff notices, details of training, staff awards and health and well-being literature.

Breakfast with the boss sessions were available to provide an opportunity for staff to talk about what was important to them. We did not meet any staff on inspection who had done this but staff knew this was an option and welcomed it. There was also a plan for two staff to look at how other maternity services work, share learning and bring back ideas, in particular to Portsmouth which had a similar sized unit and demographic.

Members of the Maternity Voices Partnership (MVP) were working with the birthing centre to increase the opportunities for women to give birth at the midwifery unit in Eastbourne. Here women who had uncomplicated medical needs were able to give birth without consultant involvement. It was reported that women in the local area were not using this service as they were sometimes unsure what it offered and if it was relevant for them.

**Learning, continuous improvement and innovation**

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

A project named ‘Avoiding Term Admissions into Neonatal units’ (ATAIN) work had improved the amount of term admissions to the SCBU. This work saw the introduction of the ‘red’ bobble hat scheme for high risk babies. Through this work, recognition was achieved from the South East Coast (SEC) neonatal network for commitment and improved results. Royal College of Midwifery shortlisting and the previous Butterfly award demonstrated recognition for the work that the midwifery bereavement team did for women and families who had sadly lost their babies. They had also developed and maintained a strong and positive relationship with the Stillbirth And Neonatal Death (SANDS) team and developed a network that was recognised as an
excellent service. The bereavement team had also a good connection with the local support culture who custom made a solid wood cuddle cot framework.
Eastbourne District General Hospital

Kings Drive
Eastbourne
East Sussex

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

<table>
<thead>
<tr>
<th>Name of Site</th>
<th>Teams or wards</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>Emergency Unit</td>
<td>The Ridge, St Leonards-on-Sea, East Sussex</td>
</tr>
<tr>
<td></td>
<td>Clinical Decision Unit</td>
<td>TN37 7RD</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Emergency Unit</td>
<td>Kings Drive, Eastbourne, East Sussex</td>
</tr>
<tr>
<td></td>
<td>Clinical Decision Unit</td>
<td>BN21 2UD</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

Activity and patient throughput

Total number of urgent and emergency care attendances at East Sussex Healthcare NHS Trust compared to all acute trusts in England

There were 109,998 attendances from April 2016 to March 2017 at East Sussex Healthcare NHS Trust as indicated in the chart above.

(Source: NHS England)
The percentage of A&E attendances at this trust that resulted in an admission increased from 2015/16 to 2016/17. In both years, rates were higher than the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for the completion of all mandatory training with the exception of information governance which had a training target 95%. No target was provided for training on the Mental Health Act.

Trust-wide

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>93</td>
<td>99</td>
<td>93.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>87</td>
<td>99</td>
<td>87.9%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>86</td>
<td>99</td>
<td>86.9%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85</td>
<td>99</td>
<td>85.9%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>84</td>
<td>99</td>
<td>84.8%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>83</td>
<td>99</td>
<td>83.8%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust's overall mandatory training completion rate for nursing staff was 87.4%. The target was met for two of the seven mandatory training modules.

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical and dental staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>31</td>
<td>41</td>
<td>75.6%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>30</td>
<td>41</td>
<td>73.2%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>28</td>
<td>41</td>
<td>68.3%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>27</td>
<td>41</td>
<td>65.9%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>27</td>
<td>41</td>
<td>65.9%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>18</td>
<td>41</td>
<td>43.9%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>86</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for medical and dental staff was 48.5%. The target was not met for any of the six mandatory training modules for medical staff. In addition, none of the 86 eligible medical staff had completed Mental Health Act training, which had no trust target.
Eastbourne District General Hospital

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for nursing staff in urgent and emergency care at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>42</td>
<td>46</td>
<td>91.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>41</td>
<td>46</td>
<td>89.1%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>40</td>
<td>46</td>
<td>87.0%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>38</td>
<td>46</td>
<td>82.6%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>38</td>
<td>46</td>
<td>82.6%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>38</td>
<td>46</td>
<td>82.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

Eastbourne District General Hospital’s overall mandatory training completion rate for nursing staff was 86.0%. The target was met for two of the seven mandatory training modules.

A breakdown of compliance for mandatory training courses from November 2016 to October 2017 for medical and dental staff in urgent and emergency care at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>18</td>
<td>22</td>
<td>81.8%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>17</td>
<td>22</td>
<td>77.3%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>17</td>
<td>22</td>
<td>77.3%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>16</td>
<td>22</td>
<td>72.7%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>16</td>
<td>22</td>
<td>72.7%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>11</td>
<td>22</td>
<td>50.0%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>51</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

Eastbourne District General Hospital’s overall mandatory training completion rate for medical and dental staff was 51.9%. The target was not met for any of the six mandatory training modules. In addition, none of the 51 eligible medical staff had completed Mental Health Act training, which had no trust target.

None of the urgent care administration and clerical team was fully up to date with mandatory training. Staff told us their last planned safeguarding training had been cancelled due to short staffing. Seven members of this team (64%) had out of date fire safety training and four members (36%) had out of date information governance training. There was no recovery plan in place to ensure this team had up to date training.

National Institute for Health and Care Excellence (NICE) and the Royal College of Psychiatrists recommend clinical staff complete training in mental health needs, learning disabilities, autism and dementia. At the time of our inspection none of the staff in the emergency department (ED) had undertaken this training.

We saw from looking at staff appraisals and governance meeting records that senior staff often struggled to release nursing staff to complete mandatory training due to pressures on the service. A dedicated practice development nurse was in post who worked with the senior nursing team to improve training compliance although data for 2017 did not show a consistent trajectory of overall improvement. The senior teams responsible for governance reviewed this on a monthly basis and noted the trust had reduced capacity for training due to the 2017/18 ‘winter pressures’ period.
Safeguarding

Safeguarding training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of safeguarding training.

Trust-wide

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>99</td>
<td>99</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>99</td>
<td>99</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>29</td>
<td>31</td>
<td>93.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>92</td>
<td>99</td>
<td>92.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>90</td>
<td>99</td>
<td>90.9%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing staff at the trust was 95.8%. Nursing staff met the trust target for all five of the safeguarding modules.

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for medical staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>41</td>
<td>41</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>41</td>
<td>41</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>30</td>
<td>41</td>
<td>73.2%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>25</td>
<td>41</td>
<td>61.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff at the trust was 83%. Medical and dental staff met the trust target for two out of five of the safeguarding modules.

Eastbourne District General Hospital

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for nursing staff in urgent and emergency care at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children L1</td>
<td>46</td>
<td>46</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults L1</td>
<td>46</td>
<td>46</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>41</td>
<td>46</td>
<td>89.1%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>39</td>
<td>46</td>
<td>84.8%</td>
<td>No</td>
</tr>
</tbody>
</table>
The overall completion rate for safeguarding training modules by nursing staff at Eastbourne District General Hospital was 93%. Nursing staff met the trust target for two out of five of the safeguarding modules.

A breakdown of compliance for safeguarding courses from November 2016 October 2017 for medical staff in urgent and emergency care at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children L1</td>
<td>22</td>
<td>22</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults L1</td>
<td>22</td>
<td>22</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>18</td>
<td>22</td>
<td>81.8%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L3</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>14</td>
<td>22</td>
<td>63.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff at Eastbourne District General Hospital was 86%. Medical and dental staff met the trust target for two out of five of the safeguarding modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff had access to an electronic national child protection information sharing system, which could be used to identify if a patient had a known safeguarding need or risk. Reception and clinical staff we spoke with said they consistently used this system and documented results in each patient record. However we were unable to confirm this was consistently used as results were not documented in three out of eight sets of records we looked at. We asked a member of staff about this who said significant demands on the department the night before had meant some required documentation was not completed as planned.

A paediatric safeguarding specialist nurse worked within the trust’s dedicated safeguarding team. They used a daily morning planning meeting to ensure the ED team were supported and had the resources needed to support patients including access to the safeguarding team on demand. This formed part of an early surveillance strategy to help identify and resolve safeguarding issues before they escalated. The team led a weekly cross-site safeguarding meeting to facilitate discussions about specific cases and ensure these were reviewed by staff with relevant expertise. The team noted that all staff undertook safeguarding training as part of their induction but felt this was minimal for medical staff and did not fully reflect the needs of patients.

The trust safeguarding team had established a patient concerns flowchart for triage staff and other clinicians in the ED. This was a quick-reference guide to support staff in obtaining urgent support when a patient had specific needs. This included rapid access to a social care crisis service, when staff had concerns relating to a statutory (section 42) safeguarding need or when patients presented with signs of domestic violence, radicalisation or self-neglect.

**Cleanliness, infection control and hygiene**

Dedicated clinical cleaning teams maintained the environment, which we observed to be clean and frequently disinfected. However some high-level surfaces in the emergency nurse practitioner (EPN) suite were very dusty, which presented an infection control and contamination risk. We spoke with a senior nurse about this who said they would address it.

The infection control team carried out monthly hand hygiene audits in the ED. Between April 2017 and February 2018 this included 102 observations with 98% overall compliance. This was an average and reflected consistently high standards of practice including eight months of 100%
compliance. However, we were not assured from our observations that staff adhered to consistent infection control and good hand hygiene practices. For example in the clinical decision unit (CDU) we observed one member of staff assist a patient with personal care and then assist another patient without washing their hands. We also saw not all staff routinely washed their hands or used hand gel between patients or when moving between different clinical areas.

Although there was signage instructing visitors and patients to use hand gel at the main walk-in entrance to the ED there was no hand gel present in this area. In addition there was no hand gel or hand washing sink at the entrance to the minors area, which saw heavy footfall at all times. This meant patients and staff were not protected from the risk of infection because there were insufficient facilities and instructions to maintain good hand hygiene at all times.

Monthly patient record audits indicated consistently poor documentation of infection control risks and assessments. Between April 2017 and February 2018, 39% of patients in the CDU had a confirmed, documented infection control status. For paediatric patients in the ED this was 29%. These were average figures and reflected two months of 0% infection control documentation amongst paediatric patients and a range between 19% and 87% for adult patients in the CDU. The trust’s target was not achieved in either group of patients in any month during this period and there was no equivalent measure for adult ED patients.

Environment and equipment

A refurbishment project had created new triage and clinical rooms in the ED. These would be used by the GP team once a new triage system was completed and provided additional capacity for nurse and healthcare assistant (HCA) triage. The refurbishment also provided more quiet waiting spaces for patients with specific needs such as relating to anxiety.

The main waiting area was too small for the number of patients presenting in the department on both days of our inspection. During one observation nine patients were waiting in wheelchairs, which partially blocked a main corridor and the area used for people to move around in the waiting area. We saw that patients and those with them often had to stand in cramped or busy spaces, which demonstrably increased anxiety. An outpatient clinic was located adjacent to the ED and patients often used this as an ‘overspill’ area to wait in so they could have a seat. However during our observations we found there was no process in place for staff to document where a person was waiting, which resulted in delays whilst staff tried to find people.

Shift coordinators used a new patient safety checklist to monitor the clinical environment such as the availability of call bells and other equipment.

None of the toilets in the ED were suitable for patients with mental health risks such as those at risk of self-harm or suicide. This was because all of the facilities had ligature points and could be locked from the inside. We spoke with senior nurses about this who said patients at risk of self-harm would always be accompanied to the toilet and a member of staff would wait outside with easy access to the room if needed.

A mental health room in the ED provided dedicated space for patients awaiting a mental health liaison team review or who staff considered to be at risk if they waited in another area. This room had a viewing panel for staff to monitor patients although furniture was not secured. This meant there was a risk patients in crisis could try to pick items up that could cause harm.

A dedicated security team provided on-call support for staff 24-hours, seven days a week. The security duty office was located in the ED, which meant staff had rapid access to help when needed. Local security management specialists and an assistant security supervisor provided on-demand specialist support to staff in managing the environment and ensuring staff and patients remained safe and aware of potential threats.
A senior fire advisor had last carried out a fire risk assessment of the ED in February 2018. The assessment found no immediate risks to the department. However the advisor found that planned fire drill ‘walk throughs’ were out of date and that both fire drills scheduled for 2017 had been cancelled by the nurse in charge of the shift due to pressure on the service. In addition the team had not undertaken training in 2016. This meant staff working within ED had not undertaken fire safety drills or checks for over two years despite a reconfiguration of parts of the department. In addition the risk assessment noted that a buildings contractor had not carried out a void detection assessment as part of the reconfiguration, which meant the area did not comply with Department of Health Technical Memorandum requirements.

Staff used a series of daily and weekly safety checklists to ensure emergency equipment, including resuscitation trollies, were fully stocked and readily available for use. We looked at the records for a two week period in February 2018 and March 2018 for all areas of the ED, including the CDU. We found staff documented checks consistently and recorded the expiry dates of emergency medicines to ensure they could be replaced in an appropriate time frame.

Assessing and responding to patient risk

Emergency Department Survey 2016

The trust scored worse than other trusts for one of the five questions on the Emergency Department Survey relevant to safety and about the same as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (01/09/2016 - 30/09/2016))

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was consistently better than the overall England median over the whole of the 12 month period from December 2016 to November 2017.
Ambulance – Time to initial assessment from December 2016 and November 2017 at East Sussex Healthcare NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Eastbourne District General Hospital

From December 2016 to November 2017 the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Eastbourne District General Hospital was stable at around 78%.

Ambulance: Number of journeys with turnaround times over 30 minutes - Eastbourne District General Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Eastbourne District General Hospital

(Source: National Ambulance Information Group)
Number of black breaches for this trust

A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From November 2016 to October 2017 the trust reported 952 “black breaches”, with a downward trend over the period. This information is not provided at hospital site level.

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

Where children presented in the ED, a paediatric nurse led triage if they were available, otherwise the adult triage nurse led this.

All paediatric nurses had up to date European paediatric life support (EPLS). However there were often significant periods of time with no paediatric nurse available and there was not always someone on shift with this training. Of the ED team overall, 86% had up to date training the level of life support training required for their role. All consultants were advanced trauma life support (ATLS) instructors and all middle grade doctors had completed ATLS training.

Staff in the ambulatory care unit used a care pathway and set risk criteria to transfer patients from the ED to ensure their condition could be safely managed. This team worked with colleagues on the medical assessment unit, to ensure patients were in the most appropriate location. For example if a patient’s condition deteriorated or needed the attention of a specialist consultant, staff in the medical assessment unit could often facilitate this.

Staff did not always document risk assessments, observations and other factors in patient records. For example in twelve patient records we looked at staff had not recorded the weight of the patient, including an eight year old who was prescribed analgesia. There was no record of a check of tetanus status for a patient with a laceration and no neurological observations for over three hours recorded for a child who presented with seizures.

Staff used the national early warning scores (NEWS) and paediatric early warning scores (PEWS) systems to identify when a patient’s condition was deteriorating. However in the 16 sets of notes we looked at, warning scores were not always completed consistently. For example in the records of a paediatric patient staff had completed three PEWS assessments in quick succession within 50 minutes and not repeated this within the following 90 minutes. The patient had been transferred to another hospital but as there was no documented time of discharge it was not possible to identify how frequently after the last recorded PEWS score these took place. This meant we were not assured that staff monitored deteriorating patients consistently.

Patient records audits indicated highly variable compliance with documentation relating to NEWS, PEWS and the recording of baseline observations. Between April 2017 and February 2018 overall compliance for the calculation of PEWS in paediatric patients was 34%, which was
significantly worse than the trust target of 90%. Data were only available for four months during this period and monthly results ranged from 25% to 44%. In the same period for adult patients in the CDU, compliance with the use of NEWS was 92% although results indicated staff escalated deteriorating patients appropriately in only 79% of cases.

The urgent care quality and safety review in February 2017 noted that all staff were due to be retrained in the escalation of patients who triggered high NEWS scores. However, quality audit results dated after this did not evidence a trajectory of improved performance. Between April 2017 and February 2018 an average of 67% of adult ED patients had a NEWS chart in place with a correct calculation. During this period audit results did not demonstrate compliance with the 90% standard in any month.

Three nurses were trained as sepsis link nurses and worked closely with the critical care outreach team and sepsis lead to ensure the sepsis pathway was consistently used. Staff used an emergency safety checklist for patients with suspected sepsis and started this within one hour of identifying the risk. Although such provisions were in line with national recommendations, patient records audits indicated practice was inconsistent. For example results from the patient record quality audit between April 2017 and January 2018 showed staff initiated the Sepsis 6 bundle appropriately in 80% of cases and in 69% of cases where the patient's NEWS score indicated a sepsis screen was needed. Neither score met the trust’s 90% standard. In paediatric patients during the same audit period staff considered a sepsis screen in 31% of eligible cases, with a range from 13% to 67%.

The practice development nurse was working with clinical staff to improve compliance with sepsis screening following variable audit results in 2017. Between July 2017 and December 2017 there was 76% overall screening compliance, with a monthly range from 52% to 87%. During this audit period an average of 63% of patients received antibiotics within one hour in accordance with the Sepsis 6 bundle against a trust target of 90%. The Sepsis 6 bundle should be delivered within one hour of a clinician identifying a need for it. During this audit period the ED achieved 19% compliance with this measure, ranging from 0% in October 2017 to 42% in December 2017.

All staff had major incident training and some matrons had completed 'train the trainer' sessions that provided them with a more advanced level of knowledge and skill. A matron was the designated link for major incidents and chemical, biological, radioactive and nuclear (CBRN) incidents. The ED team had demonstrated their knowledge and understanding of the major incident protocol during a major incident involving a gas cloud in August 2017. During this incident the team treated 133 patients without prior notification from other emergency services, which demonstrated the readiness of the department to respond to developing situations. After the incident the nurse in charge and lead for major incident training led a debrief for the team and identified learning based on staff performance. As a result major incident training and resource management was reorganised to make it more specific to the ED environment. For example the department acquired a television that could be connected to live news channels during an emergency to help staff assess the scope of the situation.

The clinical lead displayed Royal College of Emergency Medicine safety alerts and news flashes in the doctor’s office to ensure the team was aware of updates to clinical practice and guidance. However, we found from looking at the outcomes of incident reports that staff were not always aware of these.

A five-bedded bay was located adjacent to the ED and senior staff used this area as an escalation area during times of exceptional demand. This area was used to accommodate patients when there were no ward beds to admit them to or when they were awaiting a discharge plan. However the senior team recognised this area as a significant risk to the department. Use of the area improved capacity but added additional responsibilities to the ED nursing and medical teams and meant nurses were redeployed from inpatient wards or the intensive care unit (ICU) to staff it. ED matrons and the ICU matron had worked together to establish a safety briefing for...
nurses redeployed to ensure they were assigned to majors rather than the escalation area in line with their clinical skills. However nurses we spoke with said this no longer happened and they felt there was minimal oversight from the ED team when this area was in use.

The triage nurse used an assessment tool to identify patients with a need for mental health support or intervention. This triggered a referral process for patients to have a review from the mental health liaison team within two hours to establish levels of need and risk. This team had access to an urgent care lounge Monday to Saturday, which they used to transfer patients from the ED and provide a safer and calmer environment to wait in. While waiting for the mental health team, or if no out of hours cover was available, ED nurses used a safeguarding and managing risk tool to identify the risk of self-harm or risk of harm to others. Where staff identified a patient at high risk for either, they coordinated with the site team to redeploy a nurse or HCA from another clinical area to provide one-to-one care for the patient. Monthly patient record quality audits noted only two months between April 2017 and January 2018 I which data were available. In both months mental health safeguarding tools were used in 50% of cases.

The security team were also trained to support this role. However low levels of staffing in this team meant the officer on duty would also be responsible for the security of the whole site and may need to leave the patient in an emergency.

Nurse staffing

The trust has reported the following nurse staffing numbers in urgent and emergency care by site as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>50</td>
<td>47</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>47</td>
<td>48</td>
</tr>
<tr>
<td>Total</td>
<td>96</td>
<td>95</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The following nurse staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate of 12% for nursing staff in urgent and emergency care which was higher than the target of 10%:

- Conquest Hospital: 11%
- Eastbourne District General Hospital: 13%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, the trust reported a turnover rate of 14% for nursing staff in urgent and emergency care which was higher than the target of 10%:

- Conquest Hospital: 11%
- Eastbourne District General Hospital: 16%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Sickness rates

From November 2016 to October 2017 the trust reported a sickness rate of 6% for nursing staff in urgent and emergency care which was higher than the target of 3.3%:

- Conquest Hospital: 7%
- Eastbourne District General Hospital: 4%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From November 2016 to October 2017, the trust reported a bank and agency shift total of 6,701 for nursing staff in urgent and emergency care. Of the 4,779 bank shifts that were filled, 1,384 were for registered nurses. In addition, there were 1,922 agency shifts were filled, 1,448 of which were registered nursing shifts. There were 1,844 nursing shifts not filled by bank or agency staff.

Please note that we were unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and agency usage at Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/ agency</th>
<th>Healthcare assistant</th>
<th>Registered nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne District General</td>
<td>Bank</td>
<td>1,753</td>
<td>726</td>
<td>2,479</td>
</tr>
<tr>
<td>Hospital</td>
<td>Agency</td>
<td>345</td>
<td>1,048</td>
<td>1,393</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>267</td>
<td>856</td>
<td>1,123</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Three nurses had recently moved from the ED to the ambulatory care unit. This provided both units with improved understanding of each other’s’ work and enabled the transfer of patients to be completed appropriately.

A matron, two senior staff nurses, a staff nurse and two HCA’s provided nursing care on the ambulatory care unit.

The department had an ongoing recruitment programme and had implement significant improvements to the support provided to newly qualified nurses to improve retention. This included an extended period of mentorship, optional supernumerary shifts on inpatient wards and a more structured team meeting programme. This resulted from feedback from nurses who had joined as part of a large cohort in October 2017 and then left the trust citing workload and stress as key reasons for their departure.

Although overall staffing figures for the ED did not demonstrate significant, sustained shortfalls staff described high levels of pressure and working over their capacity. This was reflected in the fast turnover of new staff and in a deterioration of training and supervision standards due to pressures on the team. Where we asked staff about gaps in documentation and missed opportunities for risk assessments they told us this was because the volume of patients to be seen had an impact on their ability to work safely and to trust standards. We saw this had led to the cancellation of events such as safeguarding training, fire drills and practical competency training for nurses.

Three paediatric nurses worked in the ED, which meant only a proportion of shifts could be
covered by this team and where a nurse was unwell or took annual leave their shifts could not be covered. However after our inspection the trust advised us four ED nurses were also paediatric trained.

**Medical staffing**

The trust has reported the following medical and dental staffing numbers in urgent and emergency care by site as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>25</td>
<td>29</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
<td><strong>54</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The clinical lead told us medical staffing had significantly improved since our last inspection. This included the addition of 12 junior doctors, two clinical fellows and three substantive middle grade doctors on the rota. As a result the clinical lead told us they had been able to fill 98% of planned shifts. In addition the unit covered 95% of consultant shifts through the introduction of a twilight shift and two locum consultants. However the ED had four substantive consultants in post, which was less than the 10 needed to fully provide care and treatment in line with RCEM standards.

The trust used quality audits to monitor the RCEM standard of each patient undergoing a consultant-led review within 14 hours of admission. The latest data available in February 2018 related to September 2017 and indicated that compliance with this standard was 69%. While the introduction of an additional consultant shift and locum consultants had a positive impact on care provision, consultant vacancies remained on the service risk register and demonstrably had an impact on meeting RCEM standards.

The following medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 23% for medical and dental staff in urgent and emergency care which was higher than the target of 10%:

- Conquest Hospital: 25%
- Eastbourne District General Hospital: 21%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 17% for medical and dental staff in urgent and emergency care which was higher than the target of 10%:

- Conquest Hospital annual percentage: 25%
- Eastbourne District General Hospital annual percentage: 13%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
**Sickness rates**

From November 2016 to October 2017 the trust reported a sickness rate of 4% for medical and dental in urgent and emergency care which was higher than the target of 3.3%:

- Conquest Hospital: 1%
- Eastbourne District General Hospital: 6%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

From November 2016 to October 2017, the trust reported a bank and locum shift total of 1,944 in urgent and emergency care. Over 60% of these shifts (1,238) were for middle grade doctors. There were no shifts that were not filled by bank or locum staff.

Please note that we were unable to calculate bank and locum usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and locum usage at both Conquest Hospital and Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/locum</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne DGH</td>
<td>Bank</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Locum</td>
<td>23</td>
<td>422</td>
<td>133</td>
<td>578</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical agency locum)

Consultant cover was provided from 9am to 12am Monday to Friday and from 9am to 5pm at weekends. An on-call consultant was available at all other times and staff grade doctors and senior house officers covered a 24 hour rota with the greatest number of doctors available between 2pm and 6pm daily. Between 10pm and 8am one middle grade doctor and two foundation year 2 doctors led medical care. Changes to rotas and the implementations of improvements, such as consultant-led morbidity and mortality (M&M) meetings, reflected the driver for improvements outlined by the RCEM 2013 recommendations and benchmarking report.

**Staffing skill mix**

As of September 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the average for England.
Staffing skill mix for the 39 whole time equivalent staff working in urgent and emergency care at East Sussex Healthcare NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>29%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

There were no paediatric doctors based in the ED and cover was provided by a paediatric registrar who worked elsewhere in the hospital. Cover was available until 9.30pm only and staff told us the registrar could usually only see children under the age of one year old.

According to the standard operating procedure the on-call medical registrar provided cover for up to five patients in the annex when this was being used for escalation. However nurses we spoke with who had staffed this unit told us there was limited medical cover for patients when this area was in use. For example nurses told us it was difficult to obtain support from doctors. Two nurses told us they relied on doctors from the adjacent ED and CDU to review patients because the on-call registrar did not have capacity to do so and another told us they had relied on doctors from the ICU to provide urgent assessments when needed.

The ambulatory care unit was staffed by 2.5 consultants and junior doctors shared with the medical assessment unit.

Records

Patient records were a combination of paper-based and electronic records. For example reception staff initially booked patients in using an electronic system and then completed a hard copy ‘casualty’ card that was used by triage staff to complete an initial assessment. Nursing observations were completed using hard copy documents and some medical notes could be completed electronically. There was not a single system in place for the completion of discharge summaries and GP letters and this was completed based on the preference of the doctor.

We looked at 16 sets of patient notes and found them to be of varying standards, with significant omissions in some cases. For example one patient record did not include a signed front sheet, past medical history, initial assessment time or tetanus status despite the patient presenting with a laceration. Staff who provided care for this patient had not documented an outcome of treatment and the care plan, doctor’s name and signature were illegible. Another patient had no documented initial assessment time, no signed front sheet and no documented outcome. A member of staff had ticked a box indicating the patient needed to attend the fracture clinic but had not documented if this had been scheduled. A paediatric patient had been transferred to
Conquest Hospital but staff had not documented the time of transfer or whether they had seen a paediatric doctor in the hospital first. These examples were indicative of the wide variance in documentation standards and themes including illegible handwriting, minimal care and treatment documentation and no documented initial assessment or discharge information. Missing signatures and investigation outcomes on patient discharge summaries had contributed to a significant backlog and a bank administrator had been assigned to reducing this.

During our inspection a mental health inspector reviewed seven sets of notes for patients with identified mental health needs including for patients with significant risk of suicide and who had expressed suicidal ideation to staff. The completion of notes was highly variable. For example staff had not noted final actions or ongoing care plans for four patients who had been discharged. In one instance we saw a patient who had expressed suicidal intent had not undergone a risk assessment before discharge. Where staff noted an urgent referral to another service was needed, they had not always completed appropriate documentation. For example staff had not noted the time of specific advice they had given to a parent to refer their child urgently to child and adolescent mental health services (CAMHS). In another record we saw staff had noted a patient needed an urgent referral to community assessment and treatment services but had discharged them with no indication the referral had been made. This meant we were not assured patients were fit for discharge or that staff had evidenced reduced risk before discharging patients. In another example staff had not noted follow-up action when a patient with significant mental health illness had walked out of an assessment. Although each patient had a risk assessment tool in their records, staff had not fully completed these in any of the seven records. This included missing risk calculations and missing critical information such as symptoms, observed behaviour and the risk of absconding. However each patient had a detailed medical history and medicine review and there was evidence of consistently detailed handovers from paramedics.

Incomplete or missing patient records were noted as contributing factors in eight incidents that occurred between January 2017 and February 2018. This included a missed diagnosis on an x-ray followed by a delay that meant x-ray results were not interpreted by staff, due to short staffing in radiology, until 11 days after the patient died. Another incident investigation noted a patient was discharged with an undiagnosed fractured neck of femur, which was not identified until six days later when their x-rays were scrutinised. Other incidents included no recorded initial observations due to pressures on the triage team, incomplete documentation of investigations a failure to record when diagnostic tests had been ordered and a failure to keep contemporaneous notes. Incident investigations also identified a need for more consistent completion of risk assessments and patient observations, including when a patient was at risk of falls or was living with dementia. We also found incident investigators noted gaps in the recording of observations of up to three hours despite evidence of the patient's increasing NEWS score and a gap of six hours of observations in a patient who became unresponsive.

One incident report was raised when a patient noticed staff had documented a test result on their discharge letter they had previously been unaware of. While the management of this incident was evidence of prompt action by senior nursing staff across different divisions, the patient safety facilitator noted they were unable to identify which member of staff had documented the test results on the patient’s ED records. This was because the member of staff had not signed their name and designation and the ED team did not recognise the handwriting. It additionally meant the patient discovered a potentially upsetting, life-changing test result from a letter.

The trust audited the standards of patient records in the ED on a monthly basis. Results collected between April 2017 and March 2018 demonstrated overall inconsistent performance with limited evidence of sustained improvement in any of the 16 standards required by trust policy. Against a target of 90% compliance, the CDU achieved 70% in this period. This was an average figure and reflected two months in which no data were available and a monthly variance between 58% and 96%. During this period the CDU met the target compliance standard in two months. Of the 16 standards, seven met or exceeded the target overall and two standards demonstrated
consistently good practice. These were that the patient was happy with their care and that patients received adequate food and fluids. Compliance for each of the 16 standards was highly variable and ranged from 24% for the completion of a property disclaimer form, 25% compliance for completion of an acute kidney injury assessment to 92% for the completion of baseline observations.

Overall compliance for adult patients in the ED was 76%, representing a range of 20% for a doctor signing the ambulance care record to 95% for a clear baseline presentation record from the triage nurse. The ED did not meet the trust standards in 19 of the 25 standards for this patient group and there were no quality criteria the department fully met in every month.

The same audit was applied to children seen in the ED. Between April 2017 and March 2018 audit data was collected in four months with overall compliance at 76%. Paediatrics in the ED did not meet the trust’s record standards for any of the four months in which data were collected although four of the 16 standards consistently achieved good scores. This included the documentation of a clear medical plan, which was compliant in 97% of cases.

**Medicines**

Staff used an electronic dispensing system for medicines, which also ensured only authorised staff could access stock. Stocks of emergency medicines were stored appropriately in each ED area and senior staff monitored their use with the pharmacy team.

The ENP team provided a treat and discharge service within the ED and used patient group directions (PGDs) to issue to take away medicines for patients. PGDs enable non-prescribing nurses to administer certain medicines for specific uses without the need to wait for a doctor.

The pharmacy team provided a five-day service on site and a seven day dispensing service. This meant staff always had support for medicines guidance or advice.

Staff used secure bedside lockers in the CDU to store patients’ own medicines and monitored the temperature of these areas to ensure medicine remained fit for use. Pharmacy staff told us this presented a risk during hot weather because they could not control the temperature of the CDU and it often meant the temperature exceeded the manufacturer’s safe limit for the storage of medicine.

Staff did not consistently document the temperatures of fridges and rooms used to store medicines. We found evidence of this in our inspection of storage areas in the ED. However, clinical safety audits noted temperatures were recorded. We were not able to identify the reason for this discrepancy and whether temperature-recording constantly took place.

The pharmacy team carried out an audit of controlled drugs (CDs) every three months. In addition staff used an electronic medicine dispensing system that tracked access and stock for auditing and governance purposes. Prescription documentation was kept in the electronically-controlled storage device, which meant the pharmacy team could track access and the patients’ prescriptions were issued to.

Staff used monthly patient records audits to monitor the standard of medicines documentation. Between July 2017 and February 2018 the CDU achieved 88% overall compliance with the completion of prescription charts and medicine documentation. This was an average figure and reflected a range from 79% in July 2017 to 100% in four other months.

Between August 2017 and January 2018 35 medicine errors were reported in the ED and CDU. None of the errors resulted in patient harm and in each case the head of nursing worked with staff involved to identify contributing factors.
Nurses who worked in the annex escalation area were responsible for managing the medicines of patients in that unit. However as the nurses who covered this unit were from elsewhere in the hospital they did not have access to the ED’s electronic dispensing system. Three nurses we spoke with said this had resulted in delays in obtaining medicines for patients and this had caused conflict with ED nurses who were too busy to facilitate access to the system.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement – STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported are shown below:

The breakdown of incidents by site was:

- Eastbourne Hospital – five incidents
- Conquest Hospital – four incidents

(Source: NHS Improvement – STEIS (01/12/2016 – 30/11/2017)

Staff used an electronic system to report incidents and the senior team provided feedback through this system. The practice development nurse maintained a contemporaneous record of the
outcomes of incident investigations as well as a record of discussions with individual staff about these. In addition they recorded outcomes and changes to practice in a communication book for staff. However there was not a tracking system in place to evidence which members of staff had read and understood the information.

Between January 2017 and February 2018 the ED team reported 47 incidents, which were categorised according to severity of impact on the patients involved. One incident was categorised as major, 13 were severe, 14 were minor and 19 had no severity or impact. The incident with major impact resulted from a failure to follow local and national guidelines for the early recognition and treatment of stroke. This included failure to obtain urgent assessment from a stroke clinical nurse specialist and a slow response to stroke symptoms as staff believed the young age of the patient precluded the condition. The patient safety facilitator identified seven specific learning outcomes as a result of the investigation. This included a need to improve evidence-based care and assessment using established tools such as the Glasgow coma score and the National Institute of Health Stroke assessment tool and/or the recognition of stroke in the emergency room (Rosier) tool. Learning also identified a need for better use of existing trust care pathways and more effective communication between paramedics and ED staff.

Although there was evidence of continual review by patient safety facilitators and the ‘owners’ of incidents, we were not assured the ED team had the capacity to resolve complaints in a timely manner. For example one moderate complaint, which involved the death of a patient, had occurred in September 2017 but remained unresolved as of March 2018. The consultant involved in the patient’s care was engaged by the patient safety facilitator four months after the incident occurred and the incident tracking record indicated ongoing delays and missed deadlines in producing the root cause analysis and report.

A weekly patient safety summit reviewed all incidents and we saw from records this included collection of evidence to support investigations and learning. A separate review group was responsible for serious incidents.

The hospital had reported two serious incidents in relation to patients with mental health needs. Both incidents involved the death of a patient outside of a clinical area. The teams involved demonstrated learning from the incidents, such as in the introduction of more stringent assessments to identify if the patient is safe to leave the hospital. This included documentation of a ‘final action’ by staff although we did not find this had been completed in any of the seven records we looked at. In addition the urgent care lounge, used to provide a safe space for patients to wait in, was extended from two nights per week to four nights per week. The mental health liaison team had successfully bid for funding to increase staffing to be able to provide a future seven-day service.

The clinical lead held a monthly morbidity and mortality (M&M) meeting to review a sample of patient deaths and identify opportunities for learning in future practice. We looked at the M&M meeting record for February 2018, which was attended by two consultants and five junior doctors, and saw that alternative opportunities for treatment were identified.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers or falls with harm and three new catheter urinary tract infections from December 2016 to December 2017 within urgent and emergency care. These catheter urinary tract infections occurred in March and April 2017.

**Prevalence rate (number of patients per 100 surveyed) of catheter urinary tract infections at East Sussex Healthcare NHS Trust**

![Graph showing prevalence rate of catheter urinary tract infections](image)

(Source: Safety thermometer – Safety Thermometer)

The senior divisional team monitored harm-free care as part of monthly quality and safety monitoring, which they used to track improvements. Patient safety outcomes for 2017/18 demonstrated a broad improvement from 2016/17. This included a 6% reduction in incidents that resulted in patient harm and a 25% reduction in overall falls. The number of recorded falls that resulted in no patient harm was 46% less than the previous year and there were also reductions in hospital-acquired *Clostridium difficile* (C.Diff) and hospital-acquired pressure ulcers.

**Is the service effective?**

**Evidence-based care and treatment**

All staff had access to trust policies and national clinical guidance through the intranet. Doctors attended a weekly ‘flash meeting’ to discuss changes to national guidance and standards and monthly governance, quality and safety meetings included a documented discussion of changes to policy and practice.

The senior divisional team identified a need for improved use of evidence-based assessment tools, local and national guidance during incident investigations. Although staff had access to established tools incident reports indicated staff applied them inconsistently, which had resulted in serious harm to patients and missed diagnoses. This included tools such as the Glasgow coma score, those used to assess patients for stroke and care record documentation when patients arrived by ambulance. There was also evidence staff did not always adhere to the Royal College of Emergency Medicine (RCEM) standards for reporting radiology results or always demonstrate active awareness of RCEM safety alerts. For example one incident identified that staff had not followed instructions issued by a January 2017 RCEM safety alert relating to missed hip fractures. One incident noted staff had not followed trust policy in screening for sepsis, which was corroborated by the clinical lead in a morbidity and mortality review. The review concluded that sepsis screening was clearly indicated and there were avoidable delays in decision-making and following trust policy. Other incidents noted trust policy in relation to post-fall neurological observations was not always used and there was no use of recognised mental health assessment tools for patients presenting with serious mental health deterioration or needs.
As a result of incidents and investigations new standards and reference tools were introduced, including the patient safety reviews booklet. This was issued to all staff and included requirements and pathways for escalation. However, we did not always find staff knew about improvements in evidence-based practice or that the team had sufficient capacity to follow up to date guidance. For example as a result of previous incidents senior staff noted the disability distress assessment tool should be used for patients with mental health needs. We did not see this in use during our inspection, including for patients with mental health needs, and not all staff we spoke with were aware of this.

The ED team had reviewed the RCEM ’50 Standards for Emergency Departments’ as a strategy to improve overall standards of care and treatment. The 2017/18 audit programme consisted of eight audits including four audits in line with the Healthcare Quality Improvement Partnership National Clinical Audit and Patient Outcomes Programme (NCAPOP). These audits would contribute to national initiatives as part of the NCAPOP including data for care of patients with a fractured neck of femur, pain in children and mandatory data for the Trauma Audit and Research Network. The department was also contributing to the Department of Health Commissioning for Quality and Innovation (CQUIN) audit in improving services for people with mental health needs in the ED setting. Audits also included the use of sepsis pathways and guidance and the effective use of trauma resources. The trust’s quality report for February 2018 showed that there was a large backlog of data that presented a risk to missing two of the audit submissions.

**Nutrition and hydration**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 – 30/09/2016)

As a result of patient feedback the trust’s full main meal menu had been introduced to the CDU. This meant patients had access to a wider range of meals to meet their tastes and dietary needs.

Monitoring of nutrition and hydration in the annex when used for patient escalation was variable. This area was open on one day of our inspection and we spoke with the nurse in charge of the area. They told us they did not routinely monitor patient’s food and fluid input and output although a healthcare assistant from the adjacent CDU offered drinks and snacks at regular intervals. However we received inconsistent feedback from nurses who had cared for patients in this area. One nurse told us they had escalated the care of one patient to the site team because their lack of fluid intake indicated a risk of an acquired kidney injury. However as they were unable to obtain a medical review or secure fluids for the patient out of hours they felt the individual’s safety had been put at risk.

Staff used the malnutrition universal scoring tool (MUST) for patients who were treated in the CDU. Although we saw this in use it was not consistently used for all patients and we found no evidence of its use for patients being cared for in the annex escalation area. The trust monitored the completion of MUST as part of monthly patient record audits. Between May 2017 and January 2018 48% of patients in the CDU had a MUST completed and appropriate actions implemented. This was significantly worse than the trust standard of 90% and reflected a monthly range between 25% and 100%. The department met the standard in two months during this period.

**Pain relief**
Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.7 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 6.9 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was worse when compared to other trusts.

(Source: Emergency Department Survey 01/09/2016 – 30/09/2016)

The documentation of pain assessments and prescriptions in patient records was highly variable. In two out of seven records we looked at staff had not documented a pain score. In one record a pain score was documented as nine out of the maximum 10 but only basic pain medicine had been prescribed with no documented justification. Records of pain assessments were generally poorly completed with illegible handwriting and illegible designation of the member of staff completing the record. A patient in the CDU told us they had a headache all night but staff could not give them pain relief because the doctor in ED was too busy to prescribe it. Nurses in the CDU were not prescribers and this meant patients could experience delays in obtaining pain relief medicine.

Heads of nursing told us they had identified the need for improved pain management and discussion between clinicians and had initiated daily audits to address this.

Monthly patient records audits identified significant gaps in the recording of pain scores. In the quality audit for adult ED patients between April 2017 and February 2018 70% of patients had a pain score documented. This was an average figure and reflected monthly results between 20% and 86%. In the paediatric monthly audit in the same period 67% of patients had a pain score calculation and only 6% had this reviewed. In the same period in the CDU only 65% of patients had an initial documented pain review and 76% of patients said they were in pain but felt this was being managed. These were average figures and reflected wide variances between months. For example in November 2017 33% of patients in the CDU had an initial pain score documented and in February 2018 0% of paediatric patients had a documented pain review.

Patient outcomes

RCEM Audit: Moderate and Acute Severe Asthma 2016/17

Eastbourne District General Hospital

In the 2016/17 Moderate and Acute Severe Asthma report, the hospital failed to meet any of the RCEM standards.

The hospital’s results for the seven metrics were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

This trust did not participate in this audit.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17
Eastbourne District General Hospital

In the 2016/17 Severe sepsis and septic shock audit, the hospital was in the lower UK quartile for five standards:

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival – Hospital: 6.6%; UK: 30.4%
- Standard 4: Serum lactate measured within one hour of arrival – Hospital: 9.6%; UK: 60.0%
- Standard 5: Blood cultures obtained within one hour of arrival – Hospital: 11.6%; UK: 44.9%
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 Ml/Kg) given within one hour of arrival – Hospital: 12.3%; UK: 43.2%
- Standard 7: Antibiotics administered within one hour of arrival – Hospital: 9.3%; UK: 44.4%

The hospital’s results for the remaining three metrics were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

Eastbourne District General Hospital

The hospital met the RCEM standard for one metric.

The hospital was in the upper England quartile for two standards:

- Standard 2: Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set – Hospital: 20%; UK: 4.4%
- Standard 5: Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor) – Hospital: 100%; UK: 60%

The hospital was in the lower England quartile for two standards:

- Standard 3: There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present) – Hospital: 42.5%; UK: 69.7%
- Standard 4: There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases – Hospital: 47.5%; UK: 73.2%

The hospital’s results for the remaining two metrics were all between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16

Eastbourne District General Hospital

In the 2015/16 Procedural sedation in adults audit, the hospital failed to meet any of the audit standards (which were all 100%).
The hospital was in the upper England quartile for one standard:

- Standard 7: Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including 7a) Return to baseline level of consciousness, 7b) Vital signs within normal limits for the patient, 7c) Absence of respiratory compromise, 7d) Absence of significant pain and discomfort, 7e) Written advice on discharge for all patients – Hospital: 23.1%; UK: 2.6%

The hospital was in the lower England quartile for four standards:

- Standard 1: Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status – Hospital: 0%; UK: 7.6%
- Standard 3: Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities – Hospital: 38.2%; UK: 90%
- Standard 4: Procedural sedation requires the presence of all of the below a) a doctor as sedationist, b) a second doctor, ENP or ANP as procedurist, c) a nurse – Hospital: 5.9%; UK: 40.8%
- Standard 5: Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG – Hospital: 0%; UK: 23.9%

The hospital's results for the remaining five metrics were all between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

Eastbourne District General Hospital

In the 2015/16 Venous thromboembolism (VTE) risk in lower limb immobilisation in plaster cast audit the hospital failed to meet both of the audit standards (which were all 100%).

The hospital was in the lower England quartile for one of the two standards:

- If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment – Hospital: 72.6%; UK: 100%

The hospital was between the upper England quartile and the lower England quartile for the remaining standard.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From December 2016 and November 2017, the hospital's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally similar or better than the England average.
Unplanned re-attendance rate within 7 days – East Sussex Healthcare NHS Trust

(Source: NHS Digital – A&E quality)

Resuscitation officers led a whole-team debrief after a traumatic event or child death to ensure staff had access to support and the opportunity to reflect on events to identify areas of good practice and for improvement.

The hospital did not provide specialist inpatient services in paediatrics, surgery or women’s health. This meant if any patient presented in the ED with a related condition staff would transfer them to another hospital. This caused further delays in the ED whilst transfers and transport were organised.

Competent staff

Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Trust-wide

From April 2016 to March 2017, 82% of staff within urgent and emergency care at the trust had received an appraisal. In 2017/18 year to date, 90.4% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>66</td>
<td>77</td>
<td>85.7%</td>
<td>22</td>
<td>26</td>
<td>84.6%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>21</td>
<td>29</td>
<td>72.4%</td>
<td>13</td>
<td>13</td>
<td>100%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>7</td>
<td>11</td>
<td>63.6%</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
</tbody>
</table>
Eastbourne District General Hospital

From April 2016 to March 2017, 73.2% of staff within urgent and emergency care at the hospital had received an appraisal. In 2017/18 year to date, 94.7% of staff at the hospital had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>0</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>30</td>
<td>38</td>
<td>78.9%</td>
<td>9</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>7</td>
<td>11</td>
<td>63.6%</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>0</td>
<td>3</td>
<td>0%</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

After our inspection we asked the trust for the latest available data relating to the completion of staff appraisals. We found consistent levels of appraisal rates with compliance between May 2017 and December 2017 at 90%.

We looked at a sample of four appraisals for nursing staff that took place in the 12 months leading to our inspection. In each case staff had established structured objectives for the year ahead to progress their professional development. The senior member of staff involved in the appraisal had documented how they would support the individual to achieve this and there was a clear, constructive review of the individual’s performance to date. We spoke with HCAs and nurses about the supervision and appraisal process. One HCA said they had not had an appraisal in the previous 14 months due to the business of the department. Three other members of staff said they did not feel it was a useful exercise because the department was so busy they would not be able to achieve their goals.

Senior house officers completed appraisals every two months as part of their educational plan and foundation level doctors told us they felt they had adequate access to teaching and learning.

Nurses and healthcare assistants (HCAs) completed a competency-based training programme to be able to provide a triage service and were able to deliver this service only after completion of clinical observations. For example HCAs completed 10 successful cannulations and 10 successful bleeds under supervision before they were able to practice autonomously.

The practice development nurse (PDN) supported HCAs to complete the national care certificate, which established their skills and competencies against national best practice.

To encourage newly qualified nurses to commit to a professional development plan and to ensure they provided safe, competency-based care, the PDN and senior team introduced a seven day classroom-based training programme. This included basic emergency care such as how to respond to chest pain and abdominal pain. In addition the heads of nursing had implemented Royal College of Nursing (RCN) competencies for ED and had adapted these to this department to ensure they were relevant and met the demographics and needs of patients. Newly qualified nurses underwent two days of training in the RCN standards.

There was no formal supervision process in place for the emergency nurse practitioner (ENP) team. The team worked autonomously from the rest of the ED to treat and discharge but there was no formalised process in place to monitor their work.
There was a multidisciplinary approach to training opportunities. For example where ENPs had training days scheduled they invited ED nurses to help them access training they would normally not undertake.

Core trainee doctors had access to twice-weekly teaching sessions in ED medicine, which took place in protected time. One doctor we spoke with said they felt teaching was adequate but they felt could be improved with greater frequency. An education fellow supported specialty and core trainee doctors who had completed courses such as simulated emergency paediatric care training and an ultrasound course.

We asked the trust about specific training for staff in the care and treatment of patients with suicidal thoughts or ideation. They told us this was included in Mental Capacity Act, Deprivation of Liberty Safeguards and safeguarding training. As of December 2017 87% of staff were up to date in these training areas.

Clinical and professional development was a key element of staff appraisals. We saw short staffing had impacted the ability of some individuals to progress and the senior team worked with them to implement strategies to overcome this. The senior team used the expertise and resources available in the department to support staff to develop clinical competencies. For example after completing the theory component of suture training, nurses spent time with ENPs to develop their practical skills. Nurses also spent time with plaster technicians to practice their skills and worked to develop link roles, such as one nurse who completed training in wound dressings to develop better practice in the ED.

**Multidisciplinary working**

A multidisciplinary hospital intervention team (HIT) team was based in the CDU. The team included social workers, occupational therapists and physiotherapists who coordinated care with the ED clinical team. This meant patients received care that helped prepare them for discharge and community rehabilitation.

Senior nurses attended a daily multidisciplinary team meeting to support access and flow across all services. This was a cross-site meeting to enable staff to strategise with colleagues at Conquest Hospital to ensure challenges were addressed by the wider team.

A crisis intervention team was available on an on-call basis to collect patients.

The ED and mental health liaison teams carried out joint debrief sessions whenever they cared for a patient with significant mental health needs, such as patients at risk of suicide. We saw staff were proactive in contacting the police when they considered a patient to be at risk of self harm or suicide and they left the department without being discharged.

The mental health liaison team had introduced monthly MDT meetings to help manage the care and treatment of patients who frequently presented at the ED.

The security team worked with nursing staff to identify strategies to reduce the risk of harm amongst patients who presented with a mental health need, including those at risk of self harm. For example the security team were not able to search patients for dangerous items that could cause self-harm and instead supported the nursing team to identify communication strategies to encourage patients to disclose such items themselves.

Incident investigations indicated inconsistent multidisciplinary working that had a negative impact on patient experience and/or patient outcomes. This included the failure of the urology service to follow registrar guidelines for patient review in the ED, which resulted in a patient staying in the department for 14 hours unnecessarily. Another incident occurred when a surgical on-call registrar did not respond to an urgent referral and a patient with a suspected stroke waited over
four hours for thrombolysis due to a lack of capacity in the stroke service. Staff submitted an incident report when one patient spent 19 hours in the ED as a result of a lack of senior clinical decision-making between MDT teams.

**Seven-day services**

Consultants were available in the ED seven days a week and carried out a daily ‘ward round’ to review each patient. This was part of the trust’s drive to ensure patients were always seen within 14 hours in line with RCEM standards.

During our inspection we were told mental health services, including the urgent care lounge, were not available 24-hours, seven days a week. A senior member of the team told us from April 2018 the service would extend its hours to be available four nights each week. Mental health services were provided by another NHS trust and after our inspection we were told services were available 24 hours. We were not able to establish why this was information was not provided during the inspection.

The HIT team were available seven days a week from 8am to 8pm.

**Health Promotion**

There was limited provision for health promotion in the ED. Staff had displayed signposting information for domestic violence support agencies in patient toilets. This reflected national standards in good practice as it meant people could discreetly note contact details to access urgent support and help.

Although senior house officers undertook training in suicide prevention and the trust told us this training formed part of safeguarding and mental health training, there was limited evidence staff were resourced to understand or lower risk. For example despite ongoing evidence of patients presenting with self-harm and suicidal intent, there was no dedicated member of staff in place for this area of health. There were no resources available in the department to signpost patients and their relatives or friends to specialist non-profit agencies. However, the ED team was working more closely with the local NHS ambulance provider to recognise the signs of suicide risk earlier to help prepare the specialist mental health team.

The department was participating in the national NHS ‘#HelpMyA&E’ campaign to provide patients with information on alternative options to attending the ED to obtain non-emergency treatment. This was widely advertised on the trust’s website and in the patient newsletter. Guidance included where to obtain emergency contraception, mental health crisis support, emergency dental help and symptoms that could be managed by a pharmacist.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) training. Deprivation of Liberty training completion was not reported by the trust.
Trust-wide

The trust reported that, from November 2016 to October 2017, MCA training had been completed by 90.1% of all staff within urgent and emergency care. The breakdown of training completion for nursing and medical staff at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>96</td>
<td>99</td>
<td>97.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>29</td>
<td>41</td>
<td>70.7%</td>
<td>No</td>
</tr>
</tbody>
</table>

Eastbourne District General Hospital

The trust reported that, from November 2016 October 2017, MCA training had been completed by 87.5% of staff within urgent and emergency care at Eastbourne District General Hospital. The breakdown of training completion for nursing and medical staff at the hospital is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>43</td>
<td>46</td>
<td>93.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>17</td>
<td>22</td>
<td>77.3%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

In March 2018 93% of staff had up to date training in the MCA and 91% had up to date training in the Deprivation of Liberty Safeguards (DoLS).

The consultant or the most senior doctor on shift carried out a mental capacity assessment for vulnerable patients or those who staff were concerned could not make their own decisions. This was carried out within a best interest’s framework that meant appropriate family members were involved. However, monthly audits indicated low levels of compliance with trust standards relating to mental capacity assessments. Between May 2017 and January 2018 staff completed an assessment in 51% of cases. This reflected a range from 25% to 100% that met the trust standard of 90% in one month during this period. Despite this, senior clinical staff we spoke with demonstrated good knowledge of the Mental Capacity Act (2005) and the Children Acts 1989 and 2004, including in relation to their responsibilities.
Is the service caring?

Compassionate care

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better in comparison to the England average before increasing above the England average from July to November 2017.

A&E Friends and Family Test Performance - East Sussex Healthcare NHS Trust

(Source: NHS England Friends and Family Test)

Staff worked to ensure patient’s privacy and dignity were maintained when they were treated in escalation areas, such as a corridor used when the main ambulance provider used an immediate handover policy. For example privacy screens were stored in the department and staff used these along with signs to close the corridor to thoroughfare. In addition staff did not carry out blood tests or investigations in this area and ensured patients remained in their own clothes rather than hospital gowns.

We spoke with seven patients in the clinical decisions unit (CDU), all of whom said they were happy with the standard of care they had received. We observed staff in this unit providing care with compassion and a caring attitude. One patient said, “I came here because I was close by at the time, it’s not my usual A&E. I’m much more confident in this team after seeing how well they have looked after me.”

Staff were assessed on their ability to deliver care and treatment with compassion as part of their annual appraisal, which demonstrated the drive of the team to embed this standard into the work of the department.

During our observations of patients waiting extended periods in the waiting room we saw clinical staff demonstrated kindness, patience and compassion. For example we saw one person become increasingly anxious because of the cramped conditions and their worry about the time they were waiting. A clinical member of staff noticed this and intervened discreetly and helped to reassure the patient and move them to a calmer waiting area.

Although the majority of our observations in the main ED, waiting areas and CDU demonstrated a kind and caring approach, it was clear working pressures on the reception team impacted their ability to remain friendly and calm. In addition it was not always evident that all staff had the skills
or understanding to interact with teenagers appropriately or to ensure their safety. For example during one observation we found a member of the reception team did not speak to a teenager with compassion or respect and did not reassure them about being able to see a clinician due to being unaccompanied.

**Emotional support**
Staff we spoke with demonstrated understanding of how to provide emotional support to patients with mental health needs and those in crisis. They also understood how mental health challenges could manifest themselves and how they could tailor care and treatment to the patient’s needs.

Staff demonstrated understanding of the importance of providing emotional support to patients living with dementia in an environment that could be hectic and confusing. To address this and help them provide a calmer environment for patients the ED team had created sensory bands to help distract and calm patients.

We spoke with the parent of a child waiting in the department who said they felt staff had greeted them with respect and had shown sensitivity to their worry about their child. This corroborated our observations that staff treated people in psychological distress or who were very anxious with kindness and a reassuring approach.

**Understanding and involvement of patients and those close to them**
The trust recognised the healthcare assistant (HCA) team in October 2016 with an ‘unsung hero’ award for their work in improving the patient experience. This was reflective of the drive within the HCA team to provide patients with high quality care and to support registered clinical staff during periods of high demand. For example HCA-led triage ensured patients had their vital observations taken at an early stage of arrival in the ED, which meant patients had their needs assessed and understood at an early stage.

**Emergency Department Survey 2016**
The results of the CQC Emergency Department Survey 2016 showed that the trust scored worse than other trusts in 11 of the 24 questions relevant to caring. For the other 13 questions the trust scored about the same as other trusts.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.1</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>
### Question 22
Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 23
Were you involved as much as you wanted to be in decisions about your care and treatment?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

### Question 24
Overall, did you feel you were treated with respect and dignity while you were in the emergency department?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

### Question 25
If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 26
If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.4</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

### Question 27
Did a member of staff explain why you needed these test(s) in a way you could understand?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 28
Before you left the emergency department, did you get the results of your tests?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 29
Did a member of staff explain the results of the tests in a way you could understand?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 30
Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 31
Did a member of staff tell you about medication side effects to watch out for?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.7</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

### Question 32
Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 33
Did hospital staff take your family or home situation into account when you were leaving the emergency department?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 34
Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 35
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Question 36
Overall

<table>
<thead>
<tr>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.4</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Seven patients we spoke with in the CDU said they understood why they were there and what they were waiting for. One patient described “excellent” communication between the ED team and the paramedic crew who had transported them. They said, “The people here were waiting for me and saw me straightaway without me having to repeat everything.” However, those patients who were waiting to be discharged described frustration at a lack of information.

Between April 2017 and February 2018 56% of patient records in the CDU included evidence of the involvement of the patients’ relatives and family where appropriate. This was an average figure and included wide variances, from 0% in December 2017 to 100% in three other months. In seven of the months the department did not meet the trust’s 90% target for this standard of care.

The senior team monitored patient involvement in line with Royal College of Emergency Medicine...
guidance. In February 2018 the latest available data was from September 2017 and found 28% of patients had been made aware of their diagnosis, management plan and prognosis within 48 hours of admission.

**Is the service responsive?**

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

There were limited services for patients with mental health needs who presented to the ED overnight. The mental health liaison team provided an urgent care lounge two nights each week and this was due to be increased to four nights each week. Both services were provided by another NHS trust. However, the level of cover meant patients often spent significant lengths of time in the ED awaiting referral. We asked the service manager about this who said there were ongoing meetings at trust level to address this issue but in the meantime there was one practitioner available overnight who also covered community crisis services, reducing their ability to dedicate time to the ED.

Teenagers between the ages of 16 and 18 with mental health needs could experience extended delays due to the lack of cover from the community adolescent mental health service (CAMHS). Some staff told us CAMHS would attend the department to ‘meet and greet’ a patient but due to a lack of capacity they had to remain in the ED without CAMHS supervision. In addition, this service was not available out of hours. The service manager and three senior nurses told us staff overnight often found it difficult to provide appropriate care to this patient group because of a lack of options for specialist referral. For example, the urgent care lounge supervised by the mental health liaison team was not available to patients under the age of 18. If the patient did not have an acute medical need, which would enable them to be admitted to an inpatient ward, they remained in the ED until the mental health team were available to visit and assess. However, a service manager for mental health services was always available and staff told us they had been responsive when they had escalated patients in the past.

Resuscitation and the emergency nurse practitioner (ENP) suite both had well-equipped, dedicated space for paediatric patients. There was also a children’s waiting room separate from the main waiting area. However, this was not safely or consistently used. For example, we saw children and their parents sitting on the floor because there were not enough seats. In addition, the area was used by adults of varying ages and conditions, which meant children were not always segregated and were exposed to adults in various states of need or distress. During another observation, the children’s waiting room was crowded and children were sitting on their parents’ laps because there was no provision for child-friendly seating.

There were limited resources or staff expertise in the ED for patients who presented with needs relating to drug and alcohol use or overdose or self-harm. For example, the mental health liaison team could support patients but there were no dedicated or specialist staff available. However, staff had access to an alcohol detox protocol and doctors were able to provide daily methadone scripting for patients on an opiate recovery programme.

A multidisciplinary hospital intervention team (HIT) team worked in the CDU to help coordinate discharges for patients who needed a community rehabilitation or therapy bed. The CDU was designed to accommodate patients for up to 24 hours. However, a significant lack of capacity in community rehabilitation services meant patients often spent up to four days in the unit as there were no appropriate locations to discharge them to. The HIT team had increased their hours to 12 hours each day to meet the increasingly complex needs of patients and to ensure they had therapy whilst in the CDU to improve their recovery trajectory on discharge.

It was not evident that paramedics always had a good level of knowledge about paediatric cover available in the emergency department (ED). For example, paramedics we spoke with said they
were not always able to identify the best ED to take children to because they knew paediatric nurse cover fluctuated widely. They also said they believed this ED had paediatric registrar cover on a 24-hour seven day basis, which was not the case. The trust had a paediatric consultant on call when there was no paediatric registrar available.

Meeting people's individual needs

Emergency Department Survey 2016

The trust scored worse than other trusts for one of the three Emergency Department Survey questions relevant to the responsive domain and about the same as other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>6.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

As a result of feedback from patients the department provided portable phones for those who were cared for in the CDU overnight or for extended periods.

We were not assured from our observations that all staff knew how to meet the needs of teenage patients who presented in the department. For example we observed reception staff initially turn away a teenage patient who presented with a request for medical attention because they did not have a parent or responsible adult with them. The patient was ultimately seen but the initial interaction did not ensure the patient’s needs were immediately assessed. We asked the service manager about teenage care who said that staff should use a chaperone policy and that they should be trained in practice to help them provide appropriate care. This included in the Fraser guidelines and Gillick competencies. We spoke with a member of the reception team about this who said it was normal practice to ask the young person to call their parent or for reception to do this on their behalf. They said if the person’s parent was not available the clinical team might refuse treatment. We escalated this to the matron and safeguarding lead as an immediate concern as it meant a teenager may be denied treatment on the basis of not being accompanied by a parent, which may not always be appropriate.

Three nurses had completed dementia training and worked with the hospital’s dementia team to provide patients with an initial assessment. This team also provided specialist care for patients being cared for in the CDU who could be there for extended periods. Resources were available in the department to help staff identify and support patients living with dementia, such as ‘twiddle muffs’, butterfly symbols and Hospital passports. Where patients were at increased risk of falls or were confused and wandering staff used a falling leaf symbol to enable staff to discreetly identify the patient as having additional needs. In addition staff had access to Hospital passports and the national ‘This is me’ document. We saw the falling leaf symbol used routinely although none of the patients who may have benefited from a hospital passport at the time of our inspection had one in place.

Nurses and healthcare assistants in the CDU carried out hourly essential care rounds as a result of feedback from patients. All staff had undergone enhanced training in monitoring vital signs to ensure they identified developing problems or deteriorating patients during routine observations.
However, monthly quality audits indicated poor compliance and low levels of consistency with in some cases. Between April 2017 and January 2018 overall compliance with completion of essential care rounds after four hours in the department was 51%. This reflected a range from 15% to 100%. The department met the target of 90% in one month during this period. Although the department performed better for the completion of baseline observations, at 85% overall, the monthly target was met in three months during this period.

The ED waiting room had very limited information available for patients. Although a TV screen was in situ to show waiting times and other important notices, it was not in use. Staff told us this was due to an ongoing electrical problem. There was no facility for staff to display updated waiting times and this meant patients were left for lengthy periods of time without updated information. We spent time observing the ED waiting room on three occasions during our inspection and noted the lack of information frustrated patients and meant there was additional pressure on the reception team to answer repeated queries.

There were limited communication aids available for patients who lacked mental capacity or who had mental health needs. For example the mental health liaison team and the nurse in charge were not aware of any resources or tools to support communication. However a mental health bay and access to an urgent care lounge mitigated this to some extent as they provided a quieter space for patients to wait.

The ED team had introduced a number of initiatives to improve the care and experience of patients living with dementia. This included using digital reminiscence therapy software, sensory bands and the national ‘This is me’ tool to help staff identify strategies to help patients remain free from anxiety. In addition dementia rummage boxes were available that contained items to help occupy and distract patients in distress. Three healthcare assistants and two nurses were trained dementia champions.

The mental health liaison team had access to a learning disability liaison nurse who could visit the ED to support the delivery of care and facilitate communication.

**Access and flow**

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour.

The trust did not meet the standard for 10 of the 12 month over the time period from December 2016 to November 2017.

Performance against this standard showed a trend of improvement.
Ambulance – Time to treatment from December 2016 to November 2017 at East Sussex Healthcare NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

The trust breached the standard in every month from January 2017 to December 2017.

From January 2017 to December 2017 performance against this metric showed a trend of improvement.

Four hour target performance - East Sussex Healthcare NHS Trust

(Source: NHS England - A&E Waiting times)

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From January to December 2017 East Sussex Healthcare NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was broadly similar to the England average.
From January to May 2017 the trust performed worse than the national average. However, from May to December 2017 the trust performed better than national average with the exception of September 2017 when the trust’s performance was similar to nationally.

Performance against this metric showed a trend of improvement.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - East Sussex Healthcare NHS Trust**


**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from January to December 2017, no patients waited more than 12 hours from the decision to admit until being admitted.


**Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment**

From December 2016 to May 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average. However, it was better than the average for England in the most recent six months, June to November 2017.

Percentage of patient that left the trust without being seen - East Sussex Healthcare NHS Trust

![Graph showing percentage of patients leaving without being seen]

(Source: Source: NHS Digital - A&E quality indicators)

**Median total time in A&E per patient (all patients)**

From December 2016 to October 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average before showing an improvement in the most recent month, November 2017. In that month, the trust’s performance of 154 minutes was similar to the national average.

**Median total time in A&E per patient - East Sussex Healthcare NHS Trust**

![Graph showing median total time in A&E]

(Source: NHS Digital - A&E quality indicators)

Staff used an established escalation process to keep patient flow and momentum during times of high demand. For example where paramedics waited 15 minutes or more to hand over a patient, the matron escalated this to the site team. Where handover delays reached 30 minutes this was further escalated to a senior manager who worked with the matron to identify patients who were ‘fit to sit’ in a waiting area and did not need a trolley or bed. A patient bay with space for five beds was situated next to the CDU and staff sometimes used this as a handover bay during busy periods.

The main NHS ambulance operator that brought patients to the emergency department had implemented a new immediate handover policy to reduce waiting times. Where a paramedic crew
had been waiting 45 minutes to formally hand over a patient, they initiated this with the nursing team regardless of the capacity of the department. This took place if the patient had been assessed as stable following three 15-minute observations and in line with an established standard operating procedure. Although this meant patient safety was maintained, departmental staff told us it added significant pressure to them as the handover had to take place whether or not there was anyone available to lead it. Where this occurred, the matron or most senior nurse on shift opened a corridor adjacent to the ED as an escalation area for patients on trollies. This was used for patients at low risk of deterioration who did not need clinical observations such as echo cardiograms (ECGs) or blood work.

The ambulatory care unit provided additional capacity and was open from 8am to 6pm Monday to Friday. The team in this unit monitored the electronic patient tracking system in ED to identify patients suitable for transfer. This was a proactive process from the ambulatory care team to improve access and flow and to reduce pressure on the ED team.

During our inspection, staff did not consistently record the time each patient had their initial assessment and the time they were transferred or discharged. In seven patient records we looked at two did not include an initial time of assessment, three did not include a discharge time, one record did not include a transfer time and three others may have included times but the entries were illegible. However, monthly quality audits from April 2017 to January 2018 indicated staff recorded this information in 93% of cases. This met the trust's standard of 90% and had done so for 9 months during this period.

The ED team was in the process of implementing GP streaming in the department and had started to recruit dedicated streaming nurses to supplement this. Two GPs provided streaming from 9am to 5pm and 2pm to 10pm although this was not yet fully in place. For example on both days of our inspection the GP service was not available. Senior nurses told us this had already had a positive impact on the department and they experienced fewer RCEM standard breaches as a result. In addition the ability to stream directly to inpatient wards meant staff could proactively reduce the need for patients to spend time in the ED. Triage healthcare assistants were trained to stream patients directly to ambulatory care and urology following the implementation of training and internal care pathways.

Consultants from some medical specialties had established relationships with the ED team and routinely visited the department to identify patients they could admit. For example staff told us consultants from neurology and cardiology came to the ED daily to help identify patients suitable for admission to the specialty. They also told us that general medical consultants would visit the ED on weekends to identify patients for admission. This meant the ED team had support from medical clinicians, which helped to maintain access and flow and reduced waiting times for patients to be admitted or avoid admission where possible.

Learning from complaints and concerns

Summary of complaints

From November 2016 to October 2017 there were 102 complaints about urgent and emergency care services. The trust took an average of 34.9 working days to investigate and close these complaints which is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Twelve complaints remained open at the time of reporting and had been open for an average of 74.7 days.

The most common complaint themes were:

- Standard of care – 43 complaints
- Patient Pathway – 19 complaints
- Communication – 15 complaints
• Attitude – 13 complaints

At Eastbourne District General Hospital, there were 58 complaints, the most common themes from which were:

• Standard of Care – 24 complaints
• Patient Pathway – 11 complaints
• Communication – 11 complaints

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We reviewed a sample of four complaints received in the 12 months leading to our inspection and the trust’s actions and response in relation to each. There was evidence heads of nursing and the trust made improvements as a result of complaints in some cases. For example following a complaint of a poor experience by a patient with a learning difficulty, the ED senior team implemented a new standard of practice for staff to follow that would ensure patients with a learning difficulty receive appropriate care and treatment. The standard meant that staff should use a hospital passport or ‘This is me’ document to better understand how the patient might present themselves and try to communicate. The trust also sourced more specialist training for staff and asked for nurses to attend training and meetings with learning disabilities champions based elsewhere in the hospital. However it was not evident that these improvements had been established and embedded into practice. For example a morbidity and mortality review about the same complaint was critical of the failure of the ED team to implement basic safeguards and procedures for a seriously ill patient with learning disabilities. This included significant errors in documentation; the lack of communication with the person’s known carer and no use of the hospital passport or ‘This is me’ document. Although the hospital had a dedicated learning disability liaison nurse there was no evidence the ED team had engaged them for support.

Complaints investigations were completed with all members of the team who had been involved in the patient’s care and demonstrated a detailed review of records by the investigating person. The trust also liaised appropriately with other providers when complaints involved multiple services. A theme of the complaints we looked at was the approach, attitude or communication of staff. Where complainants noted they felt staff did not take them seriously or did not listen to their concerns there was evidence the complaint investigator met with staff involved and reflected on their practice with them.

The ED recorded plaudits received from patients and their family alongside complaints and concerns. This ensured they maintained an understanding of the proportion of both types of feedback.

Is the service well-led?

Leadership

A team of matrons worked clinically in the emergency department (ED) and led each shift. Two heads of nursing provided leadership and clinical support on a daily basis; one individual was based permanently in this ED and the second worked cross-site. The heads of nursing reported directly to the director of nursing. All of the clinical staff we spoke with were unreservedly positive about the leadership structure and said they were well supported during challenging times of high demand on the service.

There was significant lack of oversight and leadership of the urgent care administration and clerical team, which had contributed to unmitigated risks within this team. For example between 7.30pm to 7.30am there was only one receptionist on shift. This team did not have a formal handover and we found that securing a second member of staff during periods of exceptional

20171116 900885 Post-inspection Evidence appendix template v3
demand was rarely possible. This team was also responsible for scanning patient notes but as only one member of staff was on duty for 12 hours each day this was often delayed. There was also a lack of provision for the wellbeing of this team. For example when working alone reception staff had to ask a nurse to cover their position so they could get a drink or use the toilet. However pressure on nurses was significant and three members of the reception team told us they sometimes worked overnight without a toilet break. We asked the service manager about this. They told us if nurses were too busy to support the reception team this should be submitted as an incident. However four members of the reception team we spoke with said this system did not resolve the situation. In addition one individual said they had requested a security officer to sit with them at reception during a busy night shift when they felt vulnerable by themselves. However, they told us the matron on shift had said this was not appropriate and they were told they had to work alone. Although this team did have a manager they had been unavailable for several months and the trust had not implemented an interim person. In addition to operational challenges some of the team we spoke with said there was a lack of day-to-day support. For example one individual said there was nothing in place for them after they returned from a period of illness, which meant they had no back-to-work support plan. Staff told us when they asked senior nurses for help from the ED they were routinely turned down and that they expected to stay up to three hours after their shift to make sure their work was complete.

Nurses and healthcare assistants (HCAs) we spoke with described the leadership team as visible and accessible. For example an HCA we spoke with said that although the department could get very busy they felt the senior team was “very responsive” and they had never felt left alone during times of exceptional demand. All of the nurses we spoke with reported the same feelings and experiences.

Vision and Strategy

The ED team had established a values statement for the service, which was in the context of the overall trust vision and strategy. Staff had identified five common areas of importance to them such as respect and the importance of each individual’s contribution. Safe and high quality care was included and reflected a balance between supporting staff and facilitating a high standard of care to patients.

All of the staff we spoke with were aware of the trust’s overarching vision, strategy and development plan. Although each individual understood how the vision contributed to improvement of the organisation it was not always evident the trust had worked to establish how it applied specifically to the challenges in ED.

Culture

The trust operated a staff recognition and reward scheme and in May 2017 the ED team awarded as team of the year.

Staff we spoke with said they felt part of the trust and the clinical governance systems overall. For example matrons said cross-site away days helped them to keep in touch with colleagues at the Conquest Hospital ED and to share experiences and learning. Although this was effective for communication within the ED, some matrons we spoke with said this could be improved if there were opportunities to meet matrons in other clinical areas and departments. For example one matron said misunderstandings about the purpose of each ward or service and their specialties were frequent and scheduled meetings with staff in other areas could help to reduce this.

All of the staff we spoke with described the teamwork within the department positively and said all grades of staff worked well together. For example one member of staff said, “The consultants are approachable, the junior doctors are lovely and the matrons are fabulous.” This was indicative of all of our conversations with staff.
The senior team facilitated staff nurse and senior staff nurse meetings as well as whole-department meetings. The staff we spoke with said a more consistent approach to meetings had improved communication and morale amongst the team. In addition the team had worked together to provide a cohesive and stable environment for new staff and to ensure that morale remained high. For example the team had taken part in a team fundraising event for a cause of importance to them and this also acted as a teambuilding opportunity.

**Governance**

The urgent care quality and safety group, led by a head of nursing, hospital directors and the clinical lead, met monthly to review safety and operational performance. This included a review of the year-to-date record of harm-free care as well as identification of themes or trends from incidents and complaints. We reviewed the records of the group for 2017 and saw that concerns with performance or staff adherence to policies were addressed with improved training opportunities. However it was not always evident that this governance process was effective in improving care and treatment safety. For example although a need for improved responsiveness to escalating national early warning scores (NEWS) was identified in February 2017 and addressed with training in April 2017, audit results for the remainder of the year indicated consistently variable performance. The outcomes of incidents and morbidity and mortality reviews also indicated consistently poor adherence to the trust’s escalation policy, including the use of the Sepsis 6 bundle.

The divisional urgent care and senior ED teams held monthly governance meetings as part of the performance and risk management strategy. We looked at a sample of five meeting records between June 2017 and February 2018. The meetings were consistently well attended by appropriate staff and were focused on improving care and treatment safety when this was highlighted by incidents, complaints, patient outcomes or audit results. Although it was evident the team were proactive in responding to risks, we were not assured that the resulting action was always effective. For example the February 2018 meeting notes indicated that attention was needed to address poor daily audit results in the documentation of patient consent, mental capacity assessments, ED checklists and diagnostics. However monthly records audits had identified some of these areas as performing poorly over a number of months and previous governance meetings had not addressed the track records. In addition the governance meeting notes did not identify specific actions to address low performance rates, such as 20% compliance with doctors signing prescription charts. Despite these challenges there was a track record of improvement in infection control and hand hygiene practices as well as a structured review of all items on the service’s risk register.

The reception team had submitted a business case for a second member of staff on a twilight shift, to support the busy period of 5pm to 12am. The trust had not approved this business case.

The matron or senior nurse on duty maintained a quality assurance board in the ED that was used to monitor month-to-month performance in cleanliness and infection control compliance and patient feedback metrics and themes.

The heads of nursing used a bi-monthly departmental meeting with the service manager to review incidents and outcomes as well as complaints, safeguarding and compliments. In addition a weekly ‘flash meeting’ provided succinct oversight of current issues and recent incidents in the department.

The service had a mental health strategy for patients with a mental illness and this was reviewed annually by the divisional board.
Management of risk, issues and performance

Senior operational and clinical teams used a series of daily site meetings to monitor patients being cared for in the various escalation areas. The team used this process to identify which patients had not had a medical review and how long they had spent in inappropriate areas.

We asked matrons, heads of nursing, the service manager and other senior staff about the key risks to the service. The use of the escalation annex area, the ambulance provider’s immediate handover policy and patients queuing in corridors were repeated themes. Senior staff described the use of the annex for escalation care as a significant risk although mitigating strategies were in place to reduce patient risk. For example all patients cared for in this area were monitored on the ED’s electronic patient management dashboard and a standard operating procedure was in place for the use of this area.

Matrons and heads of nursing used safety huddles in the ED on an ad-hoc basis to manage risk and heads of nursing attended site meetings three times daily.

The clinical lead facilitated monthly clinical governance meetings and used these to review incident reports with senior nurses and junior doctors.

Senior divisional and departmental staff managed risks using a risk register that enabled them to track each risk and monitor mitigation strategies. An accountable person, such as a head of nursing, was assigned to each risk. Each risk was also assigned a monitoring committee, which provided oversight of risk management. We looked at the risks that were ‘live’ for the ED at the time of our inspection and the record of reviews in the previous 12 months. As of March 2018 there were three risks assigned solely to the ED at Eastbourne District General Hospital. Using the trust’s risk assessment criteria, one risk was ‘extreme’ and one risk was ‘high’. The extreme risk related to the potential for compromised patient safety due to an overreliance on locum doctors. The high risk related to the use of escalation areas during times of exceptional demand. The risk was that escalation areas provided a sub-standard environment for patients and placed significant pressure on staff in the ED. The risk had been opened in January 2018 following a period of sustained demand over capacity and strategies to counter the risk included enhanced patient monitoring and the use of risk criteria to ensure patients cared for in escalation areas were at low risk for deterioration.

A head of nursing, with oversight from the patient safety and quality group, had implemented strategies to address the extreme risk related to a lack of permanent medical staff. This included working with human resources colleagues to develop a collaborative workforce development plan that would streamline international recruitment and implement an advanced nurse practitioner role. This work had resulted in the implementation of a twilight consultant post, which staff told us had significantly improved their ability to safely meet demand during the evening.

In addition to the risks specific to this hospital, eight risks were live on the risk register that applied to all emergency care sites within the trust. One risk was rated extreme and related to the risk of breaching the national treatment standard of four hours due to short staffing and a lack of environmental capacity. A head of nursing and the emergency care board had implemented 10 strategies to manage this risk, including utilisation of ENPs, four times daily bed meetings and an updated escalation plan. The implementation of GP streaming and recruitment plans for new consultants further contributed to this. Two high risks related to a lack of capacity for mental health assessments, suboptimal specialist paediatric cover, an increase in violent incidents and the impact of a new handover policy by the local ambulance service. Each risk had documented strategies in place to reduce the severity of impact and we saw these involved multidisciplinary teams and senior trust staff and specialist committees.
Information Management

The department had an information sharing agreement for access to a national child protection monitoring system and was in discussion with the main NHS ambulance provider locally to increase information sharing between them.

There was a significant backlog, of up to three months, in sending out discharge summaries to GPs. This was caused by inconsistencies in how doctors discharged patients from the ED, including whether they completed a summary in hard copy or electronically. Not all doctors followed the same process and the relatively high number of locum doctors in the ED contributed to this. The clinical lead had met with the medical team to discuss this and it had been documented in clinical governance meetings. However there was limited evidence of improvement and administration staff showed us how they regularly identified errors and omissions in discharge summaries before sending them out. This meant another member of staff had to review the patient’s record and complete, retrospectively, the correct information. A theme had been identified that discharge reports often did not include the results of x-rays. As the reception team were not clinically trained a consultant had been allocated to completing this information before discharge summaries were sent out.

Engagement

Matrons and the clinical educator communicated with the ED team through a weekly newsletter and communication book.

The security team published a quarterly newsletter that was distributed to staff and of particular relevance to the ED team as it contained details of planned conflict resolution training, the current UK terrorism threat level and crime statistics for the hospital. We spent time with the security team during our inspection and noted they were an embedded, well-respected part of the ED and wider hospital team. Security staff worked closely with the ED administration and clinical teams to ensure their support met the needs of staff and patients. The culture of the team meant they were open about their work and how clinical staff could contribute feedback and suggestions and profiles of the whole team were published in the newsletter to encourage engagement with them.

Learning, continuous improvement and innovation

The service manager and other senior staff were working with the main local ambulance service in a project to identify frequent attenders in the ED. This would enable paramedics to maintain up to care plans for each patient and identify suitable alternatives for them rather than taking them to ED by default. The pilot scheme had seen a reduction in the number of patients who frequently presented at ED and the teams were in the process of establishing an information-sharing agreement with each other to ensure this contributed to improved patient care and access.

The Department of Health recognised the ED as the most improved nationally between June 2017 and August 2017 as a result of significantly improved performance in patient waiting times and measures in access and flow.

The practice development nurse and heads of nursing ensured nurses had opportunities to progress, which all of the staff we spoke with confirmed. A newly qualified nurse said they felt the senior team placed a lot of focus on ensuring they were supported and worked towards future progress and continual development.

In October 2017 the ED had successfully recruited to a number of vacant staff nurse posts. However they had experienced a fast turnover of new recruits who gave feedback that the
pressure of working in the department was unmanageable. To address this, the senior team restructured the initial induction and training for new nurses. This was to ensure they were more consistently supported, better equipped to work within the environment and to improve the sustainability of the service. As part of this strategy the senior team provided new nurses with more supernumerary time to help them build skills and resilience from experienced nurses, offered a preceptorship and offered the opportunity to spend time on inpatient medical wards.
Medical care (including older people’s care)

East sussex healthcare NHS Trust provide acute hospital and community health services for 525,000 people living in East Sussex. The trust operates from two district general hospitals, Conquest and Eastbourne district general hospital. Both sites offer a range of medical services, which are supported by diagnostic and therapy services.

The trust provide intermediate care services, as well as delivering services which focus on people living in the community through integrated locality teams. Other services focus on long term conditions such as bladder and bowel service, community heart failiure, tissue viability and diates specialist nurse teams.

The medical care service at Eastbourne district general hospital provides care and treatment for a range of medical conditions. We visited 11 wards as well as endoscopy, discharge lounge and therapeautic services.

The wards and areas we inspected were ambulatory emergency care unit, cardiology, coronary care unit (CCU), complex elderly, discharge lounge, endoscopy, frailty, gastroenterology, general medicine, haematology and oncology, occupational therapy, stroke services, medical assessment unit (MAU) and rehabilitation services.

Facts and data about this service

The trust had 45,580 medical admissions between October 2015 and September 2016. Emergency admissions accounted for 17,399 (38.2%), 1,563 (3.4%) were elective, and the remaining 26,618 (58.4%) were day cases.

Admissions for the top three medical specialties were:

- General Medicine: 13,181
- Gastroenterology: 9,878
- Clinical Oncology (Previously Radiotherapy): 6,136

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training completion rates

The service provided mandatory training in key skills as shown in the table below via online e-learning and face to face sessions. Staff knew how to access online training and where to book face to face sessions.

Mandatory training matrix reports are produced monthly identifying staffs outstanding mandatory training. This information is sent to each department to notify that a staff members training is due or expired.
Most of the ward matrons we spoke with were supported by a matron assistant, who kept a record of staff training and was able to track and follow up any outstanding mandatory training required.

We saw examples of staff training records showing completed training, training due and training outstanding. There was a clear system to track and monitor staff statutory and mandatory training online, which staff demonstrated to us.

During discussions with staff, it was unclear whether dementia training was mandatory. Not all staff had completed dementia training but there were dementia leads and champions within the medical and nursing teams on the medical wards. Staff were aware of dementia leads and how to contact them. Information folders were in place and observed in the matrons office with dementia information, contact information and dementia learning available for staff.

We saw sepsis policy and reviewed training data, which demonstrated staff had attended sepsis training and were aware and using sepsis screening tools on the wards.

Policy and information folders were in place for people with learning disabilities, there was a learning disability link nurse and team in place to support staff. An assessment tool is used by staff to highlight patients support needs. The tool shows support needs were in place, any specialist support required or equipment required during the patient’s stay in hospital.

Mental health team are in place 24 hours a day, seven days a week to offer support and guidance for patients and staff. Staff received training in regards to patients rights and wishes in relation to the mental health act, during their admission to a hospital ward.

Not all nursing staff we spoke to had attended mental health training, the information we received from the trust supported this with 50% of nursing staff attending mental health capacity training and with no figures for medical staff.

**Trust-wide**

A breakdown of compliance for mandatory courses from November 2016 to October 2017 for nursing staff in medicine at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>41</td>
<td>42</td>
<td>97.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>421</td>
<td>460</td>
<td>91.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>420</td>
<td>460</td>
<td>91.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>416</td>
<td>460</td>
<td>90.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>410</td>
<td>460</td>
<td>89.1%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>401</td>
<td>460</td>
<td>87.2%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>398</td>
<td>460</td>
<td>86.5%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>9</td>
<td>18</td>
<td>50.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The trust set a target of 90% for the completion of all mandatory training with the exception of information governance which had a training target 95%.

The overall completion rate for mandatory training modules by nursing staff in medicine at the trust was 89.2%. Nursing staff met the mandatory training targets for four out of the seven
modules but overall did not meet trust target.

Nine of the 18 eligible nursing staff (50%) had completed Mental Health Act training, which had no trust target.

A breakdown of compliance for mandatory courses from November 2016 to October 2017 for medical and dental staff in medicine at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>111</td>
<td>145</td>
<td>76.6%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>105</td>
<td>145</td>
<td>72.4%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>86</td>
<td>145</td>
<td>59.3%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>86</td>
<td>145</td>
<td>59.3%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>83</td>
<td>145</td>
<td>57.2%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>68</td>
<td>144</td>
<td>47.2%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>1</td>
<td>197</td>
<td>0.5%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by medical and dental staff in medicine at the trust was 50.7% which was significantly low compared to trust target of 90%.

Medical and dental staff did not meet the mandatory training targets for any of the six modules. One of the 197 eligible nursing staff (0.5%) had completed Mental Health Act training, which had no trust target.

**Eastbourne District General Hospital**

A breakdown of compliance for mandatory courses from November 2016 to October 2017 for nursing staff in medicine at the hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>238</td>
<td>266</td>
<td>89.5%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>238</td>
<td>266</td>
<td>89.5%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>235</td>
<td>266</td>
<td>88.3%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>231</td>
<td>266</td>
<td>86.8%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>230</td>
<td>266</td>
<td>86.5%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>228</td>
<td>266</td>
<td>85.7%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>5</td>
<td>10</td>
<td>50.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by nursing staff in medicine at the hospital was 87.7% which did not meet the trust target of 90%. Nursing staff met the mandatory training target for one out of the seven modules. Five of the 10 eligible nursing staff had completed Mental Health Act training, which had no trust target.
A breakdown of compliance for mandatory courses from November 2016 to October 2017 for medical and dental staff in medicine at the hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling</td>
<td>61</td>
<td>76</td>
<td>80.3%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>59</td>
<td>76</td>
<td>77.6%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>42</td>
<td>76</td>
<td>55.3%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>40</td>
<td>76</td>
<td>52.6%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>40</td>
<td>76</td>
<td>52.6%</td>
<td>No</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>31</td>
<td>75</td>
<td>41.3%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>106</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by medical and dental staff in medicine at the hospital was 48.7% which was much lower than the 90% trust target. Medical and dental staff did not meet the mandatory training target for any of the six modules. None of the 106 eligible nursing staff had completed Mental Health Act training, which had no trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

Safeguarding training completion rates

Staff understood how to protect patients from harm and abuse and to provide the right care and treatment by having the right qualifications, skills, training and experience.

The trust had systems and procedures in place to help staff identify and report concerns to protect patients. Staff we spoke with had the correct level of safeguarding training for their roles, safeguarding level two training was appropriate in line with national intercollegiate guidance for staff that only treat adult patients. The trust set a target of 90% for the completion of safeguarding training and as observed in the table below, completion rates for nursing staff at Eastbourne District General Hospital were better than trust targets.

Staff knew how to contact the safeguarding team within the hospital and were able to explain clearly how to make a safeguarding referral. We observed safeguarding folders which identified the safeguarding lead and the referral process. This showed staff were able to identify and report risk and received support to do so if needed.

Female genital mutilation and sex exploitation awareness was incorporated into safeguarding training which was delivered as part of the annual mandatory training programme as well as induction courses for new staff.

The trust have a female genital mutilation lead, all cases should be reported to the lead and they complete statutory notifications. Staff have access to safeguarding policies though the intranet and any cases of either female genital mutilation or sexual exploitation are discussed at a quarterly trust wide adult and children safeguarding strategic meeting. Any updates are placed onto the monthly newsletter for staff.
**Trust-wide**

A breakdown of compliance for safeguarding courses from November 2016 to October 2017 for nursing staff in medicine at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>460</td>
<td>460</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>460</td>
<td>460</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>436</td>
<td>460</td>
<td>94.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>427</td>
<td>459</td>
<td>93.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for nursing staff in medicine at the trust was 97.0%. Nursing staff met all four safeguarding module targets.

A breakdown of compliance for safeguarding courses from November 2016 to October 2017 for medical/dental staff in medicine at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>145</td>
<td>145</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>145</td>
<td>145</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>97</td>
<td>144</td>
<td>67.4%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>95</td>
<td>144</td>
<td>66.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff in medicine at the trust was 83.4%. Medical staff met the trust target for two out of four of the safeguarding modules.

**Eastbourne District General Hospital**

A breakdown of compliance for safeguarding courses from November 2016 to October 2017 for nursing staff in medicine at the hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>266</td>
<td>266</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>266</td>
<td>266</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>256</td>
<td>266</td>
<td>96.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>249</td>
<td>266</td>
<td>93.6%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for nursing staff in medicine at the hospital was 97.5%. Nursing staff met all four safeguarding module targets.
A breakdown of compliance for safeguarding courses between November 2016 and October 2017 for medical/dental staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>76</td>
<td>76</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>76</td>
<td>76</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Level 2</td>
<td>53</td>
<td>75</td>
<td>70.7%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>51</td>
<td>75</td>
<td>68.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff in medicine at the hospital was 84.8%. Medical staff met the trust target for two out of four of the safeguarding modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We observed nursing staff to be 89.5% compliant in infection control training and medical staff were only 52.6% compliant, these figures are both below trust target of 90%.

We observed East Sussex Healthcare agenda for annual infection prevention and control study day which highlighted topics such as urinary catheter infections, sepsis, wound care and influenza.

Standards of cleanliness were maintained across the medical wards and departments, with reliable systems in place to prevent healthcare associated infections. All of the areas we inspected were visibly clean, tidy, dust and clutter free.

There were specific cleaning schedules in place throughout all clinical areas and domestic staff were observed cleaning the wards during inspection. Cleaning schedule, audits and quality monitoring within each ward had been completed and evidence of this was observed in charts and specific folders. This provided assurances staff had cleaned each area in line with daily and weekly cleaning schedules. Schedules were up to date and had been signed by domestic staff at the necessary points of cleaning. Housekeeping in the coronary care unit has won the clean care award twice and the matron informed us of how proud they were about the cleanliness of the unit.

We saw posters in sluice and cleaning rooms which highlighted colour codes of mops and cloths to suit the cleaning task this was in line with the NHS national specifications, and house keeping staff could describe the colour coding system.

We observed the medical wards and departments using a patient electronic monitoring system. The electronic system monitors and analyses patient observations to identify when a patient is becoming unwell. Staff were observed cleaning the electronic system after patient use. We saw clean equipment was labelled with “I am clean” stickers so staff knew the items were clean and ready for use.

Medical services had infection prevention and control policies readily available for staff to access on the trust intranet. Staff were aware of the policies and knew how to access them. These included waste management policies, hand hygiene and cleaning audits which were monitored through regular environmental audits. Clinical audits observed showed us that staff were compliant in ensuring infection control.
Infection control link nurse was visible on the wards and we observed evidence of regular infection control meetings as well as a number of topics which are shared and discussed such as audits, infection control risks and concerns. Link nurse contact information was observed in poster boards in the corridors.

Patients who were an infection risk and required barrier nursing were placed in a side room. Barrier nursing is a term used to protect clinical staff and patients against patients who have highly infectious diseases by nursing these patients in a side room and using appropriate equipment such as gloves and aprons.

We observed staff washing their hands, putting on apron and gloves before entering the room and disposing of them prior to exiting to prevent the spread of infection.

There were adequate numbers of side rooms to allow any patient who presented a risk of cross infection to others to be isolated to reduce the risk. These rooms were clearly identified using signs that helped inform visitors and staff about any special precautions needed. Similarly, posters about infection control were prominently displayed at ward entranceways to encourage visitors to help in reducing the risk of cross infection by maintaining good hand hygiene and not visiting if they were unwell.

Each ward employed a ward cleaner who was responsible for decontaminating the bed and surrounding area in between patient admission. We saw this happen several times during the inspection. When the cleaner was not on duty the ward nursing staff would complete this task. This reduced the risk of the spread of infection between patients. Infection prevention and control audit results were visible in poster displays and showed 100% in the wards we visited.

Antimicrobial hand-rub dispensers were mounted on the walls outside each room or bay and throughout the wards and department. This complied with the World Health Organisation guidance ‘Five moments for hand hygiene’ (2009). The guidance was introduced to reduce the burden of healthcare associated infections. This user-centred approach is designed to be easy to learn, logical and applicable in a wide range of settings. This approach recommends health-care workers to clean their hands before touching a patient, before clean and aseptic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings.

All hand sanitiser had gel in them and there were posters displayed encouraging patients to use them. We observed staff using the hand sanitiser following interaction with patients and when going into and out of bays or as they moved around the premises, this followed the NICE quality statement QS61, statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. Ward hand hygiene audits were displayed and the majority were between 95 and 100% which showed staff compliance in completing hand hygiene.

We saw staff followed the trust policy on infection control, For example long hair was tied back, no wrist watches observed and “bare below the elbows” at all times to allow effective hand washing.

We saw personal protective equipment such as aprons and gloves in dispensers on walls and being used by staff. Body fluid spillage kits were readily available in line with trust policy. Dedicated hand hygiene sinks were available in corridors and sluices. These were compliant with the Department of Health’s Health Building Note 00-09: Infection control in the built environment, with lever handles and taps positioned to cause the least amount of splash. We saw hand hygiene posters were displayed above sinks outlining the correct hand washing technique and water in sinks was hot to allow effective handwashing.

Sharps boxes in each area we visited were assembled and disposed of in accordance with
Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 (The Sharps Regulations). We saw sharps boxes close to where medical sharps were used. Posters displaying guidance on actions for staff to take in the event of needle stick injury were present in the clinical and treatment rooms.

Decontamination of surgical instruments within the endoscopy department are completed in central sterile services department (CSSD) in line with Department of Health Decontamination of surgical instruments (CFPP 01-01) (chapter 6) and local policy.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

The areas we observed supported the safe delivery of care. There was access to emergency equipment, including portable oxygen, suction and automated defibrillators stored on purpose-built trolleys. These were stocked and checked daily in accordance with guide sheets attached to each trolley, which were collected by managers and audited monthly.

All bays and rooms we visited had piped oxygen and suction and every device we checked five and all functioned correctly. This was consistent with the emergency equipment checklists, this provides assurances of daily checks and indicates staff retained an active focus on ensuring these items were ready for immediate use should an emergency occur.

We checked two resuscitation trolleys in the Medical Assessment Unit and Folkington Ward. All consumables were in date and all checks were clearly dated, signed and complete, this provided assurances the trolleys were safe and fit for purpose. Disposable equipment was stored appropriately and all items were inspected were found to be within their expiration date.

Equipment was maintained in accordance with the trust’s medical devices and systems policy which covered repairs and planned preventative maintenance. We checked five pieces of equipment within the medical wards and all equipment had an asset barcode and log number which ensured it had been registered onto the trust’s medical devices log and had up to date servicing and electrical safety testing. Staff knew how to report faulty equipment and how to source a replacement for any essential items.

Beds, furniture and equipment were labelled with asset numbers and labels showing service dates within the past year. Staff told us that the medical equipment was well maintained centrally by the engineering service and none cited any problems in obtaining sufficient items for use. The ward stores we visited appeared clean with plentiful shelving and items clearly labelled.

**Assessing and responding to patient risk**

Systems and procedures were in place to assess, monitor, and manage risks to patients.

We saw that comprehensive risk assessments were carried out on patient admission and kept in the patient records. This included assessing the patient against the risk of falls, nutrition status, skin integrity and pain. Alongside the falls assessment a individual needs assessment is completed this checks a patients dementia and delirium, blood pressure, medication review, visual impairments, continence care plan, call bells within reach and mobility and walking aids.

We saw healthcare assistants specialing high risk falls patients on the wards and senior staff told us of plans to have specialist falls assessors on each ward, and leadership spot checks to ensure assessments have been completed.

We observed larger side rooms for bariatric patients and told us bariatric equipment and specialist pressure relieving mattresses were available.
In the sets of 10 patient records we examined, risk assessments had been regularly reviewed and updated. Staff had a good awareness of how to respond to risk. They knew how to make urgent referrals and had a clear pathway and process to follow.

Staff used a mobile electronic recording device to record and monitor patients’ vital signs to calculate a patient’s early warning signs. The data alerted staff to a patient whose health was deteriorating and the need for medical intervention.

The wards used a national early warning system (NEWS) to monitor patients’ health while in hospital. It is a simple scoring system in which a score is allocated to physiological measurements such as blood pressure and pulse. The scoring system enabled staff to identify patients who were becoming increasingly unwell and provide them with increased support.

We saw staff monitor patients national early warning signs (NEWS) scores and discuss patients within safety huddle meetings that had consistently high scores.

This high NEWS score triggered off sepsis screening and sepsis protocol in accordance with NICE guideline 51 Sepsis: recognition, diagnoses and early management. Staff subsequently started sepsis treatment if needed. Sepsis is a rare but serious complication of an infection, which needs urgent medical intervention. The tool guided staff through a series of interventions that were needed to diagnose and treat patients with sepsis.

We saw ‘sepsis six’ management and screening tools such as pre-printed stickers showing staff the triggers for referring patients to the outreach support team, the trust have 100% compliance with best care bundles for sepsis. We saw an audit with information from the mobile electronic system to assess whether patients observations have been completed on time, this audit made the trust target with 92% completed on time.

Bed charts we saw were completed legibly and accurately. Patient records showed that nursing staff escalated any concerns about deteriorating health and that decisions about changes to care or treatment plans were made by staff that were competent to do so.

We observed clear referral pathways for patients who were displaying or had mental health conditions. Staff knew where to access support and information. Staff knew about the psychiatric liaison team based in accident and emergency department and that the team were available 24 hours every day. There was an on call consultant psychiatrist. We observed emergency buzzers in the treatment and clinic rooms as well as in the corridors of the department and staff were aware use the buzzer or to call 2222 to summon assistance if a patient became aggressive.
**Patient moves per admission**

Patients had at least one bed move while in hospital. Staff told us that bed moves were rarely done at night and were usually completed at appropriate times during the day.

From November 2016 to October 2017, the proportions of patients who did not move ward and those who were moved ward once or more by site were as follows:

<table>
<thead>
<tr>
<th>Number of ward moves</th>
<th>Trust-wide</th>
<th>Eastbourne District General Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>No moves</td>
<td>12.9%</td>
<td>10.7%</td>
</tr>
<tr>
<td>One or more moves</td>
<td>87.1%</td>
<td>89.3%</td>
</tr>
</tbody>
</table>

This is based on the three medical wards with the highest numbers of ward moves: Baird, Folkington and Jevington.

(Source: Routine Provider Information Request (RPIR) P53 – Ward moves)

**Nurse staffing**

Staff felt that they did not have enough staff working each shift for the high dependency patients in the medical wards. Staff did feel that clinical staff did have the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Staffing for each ward was monitored with a mobile electronic system. The staffing levels are assessed three times a day and staff moved to the ward with the higher acuity patients. Staff informed us that staff taken from medical wards was providing ongoing stress to current clinical staff and increased pressures and risk to patient care with ratios of one trained staff nurse to 10 patients.

Senior nurses expressed concerns with staffing levels and felt the electronic roster did not show an accurate account of staffing within the wards as at times it was not updated to reflect changes.

We saw the senior nursing team and bed managers look at staffing using a new introduced system at Eastbourne District Hospital. This system allows senior staff to compare staffing levels, skill mix whilst calculating patient need and requirement on the day.

Staffing is reviewed by the site team twice daily to balance patient risk with staffing levels.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne DGH</td>
<td>292</td>
<td>344</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>458</strong></td>
<td><strong>550</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

The following nurse staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 14% for nursing staff in medicine which was worse than the target of 10%:

- Eastbourne District General Hospital: 13%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
**Turnover rates**
From November 2016 to October 2017, the trust reported a turnover rate of 7% for nursing staff in medicine which was better than the target of 10%:
- Eastbourne District General Hospital: 6%

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**
From November 2016 to October 2017, the trust reported a sickness rate of 4% for nursing staff in medicine which was worse than the target of 3.3%:
- Eastbourne District General Hospital: 4%

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and agency staff usage**
From November 2016 to October 2017, the trust reported a bank and agency shift total of 40,069 in medicine (32,162 bank, 22.9% of which were registered nurse shifts; and 7,906 agency, 60.2% of which were registered nurse shifts). There were 7,078 shifts not filled by bank or agency staff.

Please note that we were unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of bank and agency usage at Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/ agency</th>
<th>Healthcare Assistant</th>
<th>Registered nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Bank</td>
<td>15,589</td>
<td>4,603</td>
<td>20,192</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>1,954</td>
<td>3,346</td>
<td>5,300</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>1,780</td>
<td>2,257</td>
<td>4,037</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)*

**Medical staffing**
We found the numbers of doctors at appropriate grades were adequate to meet the patient needs.

Newly admitted patients received a review by a consultant trained in general medicine, we saw ward rounds taking place and patients having a daily review. There is an oncall consultant available for advice and support as well as a trust consultant on-call system seven days a week. The majority of junior doctors told us they could access advice from a consultant and felt well supported.

The trust has reported the following medical staffing numbers in medicine as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne District General Hospital</td>
<td>87</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>100</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)*
The following medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 13% for medical staff in medicine which was worse than the target of 10%:

- Eastbourne District General Hospital: 14%

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 10% for medical staff in medicine which was the same as the target of 10%:

- Eastbourne District General Hospital: 11%

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 1% for medical staff in medicine which was better than the target of 3.3%:

- Eastbourne District General Hospital: 1%

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and locum staff usage**

From November 2016 to October 2017, the trust reported a locum shift total of 4,732 in medicine. Over 60% of these shifts (3,034) were for consultants. There were no shifts that were filled by bank staff or shifts that were unfilled.

Please note that we were unable to calculate bank and locum usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

A breakdown of locum usage at both Conquest Hospital and Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne District General Hospital</td>
<td>1,983</td>
<td>93</td>
<td>558</td>
<td>2,634</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)*

**Staffing skill mix**

As of September 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was
higher than the English average. This meant the trust had a higher proportion of less experienced doctors than the average for other trusts.

**Staffing skill mix for the 148 whole time equivalent staff working in medicine at East Sussex Healthcare NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce statistics (01/09/2017 - 30/09/2017))

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

Records were shared by doctors, nurses and other healthcare professionals.

We reviewed 10 patient records and found a good standard of record keeping. The notes were stored in digitally locked notes trolley and each trolley we tested was locked. Relevant staff knew the access code and without this code you were unable to obtain patient records.

Patient notes contain admission details, progree notes were documented clearly, dated and signed. Patient risk assessments completed and care plans in place including falls, nutrition and pressure area assessments. Risks assessments were repeated as needed and actions taken to mitigate the risks identified.

Records are to be moved to electronic records from paper with administration able to access all previous case notes from archive.

On all wards we saw staff updating and referring to purpose-built marker boards mounted on walls at the nurses’ station or bay. We observed patient names written on these boards and occasionally other details. This meant that a patient’s confidentiality could be compromised as information could be seen by people passing the central nursing station.

**Medicines**

The medical department ensured the proper and safe storage and use of medicines. Medication audits are completed and results sent to governance meetings.

The trust had medicines management policies, which were readily available to staff via the trust...
intranet. Prescribers had access to the relevant resources such as current copies of the British National Formulary (BNF). British National Formulary a United Kingdom pharmaceutical reference book that contains information and advice on prescribing and pharmacology.

Emergency medicines on the resuscitation trolley were stored in drawers with tamper evident tags. General medicines were stored in wall mounted lockable cabinets. Intravenous fluids were stored in a locked room.

Controlled drugs were stored and given in line with current legislation on all wards. Spot checks on the recorded stock levels on controlled drugs matched the register.

We reviewed 15 prescription charts across the unit and found them legally valid with patient name, date of birth, patient allergy, hospital number, name of drug, dosage and prescriber signature. Patients receiving medical oxygen had this prescribed within the prescription chart.

The medicine fridge displayed the current temperature; records showed ward staff monitored this daily. Staff could describe the escalation process if the temperature was outside acceptable limits.

Nursing staff felt confident to challenge doctors if they medication instructions were not clear or there was an error on the prescription charts. All medicines administered were documented correctly but some charts we reviewed, some of the medications had been omitted with no documentation as to why this had occurred.

We observed a discharged patient’s medication left in medication fridge and we informed the senior nurse. Senior nurse told us the medication would go to pharmacy for disposable and would highlight medication disposable to staff within the daily safety huddle.

Opening dates were not always recorded on liquid medicines to ensure they were used within the correct expiry date. Staff knew how to report medicines incidents through electronic incident report form and incidents discussed with staff at daily huddles and within team meetings for lessons learned.

The antibiotic prescriptions we saw had a reason for prescribing and a review date. Nursing staff told us they if this was not recorded they would challenge the prescriber to add this information. The trust antimicrobial audit informs prescribers of good antimicrobial stewardship, information reported to consultant microbiologists as well as medical and surgical consultants.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff could tell us how they would report an incident and all knew how to complete an electronic incident report form. We were informed by staff that they all receive feedback following completing the form and within team meetings and daily safety huddles, electronic incident reporting forms and incidents are discussed to encourage learning.

Staff gave a clear description of duty of candour and gave examples following incidents. Duty of candour is a legal duty to inform and apologize to patients if there has been mistakes in their care that led to harm. Senior staff told us incidents are shared to staff through safety huddles for feedback and learning.
A staff nurse gave us an example of a duty of candour incident. Two patients discharged at the same time and one patient went home with the other patient’s medication. Incident explained to patients, apologise and correct medication given. An electronic incident report form completed and feedback given to staff.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for medicine.

*Source: NHS Improvement - STEIS (01/12/2016 - 30/11/2017)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in medicine, which met the reporting criteria set by NHS England between December 2016 and November 2017.

Of these, the most common types of incident were:

- Slips/trips/falls meeting serious incident criteria – 11 incidents
- HCAI/infection control incident meeting serious incident criteria – three incidents
- Sub-optimal care of the deteriorating patient meeting serious incident criteria – two incidents
- Medication incident meeting serious incident criteria – one incident

Eastbourne District General Hospital had eight serious incidents.

*(Source: Strategic Executive Information System (STEIS))*

**Safety Thermometer**

The national safety thermometer records the prevalence of patient harms and provides immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline intends to focus attention on patient harms and their elimination.

Data collection takes place on one day each month and reported within monthly governance meetings. All staff receives a quarterly newsletter called 'you said, we said' and gives staff information of common risks and examples of learning from incidents.

Data seen from patient safety thermometers seen displayed in poster display on the wards and departments. Ward results are discussed within team meetings and safety huddles.

Trust quality statement set their goal for harm free care between 2016/2017 as 96% but they were below this target with 93%
Data from the patient safety thermometer showed that the trust reported 48 new pressure ulcers, 10 falls with harm and 66 new catheter acquired urinary tract infections between December 2016 and December 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Sussex Healthcare NHS Trust

- Total Pressure ulcers (48)
- Total Falls (10)
- Total CUTIs (66)

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance, discussed, and disseminated guidance to staff within team meetings. Staffs were able to access local and national policies through the intranet.

We observed national and local guidelines to be up to date, referenced and hyperlinked to national and national institute of care and excellence (NICE) guidelines. Staff we spoke with were aware of national guidance and the relevance within local policies. Trust clinical effectiveness team give new national institute of care and excellence guidelines published to each division monthly to review to see if appropriate for the speciality on the ward or department.

We observed example of local and national guidelines for diabetes and blood glucose monitoring, fluid therapy and prescribing, sepsis screening and end of life care, pain relief and patient records.

Current trust audits taking place were adult asthma, dementia, diabetes foot care, end of life
care, falls, Parkinson’s disease action, pulmonary rehabilitation, and cardiology and staff were aware of audits taking place.

Recent audits took place for JAG (joint advisory group on gastrointestinal endoscopy) accreditation, which they are currently awaiting the outcome. Staff told us that the accreditation went well and were positive that the accreditation will continue.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary such as plates and cutlery so that patients are able to feed themselves. The service made adjustments for patients’ religious, cultural and other dietary preferences.

The trust used nationally recognised tools to monitor and assess a patient’s nutrition and hydration and the majority of patient’s records we reviewed had a completed malnutrition universal screening tool assessment. Dieticians were available when required with 93% of priority patients assessed by dietician within 48 hours of receipt of referral.

A matron in Cuckmere ward informed us that they will often advise local hospices and emergency departments in regards to percutaneous endoscopic gastrostomy (PEG) feed and discussed the importance of working as a team to support. A percutaneous endoscopic gastronomy feed is a tube, which passes through the abdominal wall into the stomach so that feed, water and medication are given without swallowing.

Patient’s dietary requirements were recorded on a white board and the housekeeper was responsible for giving the patients their meals. In oncology, we saw the white board had clear indications as to which food could not be given to neutropenic patients due to bacteria or other harmful organisms in food.

Neutropenic patients have a higher risk of developing serious infections as their body following cancer treatment have a low level of white blood cells. White blood cells are important in fighting off serious infections within the body.

When well and finishing treatment, patients were encouraged to eat foods they wanted and the kitchen always ensured that this happened, including providing a glass of sherry or beer to terminally ill patients on request.

We observed assessments, which showed us that patients had been assessed by speech and language therapists (SALT). We saw advice in regards to two patients feeding and swallowing requirements displayed at the top of their beds. Staff were seen talking, smiling and patiently help feed patients during mealtimes.

However, we did find that although dietary needs were placed on a white board in the kitchens not all wards had information in regards to specialist equipment such as a lipped plate to prevent patients with coordination difficulties from spilling their food. In one of the wards, five patients had their meal in the day lounge, four patients had finished their meal when the fifth patient just had theirs, and this appeared to be due to a delay in the food being given to the patient.

**Pain relief**

The trust had a pain management policy, which staff could access through the trust intranet.

The trust completed an audit in April 2017, which showed 87.2% of patient records reviewed did not have a completed pain assessment. Dementia and learning disability patients were not
having their pain assessed with appropriate tools. Following the audit, trusts key actions were to inform medical divisions of documentation needed for pain assessment and to place pain assessments in main patient notes and bed notes, as well as incorporate the results within pain study days.

We saw pain assessments completed on admission in the patient notes reviewed and staff told us pain assessments reviewed if necessary.

We saw the service used the abbey pain scale to assess pain in patients living with dementia. The abbey pain scale is to assist in assessing patients who are unable to articulate their needs.

Nursing staff informed us that patients were assessed for pain by the medical team when transferred to a ward. Pain team are available and will review a patient within two hours of referral or call and we observed the pain team in the one of the wards reviewing a patient's medication.

Pain assessments reviewed within patient records. Patients told us that they were not in pain and received pain medication promptly.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Evidence of patients’ care and treatment reviewed when looking at patient records.

The medical wards use an electronic recording device, which monitors and analyses patient’s vital signs to identify if a patient is deteriorating and alert clinical staff to carry out further treatment. Senior nursing staff were seen discussing patient care using information gained from the electronic recording device during safety huddles and with this information gained we observed how staff quickly identified a patient’s health was deteriorating and NEWS score was high and SEPSIS treatment was started.

The endoscopic services demonstrated compliance with British Society of Gastroenterology (BSG) guidelines. The service had Joint Advisory Group (JAG) on gastrointestinal endoscopy as part of JAG monitoring, the hospital demonstrated good audit practice in the department for example, patient sedation levels, consent and note audit, biopsies quality and perforations.

**Relative risk of readmission**

**Eastbourne District General Hospital**

Between September 2016 and August 2017, patients at Eastbourne District General Hospital had better than expected risks of readmission for both elective and non-elective admissions when compared to the England averages.
**Elective Admissions - Eastbourne District General Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in Clinical Oncology (Previously Radiotherapy) and Clinical Haematology had better than expected risks of readmission for elective admissions
- Patients in Gastroenterology had a similar too expected risk of readmission for elective admissions

**Non-Elective Admissions - Eastbourne District General Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in General Medicine and Geriatric Medicine had better than expected risks of readmission for non-elective admissions
- Patients in Cardiology had a similar too expected risk of readmission for elective admissions

**Sentinel Stroke National Audit Programme (SSNAP)**

**Eastbourne District General Hospital**

The trust's stroke services are located solely at Eastbourne District General Hospital.

Eastbourne District General Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in latest the audit, which covered the time period from April to June 2017. This was deterioration from the previous quarter, January to March 2017, when the hospital was in grade B.
The hospital had an overall team centred score of grade B in both quarters. In speech and language therapy and discharge processes, the hospital improved its performance. However, in thrombolysis, specialist assessments and physiotherapy, the hospital’s performance deteriorated.

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>2) Stroke unit</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>E</td>
<td>D</td>
</tr>
<tr>
<td>8) MDT working</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>9) Standards by discharge</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>10) Discharge processes</td>
<td>C</td>
<td>B</td>
</tr>
</tbody>
</table>

Team-centred SSNAP level (after adjustments): B

Team-centred Total KI level: B

Overall scores

SSNAP level
Case ascertainment band
Audit compliance band
Combined Total Key Indicator level

1 Included in IM reporting, indicator SSNAPD02

(Source: Royal College of Physicians London, SSNAP audit)
Heart Failure Audit
In-hospital Care Scores

Eastbourne District General Hospital performed better than the national average for three of four standards. At the hospital, 89.0% of patients received an echo compared with 90.1% nationally. An echo is a scan used to look at the heart and nearby blood vessels.
Discharge Scores
Results for Eastbourne District General Hospital were better than the national average for six of the nine standards. However, this hospital was worse than the national comparator for patients receiving discharge planning and being referred to cardiac rehabilitation while a similar proportion of patients had a Magnetic Resonance Aniography (MRA) on discharge. An MRA is a scan that uses a magnetic field and pulses of radio wave energy to provide pictures of blood vessels in the body.

![Discharge Scores Chart]

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

National Diabetes Inpatient Audit
The National Diabetes Inpatient Audit measured the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement. The audit attributes a quartile to each metric, which represents how each value compares to the England distribution for that audit year. Quartile one means that the result is in the worst 25%, whereas quartile four means that the result is in the best 25% for that audit year.

Eastbourne District General Hospital
Of the 56 in patients with diabetes at Eastbourne District General Hospital, 80.8% reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital. This placed the hospital in quartile two, which is similar to the average for other trusts.

(Source: NHS Digital)
Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to Myocardial Ischaemia National Audit Project by hospital site (as opposed to trust).

Eastbourne District General Hospital

Between April 2015 and March 2016, 78.6% which is better than England averages of Non ST Elevation Myocardial Infarction patients were admitted to a cardiac unit or ward at Eastbourne District General Hospital and 93.5% which were worse than England averages were seen by a cardiologist. Non ST elevation myocardial infarction is a type of heart attack.

The proportion of Non ST Elevation Myocardial Infarction patients who were referred for or had angiography at Eastbourne District General Hospital was 24.1% which was much worse than the England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 39%, which was worse than the audit minimum standard of 90%. The 2015 figure was 73%, this means the trusts performance has declined in this area.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 20.7%, which was not significantly different from the national level. The 2015 figure was 14%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 68.8%, which was not significantly different from the national level. The 2015 figure was 64%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 57.1%. This was this is not significantly different from the national level and similar to the 2015 figure of 59%.

The one year relative survival rate for the trust in 2016 was 37.2% which was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Eastbourne District General Hospital

The hospital had a multi-disciplinary working group for falls prevention where data on falls were discussed.

The crude proportion of patients who had a vision assessment (if applicable) was 76%, which was worse than the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 33%. This was worse than the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable)
was 59% which was lower than the national aspirational standard of 100%.

The metric relating to the crude proportion of patients with an appropriate mobility aid in reach was not applicable for this hospital.

(Source: Royal College of Physicians)

**Competent staff**

The service made sure staff were competent for their roles. The trust had recruitment policies and procedures together with job descriptions for all grades of staff. Senior staff described how the trust completed recruitment checks to ensure new staff were experienced, qualified, competent and suitable for their post.

Senior staff informed us that all new staff received a trust and local induction programme with additional support and training when required. Newly qualified band five nurses had a competency folder, we observed five staff nurses completed competencies, specific to the medical care taking place on the ward.

We observed five bank and agency nurses local induction guidance and completed competencies.

The risk of falls on the medical wards can be high due to the high numbers of elderly and frail patients. A falls prevention workbook is in place for all clinical staff to complete. The aim of the workbook is for staff to feel competent in recognising patients who could potentially be at risk from falls.

Health care assistants (HCA) completed a bedside emergency assessment course for health care staff with the aims to be able to competently assess a patient, to recognise and manage a deteriorating patient and to recognise early warning signs and when to escalate a patient’s condition.

Staff informed us that there were opportunities for one to one discussions with senior nursing staff and that they felt well supported. Staff felt that they were encouraged to complete not only mandatory training but also training sessions for key nursing skills specific to departments such as infusion devices, blood cultures, safe use of insulin, end of life care and catheterisation.

Training needs were identified and staff encouraged to apply for training such as mentorship. A band six staff nurse informed us she had recently completed management training.

Registered nurses were supported in preparing for revalidation, which is a process all nurses and midwives must complete in order to renew their registration with the Nursing and Midwifery Council. However, there did not appear to be a formal supervision process other than the yearly appraisal. Supervision was described as ad hoc when required and staff were not able to inform us that regular monthly supervision or one to one meetings always took place. Information requested highlights that the trust does not have a formal supervision process and no supervision template.

Staff were seen discussing NEWS (national early warning sign) scores and starting commencing sepsis screening during safety huddles and whilst seen completing observations on patients.

Staff knew their patients and were knowledgeable in the medical ward, which they were working on, they were seen to be professional and competent within their interactions with patients, relatives and carers as well as colleagues.
Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Trust-wide

From April 2016 to March 2017, 76.1% of staff within medicine at the trust had received an appraisal. This was worse than the target of 90%. In 2017/18 year to date, 87.6% of staff had received an appraisal and was on target to meet the 90% target by end of March 2018.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>55</td>
<td>56</td>
<td>98.2%</td>
<td>36</td>
<td>40</td>
<td>90.0%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>212</td>
<td>272</td>
<td>77.9%</td>
<td>173</td>
<td>190</td>
<td>91.1%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>39</td>
<td>52</td>
<td>75.0%</td>
<td>28</td>
<td>36</td>
<td>77.8%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>271</td>
<td>362</td>
<td>74.9%</td>
<td>226</td>
<td>260</td>
<td>86.9%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>11</td>
<td>15</td>
<td>73.3%</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>25</td>
<td>41</td>
<td>61.0%</td>
<td>12</td>
<td>16</td>
<td>75.0%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>5</td>
<td>11</td>
<td>45.5%</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
<tr>
<td>Additional Professional</td>
<td>1</td>
<td>4</td>
<td>25.0%</td>
<td>-</td>
<td>-</td>
<td>n/a</td>
</tr>
<tr>
<td>Scientific and Technical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Eastbourne District General Hospital

From April 2016 to March 2017, 81.3% of staff within medicine at the hospital had received an appraisal. In 2017/18 year to date, 88.1% of staff at the hospital had received an appraisal and were on target to meet trust target of 90%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>27</td>
<td>27</td>
<td>100.0%</td>
<td>18</td>
<td>19</td>
<td>94.7%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
<td>7</td>
<td>11</td>
<td>63.6%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>122</td>
<td>149</td>
<td>81.9%</td>
<td>109</td>
<td>119</td>
<td>91.6%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>160</td>
<td>200</td>
<td>80.0%</td>
<td>133</td>
<td>151</td>
<td>88.1%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>15</td>
<td>21</td>
<td>71.4%</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
</tr>
<tr>
<td>Additional Professional</td>
<td>1</td>
<td>4</td>
<td>25.0%</td>
<td>-</td>
<td>-</td>
<td>n/a</td>
</tr>
<tr>
<td>Scientific and Technical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide care.

Across the medical wards, we observed clinical and support staff working and communicating well with each other. Medical and nursing staff were seen working well as a team and staff felt they were able to have discussions and challenge constructively to senior staff and the medical teams.

Staff we spoke with told us that health care professionals such as dieticians, physiotherapist, occupational health, speech and language therapists were often visible on the wards, and we saw evidence of multidisciplinary team meetings. However, nursing staff felt that the referral process to the multidisciplinary team could be time consuming, as a written referral needs to be completed.

We observed the wards used integrated patient records, which were shared by all clinical staff and therapists that contributed to the patients care. This improved communication and meant care was better co-ordinated between healthcare professionals.

**Seven-day services**

There was seven-day medical cover provided by medical teams working between 8.30am and 5pm with doctor on-call providing out of hours care. Consultant cover was available every day including weekends with an on-call consultant if required. This was in line with the NHS services, seven days a week priority clinical Standard Six.

The out of hour crisis response service is part of the East Sussex Better Together programme which work towards admission avoidance and facilitating discharge, provided seven 24 hours a day services and were finalists in the unsung heroes East Sussex hospital trust awards.

Staff informed us in endoscopy that there was currently no seven-day services emergency nursing cover and they felt this was a concern, as well as no seven-day services in place within physiotherapy. There was no access to dieticians or speech and language therapists seven days a week and this had an impact on the care of patients particularly on the stroke ward, where dietary advice and support with eating affected recovery and discharge times and could be linked to the trust’s sentinel stroke audit results declining.

The discharge lounge was open Monday to Friday and provided a breakfast service, which started at 7am, but this meant that there was no discharge lounge available for patients at the weekend.

Discharge occurs between 8am to 8pm and only discharge outside of these hours occurs through patient choice or if discharge is necessary outside of the hours.

**Health promotion**

We observed in diagnostic areas and in the medical assessment unit a number of health promotion leaflets in regards to treatments and procedures such as endoscopy. The speech and language department had a number of feeding guides and aids leaflets, which were given to patients and their families as well as shared with their teams.
We saw poster boards in each ward and department which gave patients and staff information on dementia, infection control, tissue viability as well as current research and development taking place within the speciality.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked capacity to make decisions about their care.

Across the medical directorate staff demonstrated a good understanding of the legislation and best practice regarding consent, the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff we spoke with were clear about their responsibilities in relation to gaining consent from patients, including those that who lacked capacity to consent to their care and treatment showed compassion and caring attitudes to patients who require extra support. Following an initial patient assessment staff will assess when a full mental capacity assessment is needed.

The trust had a consent policy in place, based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, Mental Capacity Act, 2005 guidance and checklists for use when dealing with individual patient cases. Staff use the department of health consent form four for patients consent.

This information is requested within the universal provider request spreadsheets and completed within a standard template.

The trust set a target of 90% for completion of Mental Capacity Act training. Deprivation of Liberty training completion was not reported by the trust.

**Trust-wide**

The trust reported that, from November 2016 October 2017, Mental capacity Act training completed by 94.5% of all staff within medicine at the trust, this is better than the target. The breakdown of training completion for nursing and medical staff at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>459</td>
<td>460</td>
<td>99.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>113</td>
<td>145</td>
<td>77.9%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Eastbourne District General Hospital**

The trust reported that from November 2016 October 2017, mental capacity act training had been completed by 95.9% of staff within medicine at Eastbourne District General Hospital, this is better than trust target. The breakdown of training completion for nursing staff at the hospital is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>266</td>
<td>266</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>62</td>
<td>76</td>
<td>81.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion and kindness. We saw all grades of clinical and support staff across the different wards talk to patients kindly with dignity and respect. The six C’s of nursing are care, compassion, competence, communication, courage and commitment and the aim is to put the patient being cared for at the centre of any care given. Staff introduced themselves to patients and gave patients choices about their care.

Staff we spoke with had awareness of the six C’s of nursing and the staff we observed were seen to be following the principles within their practice. Staff observed introducing themselves to patients. This was in line with The National Institute of Care and Excellence (NICE) Quality Statement 15 Statement three: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

Patient’s dignity and respect was maintained at all times. Staff asked patients how they were feeling, if they had slept well and encouraging patients with their own personal care such as offering a shower or a bowl of warm water so they were able to wash themselves.

Curtains were drawn around patients and staff observed knocking on bathroom, toilet or side room doors before entering.

Patient’s personal, cultural, social and religious needs were assessed during admission and were seen to be assessed during ward handover or within safety huddle meetings. Staff spoke and interacted with patients in a respectful and considerate way.

We were given many examples of compassionate care during the inspection. Matron told us was of a young patient who was very ill, had been on the ward for a number of months, and missed his pets. Ward staff liaised with infection control around how to bring patients pets into the ward and this was able to happen. Ward staff also organised for pet therapy and a dog was able to come onto the ward to visit the patient regularly.

Staff showed an encouraging, sensitive and supportive attitude during quiet periods. Following lunch, we saw staff going into ward bays, talking to patients, interacting in discussion, asking patients how they felt and encouraging and supporting patients out of bed.

We spoke with 10 patients, and we received a lot of positive comments and statements from patients in regards to the care they had received. One patient told us “Oh they are all very kind and gentle, and will always answer the call bell quickly” with another patient stating “I love them all”.

We saw examples of thank you cards and notes given to staff members from patients and their relatives who expressed gratitude for the care they had received, they or their relatives had received.

The staff in oncology spoke to us about encouraging normality and positivity for patients. Staff encouraged patients to get dressed, and took the time to talk to patients.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 37%, which was better than the English average of 25% from December 2016 to November 2017.
The response rates at Eastbourne District General Hospital were 39%.

A breakdown of FFT performance by ward for medical wards at the trust with total responses over 100 is below. All the wards had annual recommendation rates above 90%, this meant most patients would recommend the service to family and friends.

### Friends and family Test – Response rate from December 2016 to November 2017

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Responder</th>
<th>Avg. Response Rate</th>
<th>Percentage of patients recommending the service as a place to receive treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dec-16</td>
<td>Jan-17</td>
</tr>
<tr>
<td>Endoscopy EDGh</td>
<td>2587</td>
<td>37%</td>
<td>98%</td>
</tr>
<tr>
<td>Endoscopy Conquest</td>
<td>1253</td>
<td>23%</td>
<td>100%</td>
</tr>
<tr>
<td>Seaford (1 medical assessment)</td>
<td>1103</td>
<td>42%</td>
<td>95%</td>
</tr>
<tr>
<td>JamesCCU Ward</td>
<td>763</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Admissions Unit (AAU) Conquest</td>
<td>642</td>
<td>23%</td>
<td>97%</td>
</tr>
<tr>
<td>Cardiology Unit Conquest</td>
<td>504</td>
<td>55%</td>
<td>97%</td>
</tr>
<tr>
<td>Bland NAU Ward</td>
<td>474</td>
<td>45%</td>
<td>97%</td>
</tr>
<tr>
<td>Level 3 Ward</td>
<td>380</td>
<td>43%</td>
<td>95%</td>
</tr>
<tr>
<td>:Female</td>
<td>335</td>
<td>57%</td>
<td>100%</td>
</tr>
<tr>
<td>Neurology Ward</td>
<td>319</td>
<td>45%</td>
<td>100%</td>
</tr>
<tr>
<td>Treated Ward</td>
<td>305</td>
<td>43%</td>
<td>90%</td>
</tr>
<tr>
<td>Wellbeing Ward</td>
<td>315</td>
<td>64%</td>
<td>96%</td>
</tr>
<tr>
<td>Seaford 3 (Medical Short Stay/Pall) Ward</td>
<td>250</td>
<td>65%</td>
<td>93%</td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>279</td>
<td>71%</td>
<td>90%</td>
</tr>
<tr>
<td>Macdonald Ward</td>
<td>217</td>
<td>56%</td>
<td>92%</td>
</tr>
<tr>
<td>Stroke Unit EDGh</td>
<td>261</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Cath Lab EDGh</td>
<td>245</td>
<td>24%</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Stents &amp; CCU</td>
<td>244</td>
<td>23%</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiology Ward</td>
<td>212</td>
<td>42%</td>
<td>94%</td>
</tr>
<tr>
<td>Bexley Ward</td>
<td>211</td>
<td>33%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

### Emotional support

Staff provided emotional support to patients to minimise their distress. The hospital had arrangements in place to provide support when needed, which included help from specialists such as end of life and dementia nurses.

The trust had a chaplaincy team, with access to all main to leaders of all main faiths as required and stated it was committed to respecting the diversity in culture and religion of all those in its care.

We spoke with a patient after she had been visited by the hospital chaplain and she told us how that she was happy to be able to discuss her faith and thoughts whilst being an inpatient.

Assessments were completed on all patients at admission but we also observed evidence within patient’s records of assessments frequently reassessed to ensure a patient receives appropriate care. This is in line with National Institute for Health and Care Excellence, QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. We observed staff talking to patient in regards to their daily care and listened to patient’s thoughts and wishes. Staff used the “This is me” dementia passport to help assess patients living with dementia. They involved family members in patients care and welcomed family members to stay and support dementia patients.

We saw poster displays in all medical areas identifying different coloured uniforms to recognise grades and specialities. All staff wore name badges and were heard introducing themselves to new patients.

Staff knew the patients on the ward and were seen talking at ease to relatives using first names. Family members we spoke with told us that they were happy about their relatives care and felt the nursing staff were caring. However, family and patients did recognise that staff were very busy and felt that the wards were short staffed.

We saw staff explaining patients care to them, we heard a nurse and healthcare assistant talking to a patient whilst helping them to wash. The staff member spoke in a caring manner explaining what they were doing and asking frequently if the patients was all right.

The wards had strong links with a local hospice, which gave out of hours support for staff and relatives.

Staff in the discharge lounge were keen to receive funding to make the lounge more comfortable and relaxing area for patients. We observed patients who did not have clothes to go home in wearing gowns and blankets. Staff within the lounge realised that this was not appropriate to maintain patients’ dignity and comfort and were keen to provide more suitable clothing for patients.

Is the service responsive?

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

The trust planned and provided services in a way that met the needs of local people. The medical services ensured flexibility, choice and continuity of care. Patients were admitted from their general practitioner, medical assessment unit or accident and emergency department.

The trust has a discharge lounge, which was open Monday to Friday 7am to 7.30pm. The nursing and medical teams with a multiagency approach managed complex discharges. We noticed that there were a number of patients who had been an inpatient for a number of weeks on the medical wards.

Staff highlighted that there were common issues with discharging elderly or frail patients back home or into the community and this is usually caused by the long waits to gain a social care package. One patient informed us “They can't find a carer for me to help with dressing and getting up, I could have gone home by now but the care package is not in place”.

However, staff informed us and we saw a thank you note from a patient’s mother in regarding the help and support of nursing and medical staff in the discharge of her son. The patient had been an inpatient for a number months and their discharge was complex with the importance of managing the patient’s pain identified.
The consultant and team travelled with the patient home to ensure that their pain was managed well throughout the journey.

A frailty nurse specialist team worked across the acute hospitals and community services to reduce the number of unnecessary admissions and to support patients who were best cared for in the community.

One of the occupational therapists developed a therapeutic garden for patients, which the therapists tended to at the weekends with her children and any volunteers.

Relatives of patients on end of life care are given free parking, open visiting and a room locally if required.

**Average length of stay**

**Eastbourne District General Hospital**

Between October 2016 and September 2017 the average length of stay for medical elective patients at Eastbourne District General Hospital was 2.9 days. This was better than the England average of 4.2 days.

Average length of stay for elective specialties:

- The average lengths of stay for elective patients in Gastroenterology and Cardiology were better than the England averages.
- The average length of stay for elective patients in Clinical Haematology was worse than the England average.

**Elective Average Length of Stay - Eastbourne District General Hospital**

![Bar chart showing average length of stay for different specialties compared to England average.](chart)

*Note: Top three specialties for specific trust based on count of activity.*

For medical non-elective patients, the average length of stay was 7.6 days, which was higher than England average of 6.6 days.

Average length of stay for non-elective specialties:

- The average length of stay for non-elective patients in General Medicine was higher than the England average.
- The average length of stay for non-elective patients in Cardiology was similar to the England average.
- The average length of stay for non-elective patients in Geriatric Medicine was higher than the England average.
Meeting people’s individual needs

The service took account of patients’ individual needs. We observed folders with information informing staff in regards to dementia and learning disabilities training, support information and details of dementia and learning disability lead nurses. There were also poster boards visible in the wards with information relating to dementia and the ‘This is me’ passport is used for patients living with dementia.

The trust used the butterfly scheme to support patients living with dementia. This scheme used butterfly symbol in the patient’s records. Staff are able to identify the patient has dementia or a memory related health issue and offer support from dementia leads.

Staffs use a care sheet to gain further information to support the patient. This is in accordance to National Institute of Clinical Excellence Quality Statement 5 statement nine: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.

We observed single sex bays in wards, however we were informed by matron in the coronary care unit (CCU) that this was not always possible in the recovery bay although the staff try the best they can to ensure dignity and privacy with curtains and the positioning of male/female beds.

We saw pictorial aides available for use with people with communication difficulties. Each bed had a call bell and within reach of the patient. We saw these being answered promptly by staff.

Throughout the hospital we saw leaflets and useful information on display to help patients and their relatives understand their conditions and the treatment options available. The printed information was only available in English. Staff told us that an interpreting service via language line was available for those patients who needed assistance.

A noise level monitor was observed on most medical wards following complaints from patients that the wards were too noisy at night. The monitor worked by flashing red when the noise became too loud. Nursing staff would then make an effort to reduce noise levels.

The ward corridors were spacious and clear and we observed mobility aids, handrails and hoists available in bathrooms and lavatories.
Rooms were well lit and supplied with sufficient equipment and furnishings. Corridors, treatment rooms and toilets were spacious with doors wide enough to fit wheelchairs. We saw good examples of clear direction signs utilising colour codes and symbols.

**Access and flow**

People could access the service when they needed it. Waiting times for treatment and arrangements to admit and treat patients were in line with best practice. However, some complex discharges were delayed due to delays in receiving care packages and an adult social care assessment.

Staff informed us that there were medical outliers within other wards. Outliers are patients admitted to wards outside of their speciality. However, we observed clinical staff having discussions around transferring patients. Patients where possible were moved back onto the ward suitable for their medical condition. Staff recognised and understood the risks with outlying patients in regards to staff and ward environment may not have the expertise to deal with a patient’s condition.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The performance of the trust was consistently better than the England average from December 2016 to November 2017.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Five specialties were better than the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.3%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>96.8%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>93.2%</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

None of the specialties were worse than England average for admitted RTT (percentage within 18 weeks).

(Source: NHS England)
Learning from complaints and concerns speak up guardians

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Staff confirmed that complaints were discussed within governance meetings, this information is disseminated in team meetings for information sharing and to discuss lessons learnt. We looked at a number of team meeting minutes and complaints folders, which showed information, had been shared with team members. Staff informed us they received feedback in regards to any complaints, following complaints from patients about noise levels at night, most of the wards had the noise level meter in place. Another complaint

Staff via the trust intranet could access the complaints policy. There was information observed on the ward and staff were aware on how to support patients or their families with making a complaint via the patient liaison and advice service. The patient liaison and advice service supported patients with concerns and complaints, they provided information about the NHS.

Summary of complaints

From November 2016 to October 2017 there were 129 complaints about medicine. The trust took an average of 47.9 days to investigate and close complaints. This was not in line with their complaints policy, which states the complaints process time lines are 30 days for non-complex cases and 45 days for complex cases.

Fifteen complaints remained open at the time of reporting and had been open for an average of 39.5 days.

The most common themes were:
- Standard of care – 59 complaints
- Communication – 28 complaints
- Discharge – 17 complaints

At Eastbourne District General Hospital there were 75 complaints. The most common themes were:
- Standard of care – 36 complaints
- Communication – 16 complaints
- Discharge – 10 complaints

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Overall, we found services were well-led. The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Strong, clear leadership seen. Staff said they felt well managed and well-led. Staff said matron and senior nurses were visible and supportive within the department, with the assistant director of nursing working across site. Staff felt valued, listened to and respected and felt confident to raise any concerns with their line managers.
All matrons we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their team faced in delivering good care. We also observed matrons working clinically within their teams and alongside the executive team. The trust have recognised the difficulties in matrons completing clinical and administrative work and there are now matrons assistants in post supporting with clerical side of the job such as training and collecting and collating data for clinical audits.

Staff generally spoke in positive terms about the visibility of the senior management team. They told us they had met the new director of nursing and most of those staff who had not met them aware of their name and responsibilities. They said they felt free to raise any issues with them directly or through their line manager.

Vision and Strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action. This was developed with involvement from staff, patients, and key groups representing the local community.

Through staff discussion and evidence provided in the trusts vision, the trust had a clear mission statement and vision for the future. The trusts vision is to combine community and hospital services to provide safe, compassionate, and high quality care to improve health and well being.

Staff were able to tell us what the trust values were and most carried a small card, which detailed the values.

The trust values were:

- Respect and compassion
- We care about acting with kindness
- Engagement and involvement
- We care about involving people in our planning and decision-making
- Improvement and development
- We care about striving to be the best
- Working together
- We care about building on everyone’s strength

The trust and department appeared clear as to what they wanted to achieve and we saw evidence of this through poster displays and other publications about the vision and values as we visited the wards. These were readily available for staff, patients and the public to view. In addition to information published for staff on the trust intranet, the trust published information about its mission, values and vision on its public website.

We found staff had a thorough understanding of the current values and they felt they were using the values within their practice, especially around promoting good leadership and good promotion of health and care for patients.

The trusts vision is to be an ‘outstanding’ organisation by 2020. They felt their vision, values and organisational priorities had been developed to support the achievement of this vision.
Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff felt there were a positive working culture and a good sense of teamwork. Managers spoke highly of the clinical and support staff that worked within the medical wards and they told us staff were flexible and highly motivated to provide a positive patient experience and the best patient care.

Staff we spoke with confirmed this and described in positive terms how they felt appreciated, supported and enjoyed their work, and spoke positively about the team working with medical and specialist support to provide care.

Staff said they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an “open culture” in which staff could raise concerns without fear.

Staff were aware of the speak up guardians and knew how to access the service. The trust developed a whistleblowing policy with human resources, speak up guardians and union representatives. As well as the policy, there were roadshows on acute sites.

Governance

The trust operated a divisional governance model and triumvirate working. This was a structure, which ensured that both clinicians and managers were involved in the management and planning of hospital activities at every level. The triumvirate model usually consisted of a lead clinician, a senior nurse and a manager. Each of the triumvirate leadership teams had responsibility for designated wards and departments.

Governance structures were in place to support the functions of medicine. There were clear reporting structures within outpatients and staff knew who to report to. Divisional governance meetings were conducted monthly to allow oversight of the service. Each triumvirate came together with all senior outpatient managers and clinical managers attending to report on finance, performance and governance.

Wards had team meetings and we observed evidence of team meeting minutes, however there was no formal period in place as to when meeting should be taking place and range from 4 to 8 weekly. However all wards and areas was observed to have safety huddles and ward rounds. Staff we spoke to knew their patients and were knowledgeable in the medical ward, which they were working on.

Matron and senior management informed us of monthly governance meetings, which took place and information from the meetings, were fed back through to staff via team meetings and within a governance newsletter.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

We found there were divisional risk registers in place. Managers we spoke with were aware of the risk registers and knew what the main risks were such as staffing and the actions needed to reduce the risks.

Nursing staff shared concerns with the level of staffing on most medical wards. Senior staff told us most wards have full establishment of staff at the start of a shift. However, staff are taken from the ward they are based in to work in other areas that do not have a full establishment and staff shortages.
Staff working in other areas was a concern with most staff we spoke with and felt that this put pressure onto staff working on the wards and departments as increasing risks to patients with complex medical needs due to the high patient to staff ratio.

**Information Management**

The trust collected, analysed, managed and used information well to support all its activities, with clear and effective arrangements in place using secure electronic systems with security safeguards.

The trust’s website provided safety and quality performance reports and links to other websites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.

Daily cleaning, fridge and room checks were observed to be used daily, signed and dated, and there was a clear reporting trail seen.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys and complaints.

The management team told us that any good ideas put forward by staff were discussed at weekly ward meetings and monthly team meetings. Useful suggestions and good ideas were then passed on to the clinical and quality boards. All the staff we spoke with felt informed and involved with the day-to-day running of the service and its strategic direction.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

We saw lots of innovation and enthusiasm when talking to staff. Eastbourne District Hospital was the first NHS hospital in Sussex and Kent to offer the UroLift System to treat an enlarged prostate. This minimally invasive treatment acts like curtain tiebacks to hold open the lobes of an enlarged prostate to create a channel from the bladder. Patients experience rapid symptom relief, recover from the procedure quickly. The procedure offers men an alternative to drug therapy or more invasive surgery.

The role of matrons’ assistant were introduced, was to reduce the time Matrons spend on administration and frees up their time for supervision of the ward and nursing staff. Matrons’ Assistants’ duties include ordering, typing and arranging training and appraisals.
Facts and data about this service

The outpatient department at Eastbourne District General Hospital (EDGH) is part of East Sussex Healthcare NHS Trust.

From October 2016 to September 2017 the trust had 419,410 first and follow up outpatient appointments. At EDGH there had been 221,093 appointments during this same period. Outpatient appointments are held in various locations across the site and within different divisions of the hospital. There are a range of consultant and nurse-led outpatient clinics across different specialties provided in the outpatients department. The general outpatient department core working hours are Monday to Friday 8.00am to 6.00pm. When required, clinics also ran on Tuesday, Wednesday and Thursday evenings and some Saturday mornings.

Information about the areas of the hospital that offer outpatient services are given below:

Outpatient A;
• General outpatients
• Women’s health
• Maxillofacial unit
• Blood tests

Outpatient B;
• Ophthalmology eye clinic

Outpatient B2;
• General outpatients

Outpatient D;
• Neurology
• Nutrition and dietetics
• Occupational therapy
• Physiotherapy
• Podiatry
• Rheumatology
• Speech and language therapy

Outpatient E;
• Dermatology

Speciality outpatients;
• Orthopaedic fracture clinic
• Ear, nose and throat clinic

During the announced inspection we visited all areas of outpatients. We met with 21 patients and two relatives. We met with 39 staff including; five matrons, two consultants, two middle grade
doctors, cancer pathway coordinators, specialist nurses, staff nurses, healthcare assistants, deputy heads of nursing, an improvement project lead, an associate director for operational improvement, head of clinical administration and reception and administration staff.

In addition we reviewed national data and performance information about the trust. We also reviewed a range of policies, procedures and other documents relating to operational delivery and development of the outpatient core service.

**Total number of appointments compared to England**

The trust had 419,410 first and follow up outpatient appointments from October 2016 to September 2017. The graph below represents how this compares to other trusts:

(Source: HES - Outpatient)

![Graph showing total number of appointments compared to England.](image)

**Number of appointments by site**

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from October 2016 to September 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne District General Hospital</td>
<td>221,093</td>
</tr>
<tr>
<td>Conquest Hospital</td>
<td>202,110</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>30,103</td>
</tr>
<tr>
<td>Uckfield Hospital</td>
<td>2,271</td>
</tr>
<tr>
<td>Site not recorded</td>
<td>631</td>
</tr>
<tr>
<td><strong>This Trust</strong></td>
<td><strong>457,191</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>103,794,079</strong></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments by site at the trust from October 2016 to September 2017:

**Number of appointments at East Sussex Healthcare NHS Trust from October 2016 to September 2017 by site and type of appointment**

![Graph showing appointment types]

The appointments categorised as unknown were not assigned a site by the trust.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills and areas and had processes in place to ensure all staff completed mandatory training that was appropriate to their role.

Mandatory training completion rates

The trust set a target of 90% for completion of all mandatory training with the exception of information governance which had a training target 95%. No target was provided for training on the Mental Health Act.

Medical and dental mandatory training data was not provided by the trust for outpatient services. They informed us that these staff are assigned to specific specialties.
Trust-wide

A breakdown of compliance for mandatory courses from November 2016 to October 2017 for nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>69</td>
<td>71</td>
<td>97.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>66</td>
<td>69</td>
<td>95.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>67</td>
<td>71</td>
<td>94.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>66</td>
<td>71</td>
<td>93.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>63</td>
<td>71</td>
<td>88.7%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>62</td>
<td>71</td>
<td>87.3%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>3</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by nursing staff in outpatients at the trust was 92.1%. This was better than the trust completion rate target of 90%. Nursing staff met the mandatory training target for five out of the seven modules. None of the three eligible members of nursing staff had completed Mental Health Act training, which had no trust target.

Eastbourne District General Hospital

A breakdown of compliance for mandatory courses from November 2016 to October 2017 for nursing staff in outpatients at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>28</td>
<td>30</td>
<td>93.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>BLS, ILS &amp; Resuscitation</td>
<td>28</td>
<td>30</td>
<td>93.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>27</td>
<td>30</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>27</td>
<td>30</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>27</td>
<td>30</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>25</td>
<td>30</td>
<td>83.3%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for nursing staff at Eastbourne District General Hospital was 89.6%. Nursing staff met the mandatory training target for five out of the seven modules. The one eligible member of nursing staff had not completed Mental Health Act training, which had no trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff received and had opportunities to complete mandatory training via face to face and online e-learning training sessions and modules. Staff told us they received the range of mandatory subjects as well as refresher sessions and ongoing discussions around these subjects as part of their day to day work. For example, we observed staff discussing health and safety as part of their daily huddle meeting.
There was a system in place to track and monitor staff training. A training matrix held by the Matron’s assistant showed that close monitoring of mandatory training was undertaken within the department. A traffic light system was in use to highlight where staff had completed training, where training was due and where staff were behind on certain subjects.

Staff knew how to access online training and the process for booking face to face sessions. They could access up to date information on their own training and received reminders of when training was due. Managers received reports and followed occasions where staff did not attend training courses they were booked onto.

**Safeguarding**

The outpatient service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The trust set a target of 90% for completion of safeguarding training. The overall safeguarding training completion rate for nursing staff in outpatients at the trust was 97.5%. Nursing staff met all four safeguarding module targets.

Medical and dental safeguarding training data was not provided by the trust for outpatient services. They informed us that these staff were assigned to specific specialties.

**Trust-wide**

A breakdown of compliance for safeguarding courses from November 2016 to October 2017 for nursing staff in outpatients at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Sum of Completion</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>71</td>
<td>71</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>71</td>
<td>71</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>69</td>
<td>71</td>
<td>97.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>66</td>
<td>71</td>
<td>93.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Eastbourne District General Hospital**

A breakdown of compliance for safeguarding courses from November 2016 to October 2017 for nursing staff in outpatients at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Sum of Completion</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults L1</td>
<td>30</td>
<td>30</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>30</td>
<td>30</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults L2</td>
<td>29</td>
<td>30</td>
<td>96.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children L2</td>
<td>28</td>
<td>30</td>
<td>93.3%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for nursing staff in outpatients at Eastbourne District General Hospital was 97.5%. Nursing staff met all four safeguarding module targets.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Level 1 and 2 safeguarding training covered areas such as Female Genital Mutilation (FGM), fabricated or induced illness (FII), domestic violence, child sexual exploitation (CSE) and abuse.

There were no records of level 3 safeguarding children training for nursing staff working in the outpatient department. It was trust policy that staff with children on their caseloads receive safeguarding children level 3 training. We spoke with two nurses, one working in the fracture clinic and one in ophthalmology outpatients who told us they regularly saw children but had not received level 3 training. This was not in line with Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014). There was a trust wide named nurse for safeguarding children who staff could contact for support or advice, if necessary.

Safeguarding policies and procedures were available to staff on the intranet. The Director of Nursing was the trust board lead for safeguarding children and adults. The trust had a safeguarding team of specialist nurses and staff we spoke with were aware of who to contact should a safeguarding concern arise. There was clear guidance on staff responsibilities and staff we spoke with understood their role in relation to this. Staff shared an example of an adult safeguarding concern that was identified by a member of the nursing team where a referral was made to ensure the patient received the support they needed at home. In addition we were given an example of a child safeguarding concern that was escalated to the safeguarding team where the child had not attended their outpatient appointment in the ear, nose and throat (ENT) clinic on more than one occasion.

Staff had access to the NHS Safeguarding App which provided a resource on safeguarding issues including their responsibilities, as well information on areas of safeguarding such as FGM and deprivation of liberty safeguards (DoLS). Staff also had access to Government Multiagency guidelines and the Pan Sussex Local Safeguarding Children's Boards (LSCB) Procedures. Safeguarding issues were discussed in the daily outpatient huddles and we were told that huddles were used to extend learning from mandatory training.

On discussion staff demonstrated an understanding and awareness of safeguarding concerns and situations where these might arise. There were guidelines and policies available on the intranet around caring for patients who may be vulnerable; for example, those with mental ill health, learning disabilities and dementia. Specialist nurses were available to support patients and staff in these situations and staff were aware of how to access this support.

**Cleanliness, infection control and hygiene**

There were systems and processes in place to prevent and control infection. Staff kept the environment, equipment and premises clean. Standards of cleanliness across the department were maintained, with reliable systems in place to prevent healthcare associated infections.

Infection control policies were available on the intranet and in a folder in the treatment room in the outpatient department. Policies and procedures had all been reviewed and included areas of infection control such as decontamination, hand hygiene, cross infection, universal precautions and cleaning of equipment.

We observed cleaning schedules in place throughout the department. All areas we visited were visibly clean and tidy and there were thorough infection prevention and control processes in place. Cleaning schedules were signed by domestic staff when completed in each area. Clinic rooms had ‘I am clean’ notices on the doors to indicate that the rooms had been cleaned prior to use. We also saw signed records of weekly flushing of infrequently used water outlets in line with control measures to manage the risk of legionella within the water system.

We observed staff following trust policy on infection control. For example, staff with long hair had tied it back and all staff were ‘bare below the elbows’ at all times to enable effective hand washing and minimise the risk of contamination. We observed staff following NICE QS61:
Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. We saw the results of hand hygiene audits displayed in all outpatient clinics completed in February 2018, which all showed 100% compliance.

Alcohol hand sanitiser was seen throughout the department and at all entrances. There were clear instructions for patients, staff and visitors to use the sanitiser in order to reduce the risk and spread of infection. Posters were in place, encouraging people to use the hand sanitiser and we observed staff using this in practice when entering and exiting the department.

There was sufficient personal protective equipment (PPE) available in line with trust policy. There were sufficient hand washing facilities in place with sinks with lever arch taps available in clinical/treatment areas. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap, hand towels and hot water were available next to hand basins to facilitate effective hand washing. Information was displayed by hand washing sinks, demonstrating the World Health Organisation (WHO) guidance (2009) ‘Five moments for hand hygiene’.

We saw infection control and cleaning audits for all areas of outpatients. Cleaning audits were in line with national specifications for cleanliness. Scores for cleaning audits showed high levels of compliance, with all general outpatient areas visited on inspection achieving a score of above 96% compliance. We observed all disposable curtains in treatment areas had been changed in the last six months in line with trust policy.

We spoke with staff in women’s health and ophthalmology clinics who were able to describe a process of decontamination of reusable medical equipment in accordance with Department of Health Decontamination of surgical instruments (CFPP 01-01) (chapter 6) and trust policy. We observed appropriately labelled and packaged equipment waiting to be collected for decontamination by the central sterile services department (CSSD).

not overfilled. Sharps bins had completed labels with the date they were assembled and relevant staff signatures. Sharps bins were available in treatment rooms and areas where sharps may be used. Sharps bins were not overfilled and were managed in line with Health and Safety Regulations 2013 (the sharps regulations), 5 (1) d. This requires that appropriate and secure sharps containers for the safe disposal of medical sharps, be placed close to the work area where sharps are being used.

Environment and equipment
The outpatient service was provided from suitable premises with appropriate equipment available. Staff told us that a lack of space sometimes impacted on their ability to effectively manage clinics, for example, in ophthalmology outpatients. We saw that this issue was being addressed alongside other concerns through an outpatient improvement programme. In addition, we were told that a business plan was being developed to address capacity issues in the early pregnancy assessment unit of the women’s health clinic.

Resuscitation trolleys were available in all areas of the outpatient department. One trolley kept in the main outpatient waiting area (outpatient A and B) was shared between general outpatients, ophthalmology outpatients and maxillofacial outpatients. Other resuscitation trolleys were kept in the women’s health clinic, outpatient D and outpatient E areas. We checked three resuscitation trolleys and found that these were subject to regular checks. All resuscitation consumables were in date and checks were clearly recorded, signed and dated.

Medical devices maintenance was carried out by the in-house Electronics and Medical Engineering team. We saw that the department scheduled planned maintenance and contracts with original equipment manufacturers where appropriate. Medical devices were registered to an equipment management database where planned maintenance work was scheduled based on
individual equipment requirements. Medical devices were risk rated and subject to regular safety and maintenance checks that reflected equipment needs and priorities. We reviewed six items of equipment in the outpatient department and found that all had evidence of safety checks and identification logs recorded.

Assessing and responding to patient risk
Systems and processes were in place to assess, monitor and manage risks to patients. Staff had a good understanding of how to respond to risk and had clear pathways and processes to follow, including the use of urgent referrals if required.

Staff recognised incidents and reported them appropriately. We were given examples of incidents that had been reported via the electronic reporting system, such as staffing shortages, clinic cancellations and individual patient incidents.

There were clear processes in place to check the identity of patients, including their name, address and date of birth. We observed staff checking patient details in order to verify their identity, ensuring accurate information was obtained and patient safety was a priority. The trust used the World Health Organisation (WHO) five steps to safer surgery, surgical safety checklist. The checklist was designed as a safety measure to improve the safety of patients undergoing a surgical procedure, including those under a local anaesthetic. The checklists were subject to regular audit to ensure all steps were followed appropriately.

Staff were trained to recognise patients with deteriorating health. We observed clinic staff providing extra support to patients who were unwell or frail. Reception staff told us they would receive support from the matron and other staff if they had particular concerns about a deteriorating patient. We observed nursing staff monitoring the waiting areas on a regular basis and were told that this was to identify patients who were unwell or may need additional support.

The trust had a management of sepsis policy in place and staff had access to sepsis tools and protocols. Incidents of sepsis were recorded on the electronic incident reporting system and reviewed by the clinical improvement team to identify and share learning. Staff we spoke with in outpatients told us they had been involved in discussions about sepsis and were aware of the signs and symptoms.

Staff had a good understanding of referral pathways used in situations where patients were displaying signs of mental ill health. They had access to an on-call psychiatrist and a psychiatric liaison team. Emergency buzzers were available in treatment rooms and other areas of the department. We observed staff responding quickly and appropriately when an alarm was set off during our inspection.

Nurse staffing
The trust reported the following nurse staffing numbers in outpatients by site as of October 2017:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual WTE Staff</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexhill Hospital</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Conquest Hospital</td>
<td>23</td>
<td>28</td>
</tr>
<tr>
<td>Crowborough War Memorial Hospital</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>Lewes Victoria Hospital</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Uckfield Hospital</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>62</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)
Staffing levels and skill mix were planned, based on the number of clinics and patients attending. The trust’s safer staffing acuity tool was used to establish, review and manage staffing in line with patient dependency. This tool was reviewed in real time several times a day in order to monitor staffing against patient need. Nursing staff provided support to each clinic run within the department.

Senior staff told us that generally they did not use agency staff within the general outpatients department. There was a matron, two nursing sisters, ten staff nurses, 18 healthcare assistants, a cardiac technician and an administrator. The department had two regular bank nurses and two bank healthcare assistants who supported the team and provided cover for leave and other staff shortages. All permanent and bank staff had been through the trust induction programme and a local induction within the department was also undertaken. We saw evidence of competency assessments being carried out.

Staff told us there had been some staffing difficulties in outpatients. We were told that in ophthalmology outpatients there had been difficulties recruiting band 5 staff nurses which, together with some staffing sickness had led to additional pressure on staff. We saw that this was an area for development in line with the outpatient improvement programme. One particular strategy for addressing this staff shortage included recruiting band 4 associate practitioners to extended roles. Competency packages had been implemented to facilitate the development of the role.

We saw that staff moved across departments to provide cover. For example, an absence in the women’s health clinic had been covered by a new nurse with support from a midwife to ensure that the clinic still ran. Staff told us that any difficulties with staffing cover leading to clinic cancellations or where staff felt concerned about patient safety were reported as incidents via the electronic incident reporting system.

Vacancy rates

From November 2016 to October 2017, the trust reported a trust-wide vacancy rate of 6% for nursing staff in outpatients, which was lower than the target of 10%.

For Eastbourne District General Hospital, the vacancy rate was 11% over the same time period.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, the trust reported a trust-wide turnover rate of 8% for nursing staff in outpatients, which was lower than the target of 10%:

For Eastbourne District General Hospital, the turnover rate was 11% over the same time period.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, the trust reported a trust-wide sickness rate of 6% in outpatients, which was higher than the target of 3.3%:

For Eastbourne District General Hospital, the sickness rate was 5% over the same time period.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and agency staff usage

From November 2016 to October 2017, the trust reported a bank and agency shift total of 1,950 in outpatients (1,940 bank and 10 agency). There were 153 shifts not filled by bank or agency staff.

Please note that we were unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

Senior staff told us they did not use agency staff in outpatients, using bank staff instead. Bank usage was done with regular bank staff who had been provided with an outpatient induction and worked regularly in the department.

A breakdown of bank and agency usage at Eastbourne District General Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/ agency</th>
<th>Healthcare Assistant</th>
<th>Registered nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Bank</td>
<td>450</td>
<td>375</td>
<td>825</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>20</td>
<td>10</td>
<td>30</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Medical staffing was provided by the specialities responsible for delivering the clinics in outpatients. Examples of these specialities included ENT, ophthalmology, neurology, haematology, cardiology, urology, dermatology and women's health. There are no national standards for medical staffing in outpatients. Consultants staffed their own clinics and did not report to the outpatient department.

(Source: Routine Provider Information Request (RPIR))

Records

The percentage of patients seen in outpatients without their full medical record being available was 1.6%. The trust had a clinical information system which was used in addition to the paper health records and contained all key documentation and access to diagnostics results.

The trust had implemented an administrative service improvement programme that included health records. This programme had included the centralisation of all health records, the implementation of a radio frequency location based record tracking system and the implementation of an electronic document management system (EDM). At the time of inspection we were told that all health records with the exception of cardiology and paediatric records had been scanned onto the electronic system. The transfer of cardiology and paediatric records was due to be completed in April 2018. The EDM was used alongside the clinical information system and was accessible to more than one health professional at a time. Records made during clinics and consultations were scanned onto the EDM within 48 hours.

We saw that paper records in the form of ‘day forward packs’ were stored securely in the outpatients department in locked trolleys prior to the start of the clinic. Electronic records were password protected.
We spoke with a haematology consultant and registrar about the new electronic system. They told us that the system had improved the service and the availability of health records. They could not recall episodes of cancelled clinic appointments as a result of a lack of health records since the system had been implemented.

In June 2017 the trust had invested in advanced voice recognition software in relation to medical transcription in order to improve the quality and speed of communication with GPs and other professionals. We were told that GP letters were typed off site, then returned for signing and to be sent out.

Medicines

Medicines in outpatients were managed safely. There were records of regular checks of medicines stock, both by nursing staff and by pharmacy staff. Nurses checked the expiry dates of all stock items and daily fridge and room temperature checks were carried out to ensure that medicines were stored at the correct temperature. FP10 prescription pads and forms were stored securely with serial numbers recorded so that all forms could be tracked throughout the department. Treatment rooms were locked and accessible only through use of a key pad. All medicines were locked securely at the time of our inspection. Emergency medicines were stored securely and frequent checks were undertaken and recorded to ensure these medicines were available and safe to use.

Patient Group Directions (PGDs) were available electronically for use by nursing staff in some clinic areas including ophthalmology. These were appropriately recorded and signed in line with legislation.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in outpatients which met the reporting criteria set by NHS England from December 2016 to November 2017.

This incident, which occurred in Ophthalmology outpatients, was categorised as a treatment delay meeting SI criteria and led to some permanent vision loss. It occurred in December 2016 at Conquest hospital.

(Source: Strategic Executive Information System (STEIS))

We reviewed a report of the ophthalmology SI and saw that analysis of the root cause of the incident had been undertaken. As a result changes in practice had been implemented. These included a review of referral procedures, the introduction of a minor eye condition triage and treatment clinic, a pro-forma for use in Accident and Emergency (A&E) and the appointment of a
primary care ophthalmology consultant to lead on initiatives and upskill non-medical staff in ophthalmology and A&E. The incident was shared at a department governance meeting in order to learn and disseminate lessons as a result.

Staff understood their responsibilities to raise concerns, record and report incidents. There were electronic reporting systems to allow staff to report incidents. Staff were encouraged to complete an incident report form and knew how to access the system. Staff told us they were provided with feedback following an incident report and that learning from incidents to improve safety was shared across areas via huddles and directorate governance meetings.

Incidents and risk were shared within governance/quality audit meetings as well as daily staff huddles. In ophthalmology we were told of incidents relating to episodes of ophthalmitis following eye injections that had occurred within another hospital in the trust. As a result practice was reviewed across the whole trust and protocols developed to reduce the incidence of this type of infection. Specific action included the introduction of theatre scrubs and hats and not opening the clinical waste bin while the patient was still in the room.

Duty of candour is a regulated activity which outlines openness and transparency and requires providers of health and social care services to notify patients, carers or families of notifiable safety incidents and provide reasonable support to that person. There were no incidents of duty of candour reported which required a response in line with Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014. Staff could explain duty of candour and were able to give us examples of when they had contacted patients to apologise following delayed or cancelled clinics.

**Major Incidents**

Business continuity plans were in place that covered the outpatients department, including the use of back-up systems for computer held data and cross site working.

A major incident plan was in place across the trust which included the use of the outpatients department to provide clinical care in the event of an incident. Staff told us that an incident relating to members of the public exposed to a noxious substance at a local attraction had resulted in ophthalmology staff being contacted to provide care and treatment for patients experiencing eye irritation. As a result of this incident the major incident plan was reviewed to ensure ophthalmology staff were included as routine contacts in the event of a major incident.

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harm and their elimination. Data from the Patient Safety Thermometer records new pressure ulcers, falls with harm and new catheter urinary tract infections. We did not see Safety Thermometer data on display within the outpatient department and were told that any safety information would be reported under each divisional structure. However, falls and other safety incidents were reported through the electronic reporting system and feedback received in order to improve safety.

**Is the service effective?**

**Evidence-based care and treatment**

In outpatients, staff delivered patient care in line with evidence based care and best practice guidelines. Staff had access to relevant trust policies and national guidelines to support them to deliver patient care and told us that they knew how to access them.

The identification and implementation of relevant National Institute for Health Care and Excellence (NICE) guidelines was appropriately managed across the trust and clinical divisions. NICE guidelines were distributed by the clinical effectiveness team to each division on a monthly
basis for a review of applicability and compliance as appropriate. Action plans were then produced and tracked by the clinical effectiveness team and progress was monitored via divisional governance meetings.

Staff we spoke with were knowledgeable about NICE guidance within their clinical areas. For example, staff working in the fracture clinic demonstrated a comprehensive understanding of the pathway for preventing falls in older people.

We were told by staff that bi-monthly audit/governance meetings were held across each division and speciality within the trust. General outpatient staff were included in the medicine division governance meetings. Staff in ophthalmology told us that all staff working in the ophthalmology department would attend the speciality governance meeting where possible and that discussions included a review of national guidance and performance. Records seen confirmed these meetings were held as planned.

Both national and local clinical audits were undertaken to assess compliance against NICE clinical guidance and were led by division. For example, a Parkinson’s specialist nurse undertaking a clinic in general outpatients told us they had been involved in the Parkinson’s national audit. The audit focused on a review of physiotherapy, occupational therapy and speech and language therapy pathways for patients with Parkinson’s disease. The audit involved a review of patient records, visits and consultations and a patient questionnaire. 2017 results were not yet available but 2016 results were positive and demonstrated a high level of compliance against NICE Parkinson’s quality standard (QS164).

Staff working in the women’s health clinic had participated in a national audit for patients experiencing overactive bladder symptoms. Results were comparable to the national average. Key actions resulting from the audit included improving the procedure for the completion of forms for patients’ self-assessment of their symptoms.

In ophthalmology we were told that audits were used as part of an outpatient improvement programme. For example, audits had been undertaken to review clinic timings in order to improve clinic access and patient outcomes.

The department did not participate in the Improving Quality in Physiological Services (IQIPS) accreditation scheme. This scheme is a professionally-led assessment and accreditation scheme designed to help healthcare organisations ensure that patients receive consistently high quality services in safe environments.

**Nutrition and hydration**

Refreshments were available from a vending machine and water dispensers which were located in some areas within the department. Patients waiting in ophthalmology could access the facilities in the main outpatient area. Ophthalmology staff told us that at times when demand was high, such as during hot weather, they would also supply jugs of water.

Staff told us that patients who had been waiting in the department for any length of time would be offered refreshments by staff. We saw notices to this effect in outpatient area E where patients were told to ask reception staff for refreshments if there were delays within the department.

There were dietetics clinics providing dietary advice. For example, we spoke with one patient who had previously attended a dietetic appointment following a diagnosis of gestational diabetes and who was supported to ensure optimum nutrition for an enduring and healthy pregnancy.

The Speech and Language Team offered support and were available to supply information for patients with swallowing difficulty.
Pain relief

As part of the outpatient assessment processes staff told us they would assess patient’s pain level as appropriate depending on their condition, symptoms or procedures they were having done. Staff told us that pain assessment tools were available on the intranet, including those for patients with learning disabilities or those with dementia.

Stocks of simple analgesia such as paracetamol and non-steroidal anti-inflammatory medicines were available in general outpatients. Staff told us that if a patient was in pain they were assessed and a one-off prescription was issued by a medical practitioner and appropriate analgesia supplied.

Patient outcomes

Outpatient services had processes in place to record patient outcomes after each clinic appointment. The service used an outcome box which medical staff completed at the end of each appointment. The outcome recorded whether the patient required another appointment and whether this should be with a consultant, middle grade or junior doctor, nurse or allied health professional. Other outcomes recorded included blood tests, scans, further investigations or discharge and were used to monitor patient follow up from consultation.

Across the trust patient outcomes were developed through division outcome reports and the clinical outcomes group activity. There were identified outcomes in place for different specialties, some relating to local and national audits. Patient outcomes specific to outpatients were not developed as the outpatient department provided multiple outpatient clinics and services across a number of divisions and specialties.

Follow-up to new rate

From October 2016 to September 2017:

- The follow-up to new rate for Bexhill Hospital was better than the England average.
- The follow-up to new rates for both Conquest Hospital and Eastbourne District General Hospital were similar to the England average.
- The follow-up to new rate for Uckfield Hospital was worse than the England average.
- The follow-up to new rate for appointments which were not assigned a site by the trust (designated as unknown in the chart) was better than the England average.
Follow-up to new rate

(Source: Hospital Episode Statistics)

The trust participated in a national benchmarking programme for outpatient departments in 2017. Results were published in March 2018 and at the time of inspection were under review by the trust in order to incorporate into the outpatient improvement programme with a focus on improving patient outcomes and experience.

Competent staff

Appraisal rates

This staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Appraisal data was not provided by the trust for medical and dental staff in outpatient services. They informed us that these staff were assigned to specific specialties.
Trust-wide

From April 2016 to March 2017, 70% of staff within outpatients at the trust had received an appraisal compared to a trust target of 90%. In 2017/18 year to date, 74.8% of staff within outpatients at the trust had received an appraisal. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>56</td>
<td>72</td>
<td>77.8%</td>
<td>43</td>
<td>53</td>
<td>81.1%</td>
</tr>
<tr>
<td>Nursing Registered</td>
<td>52</td>
<td>70</td>
<td>74.3%</td>
<td>28</td>
<td>41</td>
<td>68.3%</td>
</tr>
<tr>
<td>Additional Professional Scientific and Technical</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>4</td>
<td>7</td>
<td>57.1%</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>17</td>
<td>34</td>
<td>50.0%</td>
<td>19</td>
<td>29</td>
<td>65.5%</td>
</tr>
</tbody>
</table>

Eastbourne District General Hospital

From April 2016 to March 2017, 66.7% of staff within outpatients at the hospital had received an appraisal compared to a trust target of 90%. In 2017/18 year to date, 67.4% of staff within outpatients at the hospital had received an appraisal. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals completed 2016/17</th>
<th>Eligible staff 2016/17</th>
<th>Appraisal rate 2016/17</th>
<th>Appraisals completed YTD</th>
<th>Eligible staff YTD</th>
<th>Appraisal rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Scientists</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>27</td>
<td>32</td>
<td>84.4%</td>
<td>10</td>
<td>16</td>
<td>62.5%</td>
</tr>
<tr>
<td>Additional Professional Scientific and Technical</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td>Nursing and Registered</td>
<td>15</td>
<td>28</td>
<td>53.6%</td>
<td>8</td>
<td>15</td>
<td>53.3%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>3</td>
<td>8</td>
<td>37.5%</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The outpatient department operated a cascade system of appraisal where Band 7 and Band 6 staff undertook the appraisals of more junior staff. Senior staff told us that appraisal rates had been impacted by staffing shortages in 2016/17, in particular relating to some long term staff absences. We were told that efforts had been made to ensure that all staff had an appraisal.
completed for the current year. Appraisal figures were updated centrally and data provided by the outpatient matron during inspection showed that 95% of outpatient staff had received an appraisal in the last year. Staff we spoke with confirmed they had received an appraisal in the last year.

We saw evidence of competency assessments in operation within the outpatient department and specialist clinics. For example, healthcare assistants working in urology ‘stop and flow’ clinics had received training and competency assessments in undertaking bladder scans.

In ophthalmology outpatients competency packages were in place for healthcare assistants performing optical coherence tomography and instil eye drops for diagnostics. There were nurse led clinics for a number of procedures including Botox injections, removal of sutures and lacrimal syringing. We viewed examples of training and competency packages in place to facilitate this. The ophthalmology matron told us that competency assessments for healthcare assistants were usually undertaken following ten episodes of observed practice and until the staff member was signed off as competent.

In women’s health, staff told us they had been supported by the trust to attend specialist training. For example, one nurse specialist we spoke with told us they had attended a two day obstetrics and gynaecology training course, as well as colposcopy and cervical pathology training.

In general outpatients, training requirements were managed by the matron’s assistant. Nursing staff received a combination of training and supervised practice to facilitate their development in nurse-led clinics.

Link nurses and health care assistants enabled clinical areas to keep up to date with key changes in practice in areas such as infection control and dementia.

**Multidisciplinary working**

There were one stop clinics in specialities such as minor lesions, banding of haemorrhoids and urology stop and flow clinics which were run by multidisciplinary teams. In addition one stop clinics for ophthalmology were in development as part of the outpatient improvement programme.

We were told that weekly oncology multidisciplinary meetings for the major tumour groups included oncologists, radiologists, surgeons, physicians, nurses, histopathologists and pathway coordinators. Meetings included colorectal cancer, haematology (leukaemia and lymphomas), urology, breast cancer, lung cancer, upper GI cancer and gynaecological cancers. Additionally, weekly multidisciplinary meetings were held to review cancer patients referred late in the pathway from tertiary centres, or where patient choice was impacting on treatment. We were told that treatment and cancer wait times were discussed at these multidisciplinary meetings.

We observed episodes of multidisciplinary working in outpatient clinics where specialist staff worked together to provide care for patients. For example, in women’s health we saw a midwife provided support to a nurse who was new to the team during an early pregnancy assessment clinic.

**Seven-day services**

General outpatient clinics were in operation between 8.00am and 6.00pm Monday to Friday. In addition the department also provided evening clinics on a Tuesday, Wednesday and Thursday and on a Saturday morning when the need arose and staffing allowed.

Additional weekend clinics were in operation periodically in ophthalmology outpatients in order to improve referral to treatment times. This included the use of an external 18 week team of specialists who would run clinics out of hours where backlogs and longer wait times were present.
Health Promotion

There was educational literature for patients, placed around different parts of the outpatient department. Information based on national guidance and best practice was provided by clinics and in many cases was given to patients as part of their consultation.

Specific health promotion material we saw placed in waiting areas around the clinics included advice and signposting information relating to different conditions. For example there were comprehensive patient and carer resources for dementia, cancer and other long term health conditions. We saw information for patients on how to access advice and support for stopping smoking.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mental Capacity Act and Deprivation of Liberty training completion

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) training. Deprivation of Liberty training completion was not reported by the trust.

Medical and dental training data was not provided by the trust for outpatient services. They informed us that these staff were assigned to specific specialties.

Trust-wide

The trust reported that, from November 2016 to October 2017, MCA training had been completed by 93.5% of all staff within outpatients. All 71 nursing staff within outpatients at the trust had completed this training.

Eastbourne District General Hospital

The trust reported that from November 2016 October 2017, MCA training had been completed by 94.0% of staff within outpatients at Eastbourne District General Hospital. All 30 nursing staff within outpatients at the hospital had completed this training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with demonstrated a good understanding of mental capacity issues and how this impacted on patient care within the department. We were given examples of how patients were supported when they did not have capacity to make decisions for themselves. For example, staff in women’s health had been involved in best interest decision making for a patient who had been assessed as lacking mental capacity to make decisions about their health. Staff attended best interest multidisciplinary meetings to support the process of decision making. Where a patient was unable to consent to a procedure, a mental capacity assessment would be undertaken. Staff used assessment forms that were decision specific where information was recorded such as triggers for the decision, the nature of the decision, key roles of people consulted about the decision and determination of capacity.

Is the service caring?

Compassionate care

People were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who are close to them and stakeholders was positive about the way staff treated people.
Staff understood and took into account people’s personal, cultural, social and religious needs. The appointment list at the reception area in the main outpatient waiting area highlighted people’s needs. For example, there were records of patients who were hard of hearing, blind or required an interpreter. It also included a record of additional medical needs, such as diabetes, that would require monitoring. We also witnessed staff identifying themselves, asking patients if they were well and if they needed help with anything when being collected from waiting areas. This is in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

Staff interacted with patients and those close to them in a timely, respectful and considerate manner. Patients throughout the outpatients department consistently reported that staff were kind and respectful and that the service offered was good. We witnessed staff stepping aside to make space for people with mobility difficulties and asking if they needed help. Volunteers and staff at the hospital provided support and advice to patients and their families whilst using the automated check-in service or if they were unsure where they had to go.

Staff were sensitive and supportive towards people using their services and those close to them. Patients reported: “I feel that if I need to I can talk to someone privately”, “Staff were clear and explained everything at each appointment” and “reception was sensitive to my needs when I needed to change an appointment date”. We witnessed a patient with learning difficulties become anxious and agitated in the waiting area. When assistance was asked a specialist learning disability nurse spoke with the patient and spent time with them in a calm and gentle manner. The patient and their family were taken to a quite area to be seen to and to help manage the patient’s anxiety. This was well managed and done in a sensitive and respectful manner.

Staff understood and gave good examples of how they would raise concerns about disrespectful, discriminatory or abusive behaviour. Staff were familiar with safeguarding policies and conflict resolution procedures. Staff had been trained in dealing with conflict. Staff said they would use side rooms to assist in managing any issues where privacy was needed. Staff were mindful of the impact of situations on other patients waiting in the department.

Staff ensured people’s privacy and dignity was always respected. Outpatient appointment letters explained what the appointment was for, what time and date it was happening and what the procedure consisted of. In the appointment letter, there was a contact number to ensure any queries or personal preferences may be addressed prior to the appointment. During each appointment, a nurse or healthcare assistant accompanied the patient and acted as their advocate during appointments. The trust’s chaperone policy set out the requirement for all patients to have access to a chaperone of the same sex if required. Nurses or healthcare assistants acted as chaperones when necessary. Where a patient had a personal preference with regards to the sex of the person that was accompanying or examining them staff would make every effort to accommodate the patient’s request.

Dignity shorts were available in the outpatient rooms. These allowed patients to remain covered until bowel examinations took place when a small secured patch on the rear could be lowered leaving the patient’s genitals covered.

Staff demonstrated the need to respond in a compassionate, timely and appropriate way to people’s experience of physical pain, discomfort or emotional distress. In outpatient areas A, B, B1 there was a treatment room with pressure relieving equipment, both sitting and lying to accommodate patients with significant pain or mobility issues that required specialist equipment. Patients with a life changing diagnosis were offered specialist support from trained nurses as well as a physical space to address their emotional needs. This was in line with NICE QS15 Statement
2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

Staff conducted consultations in closed rooms and knocked on the doors prior to entering. Patients were able to speak to receptionists without being overheard and confidentiality was respected at all times. The chaperone service offered at the outpatients department guaranteed that any sensitive or confidential information could be discussed with the patient and their family following an appointment in a private space. Specialist nurses were also available for support with bad news diagnoses. In addition, staff at the ear, nose and throat (ENT) outpatient service tried to ensure that the same doctor always saw the same patients for consistency of care.

The NHS friends and family test is a nationwide initiative to gain feedback from patients about the care and treatment they receive in hospital. Patients were asked whether they would recommend NHS services to their friends and family if they needed similar care or treatment. We reviewed the NHS friends and family test results for outpatient services from October 2017 to December 2017. Results from this reporting period showed that 97.0% of respondents would recommend the service they had to family and friends who may need similar treatment or care. This was above the average result of 95.1% for the same period the year before and a significant improvements from previous inspections.

**Emotional support**

People who used outpatient services and those close to them were involved as partners in their care. Staff spent time talking to people and those close to them to involve them as partners in care.

Staff communicated well with people so they understood their care, treatment and condition. A healthcare assistant or nurse was present with patients during their appointments. This ensured that the patient had an advocate during their appointment, that notes were kept up to date and checked for completion and that any information given during consultation could be repeated to the patient or family outside of the appointment. In the ENT, audiology and respiratory outpatient department the matron stated she asks all staff to question patients if they understood all that was said during consultation and if they had a follow up plan to their appointment.

Quiet rooms were made available if a patient were distressed or a space was needed to support a patient being told bad news.

Patients reported they felt appropriately advised and aware of their diagnosis as well as their treatment plans. They had time and the opportunity to talk to staff about any concerns or treatment options. This was in line with NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Patients said they received copies of letters between the hospital and their GP’s. Patients told us after their appointments they were given a contact number to call if they had questions and were also given contact numbers and leaflets to access services outside the hospital that could support their condition or treatment needs.

Staff spent time talking to people or those close to them before, during and after consultation. They would ask if any further information was required and would provide leaflets and further advice and information about treatment options if requested or needed. Staff would use and update patients’ notes to identify any additional support needed. An example of this was the use of the “Butterfly scheme” were a butterfly sticker would be placed on patients notes to identify people with dementia or memory problems.
Feedback from the Friends and Family tests throughout outpatient services was good and patients we spoke to were happy with the staff and the care and treatment provided.

Understanding and involvement of patients and those close to them

Staff. People were enabled to manage their health and care when they could. People received the support they need to cope emotionally with their care, treatment or condition. This is in line with NICE QS15 Statement 10): Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

Staff were attentive towards patients’ needs and understood the impact that a person’s treatment and condition could have on their wellbeing as well as those close to them. Reception staff told us they would always look to see if someone was feeling vulnerable or alone or if coming out of an appointment they were unwell. This would then be escalated to a healthcare assistant or nurse so they could determine what was affecting the patients well-being. Volunteer staff also reported that if they noticed a patient or family member distressed or becoming anxious they would feel comfortable raising this with staff.

Staff working in outpatient services such as women’s health and general medicine clinics said that potentially complicated appointments would be made during times when staff were able to provide support. For example, longer appointments were given to allow time to explain to patients and families their condition as well as supporting them when giving bad news.

Staff supported people and those close to them to manage their emotional response to their care and treatment. Information was given to patients in leaflet format to support the information shared with them during their consultation. For example, in the maxillofacial outpatient clinic provided leaflets about skin care and post-operative care to support their patients and families. In addition, a noticeboard in the reception area provided information about general skin care. To help children understand procedures and cope with potential fears, the service would demonstrate and let children take materials such as impression trays home so they could familiarise themselves with them.

Staff were aware that patients could stop treatment despite initial consent. Staff supported patients to make decisions about treatment options. For example, in the ENT department we were told of a child who became distressed during a procedure. Staff spent time with the family discussing alternative options for treatment.

Patients consistently told us that staff took the time to explain things to them and involve them in their care and treatment.

Is the service responsive?

Service delivery to meet the needs of local people

People’s needs were met through the way services were organised and developed.

self-check-in system. The system presented patients with clear, visible writing and images and had the option of visual aids for people with visual impairment. It also gave patients the option of choosing their preferred language. Once complete, the check-in system would indicate to the patient which waiting area they should attend. The self-check-in system had recently been installed and staff at the information desk, reception and volunteers were helping people to use it.

The waiting areas we observed appeared comfortable, clean, had accessible toilets, magazines and vending machines. However, the clinical waiting area in the ear, nose and throat (ENT) department did not have high back chairs or bariatric chairs. We were told this had been addressed and was in the process or ordering.
Following our report in January 2017 it was highlighted that the outpatient service must develop play services in line with national best practice guidance. There were play areas for children with toys that could be easily cleaned in the main outpatient waiting area corresponding to waiting areas A, B and B2. However, outpatient areas D, E and Trauma and Orthopaedics (T/O) did not have a dedicated area for children. The ENT clinic had a mixed adult and children reception area with a corner dedicated to children’s books and small toys. There were plans to develop play areas for children in both T/O and ENT clinics.

There was signposting around the hospital indicating where the different outpatient areas were located. However, the signs were not always clearly visible and were written in black letters with a white background. None of the signs presented dementia or visual deficit friendly colours. Additionally there was no clear indication as to where clinics were being held. However, staff at the information desk and volunteers were helpful in guiding patients to their correct location when help was requested.

Car parking was not sufficient and all patients we spoke with described issues finding a space to park. This affected appointments, with some patients arriving late or missing appointments. The outpatient services recognised this and stated that if a patient had missed their appointment due to parking issues they would accommodate them in the next available appointment.

The outpatient service sent letters to patients to inform them of their appointment date, time and clinical speciality. Additionally the appointment letters provided information for specialised services informing of any test, samples or fasting requirements. The appointment letters also provide contact numbers should an appointment need to be re-scheduled or any questions occur. The appointment letter system was updated following patient complaints and as a response to an increase in “Did Not Attend” (DNA) appointments due to late receipt of the letters. We were informed that the distribution system has been revamped to provide effective delivery to the number of patients requiring appointments. In addition to informing patients about appointments via written letters the service has a telephone appointment reminder 36-24 hours prior to the any appointment.

Staff monitored and audited clinic waiting times. We were told that delays were handled on the day and staff worked flexibly if clinics overran.

Staff told us they would inform patients about overrunning waiting times in the clinical waiting areas. We saw staff advising patients of wait times on an individual basis. In the Ophthalmology waiting area display TV screens were used to advise patients of current waiting times, which clinics were occurring and who the doctors on call were. However, the writing on the screen was difficult to read due to reduced size and it was necessary for patients to walk up to the screen to read it.

The hospital offered some weekend and evening clinics to reduce waiting lists and to allow greater choice for working patients.

A bus service was available from the hospital with full details available in the reception area.

**Did not attend rate**

From October 2016 to September 2017:

- The ‘did not attend’ rate for Bexhill Hospital was similar to the England average.
- The ‘did not attend’ rates for the Conquest, Eastbourne District General and Uckfield hospital sites were higher than the England average.
- The ‘did not attend’ rate for appointments which were not assigned a site by the trust (designated as unknown in the chart) was higher than the England average.
The chart below shows the ‘did not attend’ rate over time:

**Proportion of patients who did not attend appointment**

![Chart showing 'did not attend' rate over time](chart.png)

*(Source: Hospital Episode Statistics)*

The outpatient department at Eastbourne hospital was undergoing an improvement programme to address issues and improve services provided to patients. The ‘did not attend’ (DNA) rate was an area of focus for improvement. Senior managers told us that this work to date had been focused on why patients DNA their appointments and how this could be improved. One of the areas identified had been that patients being ‘given’ an appointment by letter did not give them choice or appointments that were at a convenient time for them. The trust had identified a number of measures to improve the appointment attendance rate. This included; improvements to the timeliness of letters that were sent to patients; sending text and phone call reminders to patients 36-24 hours prior to their appointment; re-scheduling appointments directly with patients to meet their needs; and, in some areas of outpatients book appointments via phone rather than letter so that these were booked at convenient times for the patient. There was a clear focus on empowering patients in order to increase their commitment to the appointment and therefore reduce DNA rates. Latest data from October 2017 reported that the average DNA rate for the trust was 7.9%. This has resulted in a 3% improvement with DNA appointments for the trust from August 2016 to December 2017. This was still marginally above the national average of 7.6% for the month of October 2017.

The Trust identified other issues related with DNA rates have been adverse weather conditions, transport issues and some outpatient clinics such as Trauma and Orthopaedics having a standardised 6 month open access.

**Meeting people’s individual needs**

The trust provides details of how to access outpatient services to patients that have mobility issues. It highlights the use of blue badge areas as well as patient transport. However, patient transport arrangements cannot be done more than 14 days in advance of an appointment.

The trust was compliant with the accessible information standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents of patients with a disability, impairment or sensory loss. There were dementia friendly clocks throughout the clinics and resources such as picture based communications tools available.
The trust ensured patients had time to ask questions. We were shown when an appointment letter was given to patients these included frequently asked questions. For example, such as: “What are my treatment options?”, “What are the pros and cons of my treatment options?” and “If I need more support or advice where can I get it?”. There was also an area on the appointment letter where patients could write questions to take to the appointment. Staff said they would provide extra time during consultations to answer any questions. If clinics were running late, staff used the chaperone services and made side rooms available to address any ongoing patient queries. This is in line with NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.

Staff explained to us that each patient was always given individual attention and there may be emergency situations leading to clinic times running over. Therefore, while they try to keep to appointments running to time this is not always possible. If however, patients waited longer than 30 minutes a clinical member of staff would personally apologise and provide a brief explanation as to why the clinic was running late.

Staff attached Dementia ‘Butterfly’ stickers to patient notes and waiting lists had side notes detailing patient’s extra needs. This was used as a way of alerting staff to patients living with dementia or who required more monitoring so they could be responsive to their additional needs. Patients were encouraged in the outpatient appointment letter and by receptionists to advise staff of any special needs during their visit to the hospital.

We viewed a ‘supporting the vulnerable patient’ mission statement on view in the outpatient department. The mission statement referenced that staff would be appropriately trained to support patients who were vulnerable and that quiet spaces would be identified where needed. The outpatient department took into account the needs of people by attempting to book morning appointments for people with learning disabilities and complex needs to minimise the impact of waiting and busy environments on the patients. Receptionists told us that if a patient or family members with dementia or complex needs was feeling distressed or experiencing discomfort they would talk to the consultant to accommodate their visit as soon as possible.

The Trauma and Orthopaedics clinic told us they provided services to Lewes prison. These visits were established at the beginning of clinics and used secure and private spaces.

The trust had access to easy read leaflets for those with communication difficulties or where English was not the first language. Patients could request leaflets in other formats such as large print or alternative languages through the Equality and Human Rights Department.

The Trust’s appointment letter highlighted that if a patient required an interpreter they should contact the appointment centre who would arrange this for the date of the appointment. We were told by staff that if a patient did not request an interpreter prior to their appointment they would try to arrange one for that day but could not guarantee it would successful. Alternatively, an appointment would be re-scheduled as soon as possible and a request for an interpreter made at the time of re-scheduling.

Staff told us that if a follow up appointment was required they would try to arrange it on the day. Staff also told patients that if they felt they would like further information regarding their medical condition or other health matters they should ask before leaving the clinic.

Staff reported they were always keen to hear feedback about patient experience and suggested to patients completing the Friends and Family survey before leaving the department. Posting boxes and surveys were available in all waiting areas. Staff also said patients could leave feedback via the trust website.
Access and flow

Patient access and flow varied, dependent on different clinics within the department and the outpatient service as a whole.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From November 2016 to October 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently worse than the England overall performance. The latest figures, for October 2017, showed 85.0% of this group of patients were treated within 18 weeks versus the England average of 89.1%. This was an improvement on the 80% figure recorded in January 2017.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, East Sussex Healthcare NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Five specialties were above the England average for non-admitted RTT (% within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>98.9%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.6%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>89.1%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Urology</td>
<td>88.6%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>87.8%</td>
<td>85.2%</td>
</tr>
</tbody>
</table>

Eleven specialties were below the England average for non-admitted RTT (% within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>93.5%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>89.3%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>87.7%</td>
<td>88.9%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>84.6%</td>
<td>92.7%</td>
</tr>
<tr>
<td>ENT</td>
<td>84.0%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>83.3%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Other</td>
<td>82.6%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>82.1%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>82.0%</td>
<td>87.4%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>77.9%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>56.3%</td>
<td>82.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
The Neurological outpatient consultant told us that non-admitted RTT results were mainly linked to the service accepting referrals for all types of neurological conditions including headaches, migraines and unclear neurological diagnosis. This meant that some patients would require long-term reviews of their conditions prior to initiating treatment. However, the consultant reported that links to specialist groups, the use of MS and Parkinson’s disease packs and linking patients with specialist nurses and GP’s were actions taken to minimise this.

Referral to treatment (percentage within 18 weeks) – incomplete pathways

The trust’s referral to treatment time (RTT) for incomplete pathways was worse than the England performance from December 2016 to February 2017. However, from March 2017 onwards, the trust performed better when compared nationally.

The latest figures for November 2017 showed that 91% of patients at the trust were treated within 18 weeks versus England average of 89%.

Referral to treatment rates (% within 18 weeks) for incomplete pathways, East Sussex Healthcare NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Thirteen specialties were above the England average for incomplete pathways RTT (% within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>99.5%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>98.5%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>98.4%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.2%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>96.1%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.0%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.7%</td>
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</tr>
<tr>
<td>Urology</td>
<td>92.7%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Other</td>
<td>92.5%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>91.1%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.8%</td>
<td>88.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>87.9%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>85.4%</td>
<td>84.1%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (% within 18 weeks).

(Source: NHS England)
The outpatient department at Eastbourne hospital was undergoing an improvement programme to address service issues and improve services provided to patients. This programme addressed issues that were impacting RTT times such as how appointments were booked, queuing systems for specialist doctors, clinic durations and capacity and demand of the service. This programme was initially implemented in the paediatric outpatient department in January 2017 leading to a change from a 25 week waitlist to a current 2 week waitlist.

During our inspection, the ophthalmology department was implementing this programme using the same lean methodology. This resulted in improvements to the service with new diagnosis to follow up ratio increasing and d/c decreasing. Department had developed an action plan to address further access and flow issues within ophthalmology. This included; writing up standardised clinical pathways for all services creating one stop super clinics with a consultant in a supervisory role; and, introducing standardised clinical times creating a balanced distribution of clinical time.

In addition, senior managers told us they had taken practical steps to improve patient flow within the service. For example, they had identified issues with short notice cancellations so had taken specific action such as increasing the notice time for medical staff to request annual leave to allow for better planning. In addition, vacant clinics were scheduled so as to accommodate any cancelled clinics and all cancelled clinics were aimed to be rebooked within a month. We were told that all vacant clinics were always filled eventually.

Because one of the main issues impacting patient flow within ophthalmology outpatients was a lack of space, the trust had run weekend clinics from time to time to manage referral to treatment times. This included the use of an external 18 week team to help clear some of the treatment backlogs. At the time of inspection we were told that this had taken place over three weekends since the beginning of January 2018.

At the time of inspection the outpatient department had four ongoing workstreams aimed at improving access and flow:

- Outpatient data: aimed at accessing the right data to forecast and view population needs
- were being over/under used; Creating a new follow-up electronic database to improve appointment booking, follow up and prediction of clinical needs and capacity.
- Improving radiological diagnosis: the trust had identified the need for a tracking system to maximise use and reduce delays in radiological diagnosis.
- Engaging service development by creating a strategic vision for outpatients as a whole integrated department rather than one divided into specialities.

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral from Q3 2016/17 to Q2 2017/18 (October 2016 to September 2017). The performance over time is shown in the graph below:
Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) from Q3 2016/17 to Q2 2017/18 (October 2016 to September 2017). The performance over time is shown in the graph below:

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral from Q3 2016/17 to Q2 2017/18 (October 2016 to September 2017). The performance over time is shown in the graph below:
Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

![Graph showing percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment.](Image)

(Source: NHS England – Cancer Waits)

The trust had patient pathway co-ordinators to keep track and monitor waiting times for cancer patients through all cancer pathways. Issues arising from these waiting lists would then be escalated to weekly MDTs within each specialist area and then to PTL for all oncology. A patient pathway co-ordinator informed us that they would regularly monitor the waitlist.

The patient pathway coordinator explained that the 62 days wait list was above national average because it took into account patient led delays such as patient requests, patients being unwell and patient choice. We saw the waitlist and reasons for the delays in patients waiting over 62 days for Gynae and skin oncology treatment were documented and had action plans linked to their status. Additionally, the trust had a staffing issue when one consultant was absent causing delay in theatre lists.

The patient pathway co-ordinator explained they were actively attempting to reduce waiting times by planning appointments whilst liaising with follow-up teams and requesting re-bookings occur at the earliest time possible. If they were unable to do so this would be escalated to service managers who would then add more clinics or liaise with consultants for extra clinical time. For non-operative patients a specialist nurse would call patients and identify reasons for anxiety or reasons for non-attendance and address these issues.

Learning from complaints and concerns

Summary of complaints

From November 2016 to October 2017 there were 171 complaints about outpatients. The trust took an average of 31.7 working days to investigate and close these complaints which is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Ten complaints remained open at the time of reporting and had been open for an average of 30.2 days.

The most common themes from the 171 complaints were:

- Communication – 50 complaints
- Patient Pathway – 50 complaints
- Standard of care – 39 complaints
- Attitude – 18 complaints
At Eastbourne District General Hospital, there were 88 complaints, the most common themes from which were:

- Patient pathways – 29 complaints
- Communication – 26 complaints
- Standard of care – 18 complaints

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. We saw that complaints were a standing agenda item on all governance meetings. We heard that outcomes from these meetings were shared with staff and key points were raised at team meetings.

Staff felt empowered to deal with complaints and knew how to escalate them appropriately. The services used complaints and concerns as an opportunity for improvement. As an example, following a Panorama report concerning the dangers of using vaginal mesh, staff at the women’s health outpatient clinic adjusted clinical time and directed people to their secretary to reassure and put patients who had seen the report at ease.

Staff were aware of their duty of candour and said they would recognise and apologise to patients should any errors occur. We observed staff apologising to patients in waiting areas about any delays.

Staff provided complainants with contact numbers or directed people to the Patients Advisory Liaison Services if needed. The trust’s Patients Advisory Liaison Service provided advice and support to patients who had complaints, comments, compliments and concerns. All staff we spoke with knew about the Patients Advisory Liaison Service and said if they could not resolve concerns locally, they would refer patients to this service.

Staff handled complaints in line with trust policy. The outpatient matrons initially handled concerns and then escalated these to service managers if they were unable to resolve the issue. Staff assured service users that raising a complaint would never affect the quality of their care and treatment received. Staff said they valued feedback and told us it was used to help enhance or improve the service provided.

We saw that information relating to action taken as a result of feedback from patients was recorded in the form of ‘you said, we did’ information on notice boards in waiting areas. For example, in the maxillofacial outpatient waiting area we saw that complaints about delays had led to improved action on communicating with patients and providing explanations.

Patients we spoke with knew how to make a complaint and most would direct their complaints to the receptionist or matron.

The trust website also gave information on how to raise a concern and where patients should send complaints. It highlighted if guidance or support in making a complaint was needed, people could contact the Support Empower Advise Promote (SEAP) Advocacy Service. However, no information was provided to patients on what expected response times where.

Is the service well-led?

Leadership

The organisation was structured into divisions; emergency department; medicine; diagnostics, anaesthetics and surgery; women, children and sexual health; and, out of hospitals. The general outpatient’s department was structured within the medicine division. Other clinics operating
within the outpatient department operated within their own division, for example ophthalmology was structured within the surgical division.

There was a general outpatient matron who took overall responsibility for the department on a daily basis. General outpatient’s covered outpatient areas A, B and B2 on the main entrance level and satellite clinics D and E on the lower ground level of the hospital. In addition there were matron’s located in other specialist areas of outpatients, for example, in; ophthalmology; ear, nose and throat; trauma and orthopaedics; and, maxillofacial.

Overall, we found that services were well-led. Matrons were highly visible within the department, working clinically and managerially to provide support for their teams. Deputy heads of nursing were also visible within the department, providing support to matron’s and staff alike. Matron’s had administrative assistants working alongside them to free up time to provide clinical support to their team. The trust had managers at all levels within the service with the right skills and abilities to provide the service.

Staff we spoke with generally told us they felt listened to and that senior managers were visible. For example, staff spoke of the Chief Executive Officer attending huddle meetings and visiting the department to check in with them. Senior staff we spoke with had a good understanding of the challenges relating to outpatients and the priorities for developing the service. There was a clear commitment to develop the service in order to improve waiting times, patient access and patient experience. There was also an emphasis on communication and promoting a positive work environment for staff. Staff told us they generally felt supported and spoke positively about the support received from managers. However, some administrative staff felt that managers didn’t always understand the pressures relating to booking patients into overstretched clinics and where backlogs occurred.

Vision and Strategy

combine community and hospital services to provide safe, compassionate and high quality care to improve the health and wellbeing of the people of East Sussex. Safe patient care was identified as the highest priority alongside high quality clinical services and outcomes while providing excellent care experience for patients.

Trust values were; respect and compassion; engagement and involvement; improvement and development; and, working together. Trust values were displayed throughout the hospital and staff demonstrated a good understanding and commitment to these.

The trust had developed ESHT 2020, an overarching organisational strategy setting out the direction for clinical services. Key strategic objectives and responsibilities of this strategy had been developed and where clear. At local, departmental level key objectives for matrons, clinical leads and managers where to focus on good multidisciplinary team working ensuring patients received good quality care, and, to lead and implement quality development plans to make improvements while learning from patient feedback.

We saw evidence of quality improvement work within the outpatient department. A quality improvement programme had been implemented in order to ‘meet constitutional standards for outpatients whilst providing a safe service that satisfies patients’ needs and supports staff to feel proud and satisfied in their work’. Benefits of the project had been identified as, improving; patient experience; efficiency and productivity; and, patient safety. Four key work streams had been identified; outpatient data; capacity and demand; radiological diagnostics; and, service development.

Senior staff we spoke with told us that as part of the improvement work an outpatient strategy would be developed. Key actions already taken included those relating to improving referral to treatment times, centralisation of health records and implementation of an electronic management system, improving outpatient booking services, reducing DNACPRs, and the
development of new clinical pathways to guide junior doctors on patient discharge and reducing long term follow up.

Culture
All staff we spoke with were passionate about providing a good service, with quality of care as a priority. Staff appeared to be proud of their work and the services they provided. There was a real emphasis on improving the patient experience and making patient visits to the department as comfortable as possible.

Staff generally told us there was an open culture and they felt they had the opportunity to express their views. These views would be listened to and considered by senior staff. We received positive feedback from staff around changes and improvements made within the department. Staff told us there was a good team approach and a supportive environment. We observed staff working together across teams and disciplines, supporting patients and each other in the delivery of services and care.

Managers told us that staff working within outpatients were flexible and motivated to provide high quality care and a positive patient experience. We were told that staff would flexibly cover shifts when needed and would move around clinics to ensure cover and support were provided. We observed experienced staff working with newer staff and student nurses and saw that a culture of learning and development was apparent. Team meetings were held regularly and daily huddles provided an opportunity for staff to discuss issues, concerns, learning and positive experiences. Staff told us they generally felt well informed and valued and were treated with respect by senior staff and managers across the trust.

We observed senior staff sharing feedback with staff at a team huddle, including reminding them about expected action in relation to observed behaviour and practices. This was dealt with fairly and positively. There was a focus on explaining to staff why certain practices and behaviours were important, including the potential risks that may occur as a result.

Governance, management of risk, issues and performance
Governance structures were in place to support the delivery and development of outpatient services. There were clear reporting structures within outpatients services and staff we spoke with knew who to report to. Divisional governance meetings were held on a monthly basis, with speciality audit meetings held on a bi-monthly basis. General outpatients was included in the governance structure of the medicine division. We viewed minutes of these meetings and saw that issues such as incidents, complaints, risk registers, safeguarding, audit proposals, quality improvement projects and health and safety issues were discussed.

We were told that divisions regularly attended the Quality and Safety Committee to provide updates, as well as attending the audit committee on a rotational basis to provide an overview of their risk registers and clinical audit programme. Members of the board and executive directors undertook ‘quality walks’ of services. Staff in outpatients departments confirmed that this had occurred.

As part of the outpatient improvement programme a project governance structure was recorded with clear lines of accountability for clinical governance. There was a process in place for recording and escalating clinical governance risks and issues.

oversight of the hospital’s referral to treatment (RTT) performance and could demonstrate that the systems for recording data in the form of RTT status updates supported this. We saw that improving data streams and using pro-active management and taking early action on negative trends formed part of the outpatient improvement plan. Senior staff demonstrated that key performance targets relating to RTT and ‘Did Not Attend’ rates showed some improvement at the time of inspection. Specific actions to improve performance included advanced planning for annual
leave to reduce the impact of short notice cancellations and using vacant clinics so any cancelled clinics could be rebooked within a few weeks.

Key performance targets showed that the 62 day wait for cancer treatment had been breached. We were told that this was partly due to late referrals and patient choice. Actions taken to improve performance including weekly review meetings, liaison with follow-up teams and specialist nurse support for patients were fed back through the governance structure. RTT, diagnostics and cancer performance were reported on through the quality and safety committee which fed into the trust board.

There were effective systems for identifying risks using high level and divisional risk registers. Risks were rated as red, amber or green (RAG) depending on the severity of the risk and the potential for harm. One such example relating to outpatients was the risk that patients may not receive a timely follow up appointment due to insufficient clinic capacity. It was recognised that the data system was not robust and that the clinical timeframe to plan and respond to demand was not readily obtainable. It was identified that this may lead to delays and omissions in follow up appointments which may in turn impact on timely diagnosis and treatment, with potentially serious consequences for the patient and the trust. We saw that controls in place included systems to collate and monitor follow up appointments and the use of local databases. Management staff were also tasked with regularly liaising with reception teams about issues with booking follow ups. Planned actions involved the development of a follow up waiting list to be monitored at specialty and consultant level in order to improve timeframes for appointments. We saw that these plans had been incorporated into the outpatient improvement programme. The programme had already been developed in children’s outpatients and was in the process of being developed across ophthalmology. This demonstrated that the trust took action to reduce identified risks.

Information Management
The trust used secure electronic systems with appropriate security safeguards. New systems had, and continued to be developed to ensure that information was used to deliver high quality, accountable services. It was widely recognised that paper based information needed to be transferred into electronic formats to ensure a more accurate and timely capture of data to support patient pathways.

A health record improvement project was nearing the end of completion at the time of our inspection. We were told that all but cardiology and paediatric health records had been transferred to the new electronic system. Staff we spoke with were consistently positive in terms of how this had improved the availability of patient information. Staff had access to up-to-date, accurate and comprehensive information on patient’s care and treatment. We were told that consultation notes were recorded by hand and then scanned onto the system. This would take up to 48 hours but staff felt this was a significant improvement on the old paper based system where patient records would frequently not be located due to tracking issues. A new electronic tracking system had ensured that where paper records were required they were more easily accessible. The associate director for operational improvement and elective performance told us that in November 2016 1100 incidents had been reported that year relating to health records. For the same period in November 2017 after improvements to the system 46 incidents had been reported.

There were clear and effective arrangements in place for information used to monitor, manage and report on quality and performance across the department. We observed data being used in each clinical area. For example, performance related data was recorded on white boards in each waiting area. Information included aspects of infection control, actual staffing in comparison to planned numbers, ‘did not attend’ (DNA) data and patient feedback including action taken by the trust.

Trackers were in place to monitor staffing levels, staff performance reviews and training. Data
relating to this was used to inform quality performance meetings and was disseminated to relevant managers and staff. Outpatient meetings were held on a monthly basis and information was shared with staff about a number of areas of performance. Daily huddles were used to cascade information and address immediate issues relating to quality of care, safety and performance.

**Engagement**

The trust had systems and processes in place to engage well with patients, staff, the public and other stakeholders to plan, manage and develop services.

Staff engagement sessions and focus groups took place regularly across the trust. Staff survey results were shared and feedback obtained in order to develop key priorities for action to improve. Key priorities included improving communication, reducing bullying and harassment, and continuing to make the trust a great place to work.

Trust wide initiatives have included emotional resilience workshops, mindful activities and massage. Staff had access to a Speak up Guardian who monitored any episodes of bullying and harassment and supported staff wellbeing. One team we spoke with told us they had received support from the Guardian about a dignity at work issue and found the trust to be fully supportive.

Staff within outpatients told us they had opportunities to engage with each other through daily huddles and monthly meetings. Managers told us that deputy heads of nursing invited staff to meetings on a bi-monthly basis. These meetings included guest speakers and tea and cake was provided. Monthly staff meetings were held and also included guest speakers to address relevant issues or learning needs. Regular newsletters for staff were in use. For example, ‘you said, we did’ newsletters relating to incident reports and action taken by the trust were cascaded to staff. We were given examples of where specific issues and changes relating to outpatient administrative processes had led to team meetings with a focus on improving communication and ways of working. Senior staff told us this had led to improvements in communication.

A ‘how are we doing’ board in the matron’s office of outpatients included both positive feedback and areas for improvement. Patient information boards were placed in each waiting area and included feedback comments from patients in a ‘you said, we did’ format, as well as results from the friends and family test (FFT). Examples of feedback included issues with car parking and waiting times. Specific action included letting patients know that staff were aware of the car parking issues and that this was being considered at board level within the organisation. We also saw that staff had taken specific action to inform patients of delays to appointments and waiting times during the course of clinics as they arose.

Senior staff we spoke with understood the pressures within outpatient services and their impact on staff. We observed senior staff providing support and being visible in the department. For example, we observed the deputy head of nursing checking in with the ophthalmology matron and staff in response to known staffing shortages that day.

**Learning, continuous improvement and innovation**

The trust was committed to developing and improving services. Performance dashboards were in use in both clinical and administrative areas of the department. Learning was evident from both incidents and from things that had gone well. Information was shared and cascaded to ensure that all staff could benefit from and contribute to learning. We saw evidence of learning being discussed as part of governance and department meetings.

Staff working within outpatients gave us examples of innovation including the development of improvement plans. These incorporated changes to systems and processes in order to improve patient access and flow, as well as the patient experience. Particular areas of measurable improvement included the development of electronic patient records and the use of electronic tracker systems to improve the accessibility and availability of patient information. Staff were very
positive on how these changes had improved their working lives and patient safety.

Other examples of improvement and innovation included the successful accreditation of the women’s health urogynaecology unit from the British Society of UroGynaecology in 2017. There was also evidence of staff led improvements, for example we were told of a pro-forma that had been developed by a healthcare assistant in the department to provide guidance in relation to a specific procedure.

There were also clear plans in place for ongoing and continuous improvement. For example, following the successful implementation of an electronic records system there were plans in place to develop electronic wait lists.