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**

**Acute hospital sites at the trust**

A list of the acute hospitals at East Sussex Healthcare NHS Trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>The Ridge, St Leonards-on-Sea East Sussex TN37 7PT</td>
<td>Medical and surgical wards, 24-hour emergency department, Magnetic Resonance Imaging (MRI), Computer Tomography (CT) and interventional radiotherapy.</td>
<td>Hastings and Rother area</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Kings Drive, Eastbourne East Sussex BN21 2UD</td>
<td>Medical and surgical wards, 24-hour emergency department, Magnetic Resonance Imaging (MRI), Computer Tomography (CT) and interventional radiotherapy.</td>
<td>Eastbourne, Hailsham and Seaford areas</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Holliers Hill, Bexhill-on-Sea East Sussex TN40 2DZ</td>
<td>Ophthalmic day surgery, physiotherapy, radiology, Wet Age-related Macular Degeneration (AMD) and diabetic retinal screening.</td>
<td>East Sussex</td>
</tr>
</tbody>
</table>
The trust works in partnership with the locally focused and integrated health and social care network with teams providing acute hospital and community health services.

Acute services are provided from Conquest Hospital in Hastings and Eastbourne District General Hospital. High risk trauma and orthopaedics, high risk and emergency surgery, and consultant led maternity and paediatric inpatients are located at Conquest Hospital. Stroke services are provided from Eastbourne District General Hospital which also has a midwifery led unit and short stay paediatric assessment unit.

The trust is part of the Sussex Health and Care Partnership Sustainable and Transformation Partnership (STP) and are working with partner organisations to develop an East Sussex integrated care provider model.

The trust provides acute hospital and community health services for the 550,000 people living in East Sussex. The area has the highest proportion of over 85s in England and significant deprivation in one of the major towns, Hastings.

Trust data showed that the trust had:

- 7,100 employees
- An annual turnover of £410 million
- 800 beds
- Over 110,000 inpatient spells in the last year
- 410,000 outpatient attendances
- 130,000 attendances at the Emergency department

(Source: Trust Website / Routine Provider Information Request (RPIR) – Sites tab)

Is this organisation well-led?

Leadership

Leaders had most of skills, experience and abilities to run the service. Where members were new to the board or leadership roles there were arrangements in place to support them. The trust leadership team had knowledge of current priorities and challenges and were acting to address these.

Board Members

The board comprised a chair, seven non-executive directors, the chief executive and seven executive directors. The executive team was broadly stable and had made great strides in improving performance and financial sustainability.

Steve Phoenix - Chair

- Held a number of non-executive roles at Maidstone and Tunbridge Wells NHS Trust since 2017
• Was special advisor to the Minister of Public Health in Qatar
• Was Chief Executive of the General Hospitals and Organisational Development at Hamad Medical Corporation and executive lead of three of the group’s acute hospitals
• Has extensive NHS Board level experience with several senior leadership roles in the NHS across the South East spanning regional, commissioning and community provider roles.
• Was Chair and non-executive director (NED) of Health in Europe Ltd and a NED at Match Health Care Ltd
• Held an academic appointment at the London School of Economics

Executive Directors

Dr Adrian Bull - Chief Executive

• Joined the Trust as chief executive in April 2016
• Previously the managing director of Imperial College Health Partners and chair of the national Academic Health Science Network
• Chief executive of Queen Victoria Hospital NHS Foundation Trust from 2008 to 2013
• Began his medical career by serving for six years as a medical officer in the Royal Navy
• Qualified as a general practitioner before continuing as an epidemiologist at Southampton MRC Unit and consultant in Public Health Medicine for the NHS in Yorkshire
• Was consultant in Public Health Medicine at East Sussex Health Authority before becoming medical director for Eastbourne and County NHS Trust
• Worked in the private sector for a number of years in senior executive positions at AXAPP Healthcare then as managing director of Carillion Health, including leading the national CBI Health Policy Committee

Vikki Carruth - Director of Nursing

• Joined the trust as Director of Nursing in October 2017
• Registered nurse with a clinical background in acute medicine
• Undertook a number of post-graduate studies at the University of Brighton
• Worked in the NHS since 1989, holding a variety of senior nursing posts in trusts in London and the South
• Is director for infection prevention and control and executive lead for MHA

Joe Chadwick-Bell - Deputy Chief Executive and Chief Operating Officer

• Joined the Trust in November 2016
• Worked in ambulance and acute provider trusts along with a period of time at the Strategic Health Authority and was a board director at Surrey and Sussex Healthcare NHS Trust
• Was regional director for London for Care UK

Jonathan Reid – Director of Finance

• Joined the trust as director of finance in June 2016
• Has worked in public finance for over 20 years
• Studied accountancy at Queen’s University, Belfast and trained as a chartered accountant at the National Audit Office
- Worked at Brighton and Hove PCT (now CCG) as deputy director of finance, and later took up the same role at Brighton and Sussex University Hospitals NHS Trust
- Worked at Sussex Community NHS Foundation Trust in 2011 as director of finance and was deputy chief executive
- Is the data lead and senior information risk owner for the trust

Dr David Walker MA MD FRCP FES - Medical Director and Consultant Cardiologist

- Has been Consultant Cardiologist at Conquest Hospital since 1998
- Qualified from Cambridge University and St Thomas’s Hospital Medical School in 1985. Trained in Cardiology at University College Hospitals, Wessex Cardiac Centre, St. Mary’s Hospital (Paddington), and the Hammersmith Hospital
- Has been both medical director of the Sussex Heart Network, and chairman of the Network Heart Failure Group
- Was national clinical lead for heart failure at NHS Improvement and co-wrote national guidelines on “End of Life Care in Heart Failure” and “Hospital based Heart Failure services”. As chairman of the British Cardiovascular Society Working Group on Acute Cardiac Care has written the National Guidelines on Acute Cardiac Care
- Currently on the board of the Acute Cardiovascular Care Association of the ESC, and chairman of the committee on the Website and Communication Strategy
- Vice president of the British Cardiac Society (Corporate Finance and Development)
- Is trust Caldicott guardian and guardian of safe working hours

Other executive directors

Catherine Ashton, Director of Strategy

- Has worked in health, social care and the voluntary sector in both provider and commissioning organisations for nearly thirty years; has undertaken national development work and local policy and strategy development for a number of organisations in both the public and voluntary sector
- Was associate director of strategy and whole systems with the local clinical commissioning group
- Holds an MBA in public sector management
- Is quality improvement lead

Monica Green, Director of Human Resources

- Been director of human resources since 1998
- Has had long career in the NHS working for different trusts and NHS bodies (and in the private sector)
- Leads all aspects of human resources including recruitment, employee relations and education and development. Trust lead for organisational development and staff engagement and wellbeing and manages childcare facilities and libraries.
- Chairs the HR Director Network for Surrey, Sussex and Kent and is a member of the National Staff Council
- Member of the Local Workforce Advisory Board; chairs the workforce group across Sussex and East Surrey

**Lynette Wells, Director of Corporate Affairs**
- Joined the Trust in February 2012
- Worked in the NHS in 2008 and previously held company secretarial positions in the commercial sector
- Is a qualified company secretary, with a master’s degree in medical law
- Has responsibility for corporate governance, including legal and communication
- Is the director responsible for equality and diversity

**Non-executive directors**

**Jackie Churchward-Cardiff**
- Extensive experience of healthcare having worked in both the private and public sector.
- Worked in the NHS for 22 years; last position being Director of Operations at Barts and Royal London NHS Trust.
- Worked for an infrastructure company for 11 years ending as chief executive
- Chairman of Avante Care and Support
- Non-executive chair of Quality and Safety Committee

**Miranda Kavanagh**
- Executive Director of Evidence at the Environment Agency
- Worked at senior level in the Healthcare Commission
- Worked for Pfizer UK
- Non-executive chair of People and Organisational Development Committee

**Karen Manson**
- Managing Director of Manson Associates, a UK-based, global business consultancy specialising in healthcare and sustainability
- Originally trained as a veterinary surgeon, practicing for over seven years in New Zealand and the United Kingdom
- Worked at Janssen, the pharmaceutical companies of Johnson & Johnson, gaining over 20 years’ experience of the pharmaceutical industry in both large multinational and start-up biotech companies

**Barry Nealon**
- Recently retired from business having held a number of senior executive positions in the private sector
- Was executive chairman of Reliance Facilities Management and a director of Monteray Ltd
- Non-executive chair of Finance and Investment Committee
Paresh Patel

- 25-year career in financial services and healthcare
- Held senior roles at PwC and Fidelity International
- Developed a single specialty eye hospital and expanded the company’s ophthalmic business domestically and internationally
- Was director of strategy and business growth at Ramsay Healthcare UK

Nicola Webber

- Fellow of the Institute of Chartered Accountants of England and Wales and spent last 15 years working in the financial sector
- Was assistant director at Deloitte LLP and Commercial Director at INSYNERGY Investment Management
- Non-executive chair of Audit Committee

Carys Williams

- Held a number of senior executive roles within Lloyds Banking Group and currently the organisation’s fraud and disputes director
- Started career as an auditor with KPMG and MBNA

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 62% were female.

Of the non-executive board members 12% were BME and 62% 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%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>12.0%</td>
<td>62%</td>
</tr>
<tr>
<td>All board members</td>
<td>6.0%</td>
<td>62%</td>
</tr>
</tbody>
</table>

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

The executives had clearly defined areas of responsibility. See below for a summary of these.
Non-executive directors fulfilled a number of “champion” roles where they closely linked to specific areas; for example, health and safety, emergency planning, dementia and organ donation.

Executives were able to discuss all areas of their portfolio and showed an appreciation of the challenges and issues that faced their colleagues. All board members in agreement when discussing the key strategic risks to the organisation. The chief executive was respected, trusted and accessible. He role modelled the values of the organisation and showed a strong grip of the organisational values, culture, strategy and performance.

Board members were highly visible, and staff we spoke with during our core service inspections confirmed this. The trust governance structure provided clear accountability and assurance flows from “floor to board”. The board engaged with divisions and departments in business planning where current and future challenges, developments, innovations, risks and opportunities were shared. The trust board undertook “deep dives” at board seminars and committees. For example, the cancer service and radiology service attended the board seminar in August and divisions regularly attended the quality and safety committee to give updates: this included a number of areas including end of life care. Representatives from the divisions also attended the audit committee on a rotational basis to provide an overview of their risk registers and clinical audit programme.

Board members undertook several different activities to triangulate information contained in board and committee papers with observations and interactions with patients, staff and stakeholders. This included “quality walks” to services and departments, participating in mock inspections and celebrating good practice, for example by attending the Clinical Audit Awards and Trust Staff Awards. Non-executive directors had developed in-depth knowledge of the day to day operation of the trust and described how they sought to triangulate information provided to the board through talking to staff and analysing data provided in detailed board packs.
Non-executive directors, in particular, highly valued the quality walk programme as a method of gathering real time information about the culture and performance of the trust, its challenges and risks, and to experience good practice and achievement. Staff commented positively about the interaction with board members during these activities and valued them. We reviewed the log of quality walks from August 2018 to July 2019 and saw there were between 14 and 28 quality walks each month. These included visits by both executives and non-executives and included all trust sites and services, including support services. However, although levels of challenge from non-executives were good in board meetings and in committees, they appeared to rely on gaining detailed levels of personal assurance in initiatives such as quality walks rather than relying on the operation of trust systems and processes.

Detailed data was provided to committees and board meetings and was used by non-executives to confirm their assurance about executive grip and control. We noted that board papers were of a high standard, were comprehensive and contained data and real assurance. However, we also noted although the reports were data rich, they did not include summary analysis leaving readers to draw their own conclusions. The expert analysis and judgement that the report authors could provide was therefore not readily available. There was a risk that board members may not fully appreciate the significance of data presented and had to spend considerable time reading board papers.

NHSI recruited non-executives, and personnel records confirmed this. There was no formal system for the trust to identify the skills required from new non-executive directors that would ensure the non-executive body had the full range of skills required. However, board members described an informal system of skills analysis between the chair and the board to make sure that overall the non-executives had relevant skills as a group. We noted that that the non-executives had a broad range of applicable and transferable skills.

The board was aware of its development needs. There was mixed experience among board members, especially within the non-executive body. NHS Providers supported non-executives with induction, and this was supplemented with local induction activities, often of a practical nature. The trust board had recently undergone a process of psychometric testing, with the outcomes shared. Board members said this enabled them to better understand the way in which colleagues worked and their strengths and areas for development. This, they felt, had started to positively influence the way in which they interacted and collaborated. The trust had prepared a new board development programme starting January 2020. Recently, the board had focused development sessions on the outcomes of psychometric testing but going forward the programme was more focussed on developing the boards skills. For example, the trust told us that there were plans to increase reliance on strategic sources of assurance.

Board members’ performance was appraised. The chief executive appraised the executive directors, and this was reported to the remuneration committee. The senior independent director appraised the chair; the chair appraised the non-executive directors. The trust shared a summary of the reviews for the chairman, chief executive and non-executive directors with NHS Improvement. We saw records of director appraisal in personal files although some were absent. A report to the remuneration committee dated November 2019 stated, “Annual appraisals have taken place” (in relation to directors).

The trust had a Leadership and Talent Management Strategy (2017-2020) which outlined the expectations of leaders, what support they could expect and the organisation’s approach to talent
management. The trust was committed to developing the capabilities of its leaders and managers. They had provided a range of multi-professional opportunities which are available for leadership development for all levels of staff including bespoke programmes, workshops, masterclasses and coaching and mentoring. The organisation supported several people to attend NHS leadership programmes. The trust was actively taking part in the sustainability and transformation plan (STP) leadership and talent management group and through this group had provided a range of development opportunities to staff including a system-wide leadership programme, operating department practitioner programme and introduction to coaching. The trust had also been piloting an approach to talent conversations based on the NHS leadership academy toolkit resources and had developed a high potential programme. A summary of trust leadership programmes is shown below:

<table>
<thead>
<tr>
<th>Who should attend</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-management roles, suggested bands 1-5</td>
<td>Aspiring Leaders – programme in development</td>
</tr>
<tr>
<td></td>
<td>QI Pop up Training</td>
</tr>
<tr>
<td></td>
<td>QI Bitesize Training (as a team of aspiring leaders)</td>
</tr>
<tr>
<td></td>
<td>Leadership Academy – Edward Jenner e-learning</td>
</tr>
<tr>
<td>Supervisor roles, suggested bands 3-5</td>
<td>Effective supervisor programme</td>
</tr>
<tr>
<td>Managers, team leaders, band 5/6/7, doctors and above</td>
<td>New managers orientation / follow up workshop</td>
</tr>
<tr>
<td></td>
<td>First 100 day checklist</td>
</tr>
<tr>
<td></td>
<td>First line manager programme</td>
</tr>
<tr>
<td></td>
<td>Appraisal skills</td>
</tr>
<tr>
<td></td>
<td>HR conversations</td>
</tr>
<tr>
<td></td>
<td>Business Essentials</td>
</tr>
<tr>
<td></td>
<td>Human Factors</td>
</tr>
<tr>
<td></td>
<td>Apprenticeships – business admin, customer service, management</td>
</tr>
<tr>
<td></td>
<td>Leading Services</td>
</tr>
<tr>
<td></td>
<td>QI Fundamentals (anyone working in project development/management)</td>
</tr>
<tr>
<td></td>
<td>LEAP</td>
</tr>
<tr>
<td>Clinicians / Doctors</td>
<td>Coaches</td>
</tr>
<tr>
<td></td>
<td>Quality Improvement</td>
</tr>
<tr>
<td></td>
<td>Leading Excellence</td>
</tr>
<tr>
<td></td>
<td>Myers Briggs Type Indicator</td>
</tr>
<tr>
<td></td>
<td>Apprenticeship – management degree level</td>
</tr>
<tr>
<td>Experienced organisational leaders and managers, experienced band 6/7/8/consultants and above</td>
<td>Accelerated Director Development Scheme</td>
</tr>
<tr>
<td></td>
<td>Apprenticeship – MBA level 7</td>
</tr>
<tr>
<td>CEO nominated aspiring directors</td>
<td>Accelerated Director Development Scheme</td>
</tr>
<tr>
<td></td>
<td>Apprenticeship – MBA level 7</td>
</tr>
<tr>
<td>All managers and leaders, suggested band 6 and above</td>
<td>LEAD sessions – in development, dates to be advertised in due course</td>
</tr>
</tbody>
</table>

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires organisations to have processes that ensure director level employees are fit and proper persons of good character on appointment and thereafter. The trust had a Fit and Proper Person Policy and Procedure which the trust had revised in December 2019 which set out the trust’s approach to ensuring all directors were fit and proper persons. The policy reflected the requirements of the regulation. The director of human resources provides an annual report regarding fit and proper persons procedure to the renumeration committee with the last dated November 2019. We reviewed seven director’s personnel files. These were difficult to navigate. The policy obliged board members to complete an annual declaration of their fitness, and they usually completed this at a board meeting. We could not find annual declarations in all the files we looked at. It appears that the previous year some directors completed an electronic declaration which the trust told us explained the missing documents. The committee report notes “Personal files are currently a mixture of paper and electronic documents and this can make it difficult to find documentation when it is in more than one place. We will therefore review all files and scan documentation, so each board member has a single electronic file.” The report also noted disqualified directors and insolvency checks were undertaken with no concerns identified and that, “The chairman and two associate non-executive directors were
appointed, and background checks and reference were undertaken and confirmed by NHS Improvement. The trust has undertaken disclosure and barring service (DBS) and occupational health checks, declaration of interests and fit and proper persons declarations for all new appointments.”

The board committee structure was clear and supported the board in its work. Each committee was chaired by a non-executive director with executives in attendance. Board minutes showed board committees produced regular reports which committee chairman presented at board meetings. We noted that there was challenge to, and discussion of these reports and their recommendations.

Board committees were supported by many specialist groups. Although there were many of these groups and sub-groups there was a clear reporting structure and each had terms of reference. For example, the leadership and culture structure is reproduced below.

**LEADERSHIP & CULTURE**
However, in our discussion senior leaders commented sometimes there was duplication of areas of responsibility between the various board committees. We found minutes of committees showed detailed challenge from board members, rather than relying on assurances arising from the operations of systems and processes.

The board met regularly. There were public board meetings held monthly, and these were followed by a private board meeting where confidential and commercially sensitive agenda items were dealt with. In the intervening months the board met for a board seminar or a “deep dive” into an area or issue of current interest. The non-executive directors met independently prior to board meetings.

We have attended the trust annual general meeting and trust board meeting in September 2019. We noted the agenda was balanced between quality, finance and performance and adequate time given for each aspect with an integrated performance report for the month. There was focused discussion around the results of an audit and the outcomes of a recent health and safety inspection. The chair gave all board members opportunity to speak and focussed on those with responsibility in the area discussed. Performance issues and finance were discussed in public showing transparency. An independent review of the board in 2017 had recommended the non-executives should challenge more. From our review of board meeting and in discussions, it was obvious this recommendation had been implemented and all board members appropriately challenged their colleagues in board meetings to better understand the issues, and to ensure the board had considered all aspects and implications of their decisions.

Vision and strategy
The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress

The trust had developed a vision for the organisation which was well publicised and understood by staff, managers and leaders we spoke with. The vision was:

“Our vision at East Sussex Healthcare Trust 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 vision was underpinned by a four value statements which described the trust approach to achieving the vision. These values were well publicised around the trust sites and in their literature. Staff were able to discuss the values during our core service inspections and give examples of how they informed their daily work. The values were expressed in the following way:
The trust had set itself clear, high level objectives which further supported the vision, and reflected the organisational values. These were:

“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 our 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 had a strategy which detailed how the trust intended to make its vision and values a reality. ESHT 2020 was the overall arching organisational strategy and covered all aspects of leadership and culture; specifically including, recruitment and retention, the development of new roles, staff education and development, organisational design and the development of career pathways. It was developed in consultation with staff and was refreshed and reviewed on an annual basis. ESHT 2020 was discussed at the trust board, leadership conversations and the senior leaders’ forum, and was shared with staff side organisations.

The trust expressed its overall strategy in graphic form to aid staff, public and stakeholder understanding.
The strategy set out a clear goal of what it wanted to achieve, how this would be reflected and could be recognised at the trust, and the plans for achieving this (next steps). This was included for the domains of quality and safety, clinical strategy, leadership and culture, access and delivery and finance and capital. The following is an example of how the trust expressed its strategy aims.

<table>
<thead>
<tr>
<th>What we will have achieved</th>
<th>What it will feel like</th>
<th>Our next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Strategy: 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</td>
<td>We will have a clear strategy for the organisation to fulfil its role as the lead provider of hospital and community healthcare services in East Sussex. The strategy will be fully aligned with the joint strategy for the local health and care economy ‘East Sussex Better Together’. It will also take full account of the commissioning strategy for Lewes Havens &amp; High Weald. Each clinical service will have a clear and settled view of its planned development over the next five years.</td>
<td>• We will develop and implement a long term strategic plan that will enable us to right size our resources and deliver safe and sustainable services to our population. • We have participated in the development of the Sustainability and Transformation Plan (STP) for Sussex and East Surrey, and continue to contribute to the review of acute services. • Each of our clinical units and clinical specialities will be supported to develop clinical strategies and transformation plans in the context of the STP and ESBT. • Clinical leaders will develop and own these clinical strategies • We will engage and support system wide strategic planning with primary care, local CCGs, and social services. • Our clinical and care strategies will encompass end to end patient care pathways focusing on maintaining health, preventing deterioration, and providing rapid acute response when required</td>
</tr>
</tbody>
</table>

The trust was able to monitor progress against its objectives. The trust had identified key, high level metrics in each of its domains, so it could track progress. The finance and capital domain had targets for 2018/19 and 2020 but not historical performance recorded. The latest version of the strategy showed actual data for the years 2016/17, 2017/18 and the targets for 2018/2019 and for 2020. Additional metrics had been added through the life of the strategy. We saw that for the vast majority of metrics, there was an improvement in performance showing the trust was achieving its strategy aims.

The trust considered the strategic enablers to its strategy. These were focussed on estates and facilities and digital solutions. The strategy document identified the priorities in these areas.

The trust recognised the increasing importance of relationships with health economy partners and health systems in assuring trust financial sustainability and the quality of service provided. Overall, we found trust plans were well aligned with the strategic plans of the integrated care system/partnerships. The local clinical commissioning group and the trust had worked together to improve overall financial stability across the system. The trust director of finance had collaborated with system partners In the year 2017/18 the there was a shadow aligned incentive contract which had just become a hard aligned incentive contract at the time of our visit.

The chief executive and trust chair showed a good understanding of the opportunities and challenges presented by the local integrated care system and integrated care partnerships arrangements. For example, the trust was exploring the relationships with GP’s, especially in relation to the provision of its community services and the integration of primary care. We noted that senior leaders at the trust were taking on leadership responsibilities in the integrated care system. The local system had conducted an analysis of the local population health needs published as “our population health check – the clinically-led diagnosis of what needs to change across our local health and care”. This is summarised below:
In 2019 the trust participated in the publication of the “State of the County 2019 – Focus on East Sussex” report which set out a detailed analysis of available health and care data for the local health system.

There was recognition by all system partners that there was still significant work required to strengthen and enhance the strategic plans and that they will then need to be translate into detailed operational delivery plans by the end of March 2020.

An integrated group chaired by commissioners which included the director of strategy and linked to the directors of finance group for East Sussex, was working on the following workstreams at the time of inspection.

- Defining and/or updating projects, objectives, KPIs and benefits reflecting the programme priorities for 2020/21
- Feeding this into organisational operational and business planning processes for 2020/21
- Linking this with the work to develop financial modelling and assumptions at the Sussex-wide and East Sussex level, and the detailed plans for 2020/21 as they emerge
- Reviewing the integrated Outcomes Framework to ensure they reflect the LTP priorities

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.**

In our discussions with staff in focus groups and with non-executive directors we were told the culture of the organisation had been “transformed” since 2015. The culture was described as open and welcoming of alternate views. There were a change in leadership attitude with executive behaviour encouraging change and with ideas being generated at appropriate levels rather than
being imposed or stifled. The culture was described as “a culture of improvement”. Trust leaders had, and communicated, clear expectations about behaviours and performance and “mediocrity was not tolerated.” Senior leaders noted staff believed in the trust vision and its achievability.

**Staff Diversity**

In 2018/19 across all staff groups trust data showed that:

- 77.7% of all staff identified as white British or white other.
- 13.4% of all staff identified as BME.
- 9% of staff had an unknown ethnicity.
- 17.8% of all clinical staff were identified as BME.
- 82.2% of all clinical staff were identified as white British, white Irish or white other.
- 5.1% of all non-clinical staff were identified as BME.
- 95.0% of all non-clinical staff were identified as white British, white Irish or white other.
- The relative likelihood of white staff being appointed from shortlisting in 2018/19 compared to BME staff was 1.28 times greater. In 2017/18 the relative likelihood of white staff being appointed from shortlisting compared to BME staff was 0.91 times greater.
- Staff identified as BME were 1.8 times more likely to enter the formal disciplinary process compared to staff identified as white British, white Irish or white other.
- White staff were 1.3 times more likely to access non-mandatory training compared to BME staff.

(Source: Routine Provider Information Request (RPIR) – P10)
NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.

There were no themes where the trust’s scores were significantly higher (better) or lower (worse) when compared to the 2017 survey.

(Source: NHS Staff Survey 2018)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators one to four and indicator nine is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators five to eight are included in the NHS Staff Survey.

Notes relating to the scores:
- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, two, four and seven, a higher percentage is better while for indicators three, five, six and eight a higher percentage is
worse.

The presence of a statistically significant difference between the experiences of BME and white staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts’ circumstances.

<table>
<thead>
<tr>
<th>WRES Indicators from ESR (HR data)</th>
<th>BME Staff</th>
<th>White Staff</th>
<th>Are there statistically significant difference between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8+</td>
<td>2.6%</td>
<td>3.8%</td>
<td></td>
</tr>
<tr>
<td>1b. Proportion of non-clinical staff in senior roles, band 8+</td>
<td>5.0%</td>
<td>5.5%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>2. Proportions of shortlisted candidates being appointed to positions</td>
<td>6.2%</td>
<td>5.7%</td>
<td>-1.7%</td>
</tr>
<tr>
<td>3. Proportion of staff entering formal disciplinary processes</td>
<td>1.1%</td>
<td>0.7%</td>
<td>0.8%</td>
</tr>
<tr>
<td>4. Proportion of staff accessing non-mandatory training and CPD</td>
<td>9.5%</td>
<td>10.5%</td>
<td>Not assessed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WRES Indicators from the NHS staff survey</th>
<th>Proportion of respondents answering “Yes”</th>
<th>Are there statistically significant differences between...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BME staff</td>
<td>White staff</td>
</tr>
<tr>
<td>5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust</td>
<td>32.3%</td>
</tr>
<tr>
<td></td>
<td>Peer group</td>
<td>27.9%</td>
</tr>
<tr>
<td>6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>Trust</td>
<td>29.3%</td>
</tr>
<tr>
<td></td>
<td>Peer group</td>
<td>29.3%</td>
</tr>
<tr>
<td>7. Staff believing that the trust provides equal opportunities for career progression and promotion</td>
<td>Trust</td>
<td>74.5%</td>
</tr>
<tr>
<td></td>
<td>Peer group</td>
<td>69.5%</td>
</tr>
<tr>
<td>8. Staff experiencing discrimination at work from a manager/ team leader or other colleague?</td>
<td>Trust</td>
<td>17.1%</td>
</tr>
<tr>
<td></td>
<td>Peer group</td>
<td>15.9%</td>
</tr>
</tbody>
</table>

### Key
- ✔ Statistically significant or negative finding
- ✗ Not statistically significant
- 🟢 Positive finding
- 🔴 Statistical analysis not undertaken as less than 30 BME staff responded
- 🟢 Statistically significant improvement
- ➡ No statistically significant change
- 🔴 Statistically significant deterioration

As of March 2018, none of the ESR staffing indicators shown above (indicators 1a to 3) showed a statistically significant difference in score between white and BME staff.

Of the four indicators from the NHS staff survey 2018 shown above (indicators five to eight), the following indicators showed a statistically significant difference in score between white and BME staff:

5. In 2018, 32.3% of BME staff experienced harassment, bullying or abuse from patients, relatives and the public in the past year which was significantly higher when compared to 26.3% of white staff. The score had remained similar when compared to the previous year, 2017.

7. In 2018, 74.5% of BME staff believed that the trust provided equal opportunities for career progression and promotion which was significantly lower when compared to 86.2% of white staff. The score had remained similar when compared to the previous year, 2017.
8. In 2018, 17.1% of BME staff experienced discrimination from a colleague or manager in the past year which was significantly higher when compared to 6.0% of white staff. The score had remained similar when compared to the previous year, 2017.

There were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

The trust supported staff with protected characteristics through its staff networks. There were three principal networks:

- Black and Ethnic Minority Staff Network
- Disability Staff Network
- LGBT+ Staff Network

We were clearly told by staff that equality and diversity were an important part of the leadership agenda. The trust had a dedicated equality and HR lead and the director of human resources had executive accountability for the agenda. This commitment was made clear by the chief executive and director of human resources chairing networks. The equality and diversity lead kept staff across the trust informed of issues about equality and diversity via a quarterly newsletter, which we saw.

The black and ethnic minority staff network was reported to have grown in numbers to about 60 participants. The chief executive chaired this network, and was attended by the equality lead, union representatives, human resource managers, leadership managers, staff health and wellbeing and engagement leads. The network aimed to provide a safe place for staff to raise concerns, support one another and identify best practice. The network also aimed to identify training and development opportunities for staff as well as hosting speakers to support career development and promote inclusive practices. Leadership and talent management were discussed regularly at the black and ethnic minority staff network and all leadership and talent management opportunities including the high-performance programme were shared directly with group members and beyond. The trust had supported a number of black and ethnic minority staff to attend “Ready Now” and “Stepping Up” programmes.

The trust participated in various initiatives to promote equality week and black history month during 2018/19. The national director for WRES Implementation attended a meeting with the trust board and delivered a presentation on evidence-based strategies for improvement. The team also delivered a workshop for staff focusing on WRES and the importance of networks. The equality team focused equality week on staff networks along with career development workshops.

There were also informal smaller networks such as Filipino staff who had been introduced to other Filipino nursing staff at induction events and continued to meet regularly supported by an associate director of nursing and the clinical education manager. The associate director of nursing (corporate) had developed a buddy scheme where overseas nurses were buddied with other overseas nurses to help them integrate into the hospital and local community. They had also developed a list of useful phrases or sayings that are part of everyday use but are not taught in English language lessons.
The trust aimed to have a member of black and ethnic minority staff on any interview panel for roles at band 8a and above. However, it is not always possible. They had run specific training programmes to develop staff to do this and had 18 people trained and ready to participate.

Staff side organisations told us senior leaders embraced the LGBT groups at the trust and they were very supportive and positive about the work they did. We were given an example of a successful project whereby the LGBT network and implemented the rainbow badge scheme which required staff to sign a pledge to advocate for LGBT people, and to signpost them to sources of help. This initiative had created a virtual network of some 4,000 staff and we saw staff wearing their badges in our core service inspections. The network had also set up a closed social media group for LGBT trust staff to access.

Staff felt they could raise issues with executives without fear. Staff side organisations described how some trust staff had raised concerns directly with the chief executive who took action or signposted the staff member to other sources of help and support.

The freedom to speak up guardian sat on meetings held with the black and ethnic minority group, in team meetings and also attended junior doctor events to gain intelligence and raise awareness.

The trust was monitoring implementation of the EDS2 quality system. Each outcome explored a different area of the trust the trust had completed grading bi-annually. The EDS2 approach to grading was currently under review to improve the system and process to ensure outcomes are managed appropriately and graded by its stakeholders.

The trust was committed to eliminating bullying and harassment. Staff survey results showed that staff did not consider bullying and harassment to be a major concern at the trust. There was a current Anti-Harassment and Bullying (Dignity at Work) Policy due for review in 2020. The policy set out the trust expectations and responsibilities for all staff. It covered harassment or bullying which occurs at work and out of the workplace, such as on business trips or at work-related events or social functions. It covered bullying and harassment by staff (which may include external consultants, volunteers, contractors and agency workers) and also by third parties such as patients, suppliers, or visitors to our premises. This policy formed part of contracts of employment and reassured staff that raising a concern regarding harassment or bullying meant privacy and confidentiality would be respected as far as possible.

The trust had a appointed a freedom to speak up guardian (FTSUG) in line with national requirements. The FTSUG was not part of the management structure of the trust and was empowered to act independently in response to the concerns being raised with them. The post holder has been full time in the role for three years and reported to the chief executive and had ready access to the board. The FTSUG had individual meetings with the chief executive, who was the executive lead for freedom to speak up supported by a named non-executive. The FTSUG also had individual meetings with the director of nursing, the chief operating officer and the human resources director. The FTSUG had an office but was often out seeing staff or walking the floor at the hospitals.

The board were given assurance about the activity of the FTSUG through regular reporting. We reviewed the FTSUG board reported dated June 2019. Staff side organisations were aware of the work of the FTSUG and described how they worked well together, and that staff felt safe in reporting issues the FTSUG.
Numbers of staff coming to the FTSUG started high but had stabilised. Reports of what has been raised were sent to the Freedom to Speak Up National Office on a quarterly basis and these were broken down by group profession. Any themes identified were reported to the chief executive.

During the business year 2017/18 there was a total of 297 contacts with the FTSUG: an average of 24.75 a month. The FTSUG was away for one month during 2018/19; the year saw a total of 264 contacts at an average of 24 a month. The highest scoring categories for contacts remained the same and related to behavioural and relationship issues, and concerns about systems and processes., but there was a significant decrease in contacts concerning bullying and harassment from 73 in 2017/18 to 45 in 2018/19.

The trust took action when concerns were raised. We were given an example whereby poor behaviours around car parking were raised. Human resources and clinical leads got involved to resolve the issue to everyone’s satisfaction. Also, a meeting charter had been developed and put into all meeting rooms in the organisation, and on the intranet, to provide a visible reminder of the trust values for all staff and the behavioural expectations. A newsletter for staff was published periodically which provided re-assurance to staff that their concerns were taken seriously and addressed. The trust’s electronic reporting system was utilised to monitor investigations, ensure appropriate actions were taken, learning was shared, and feedback given to staff.

There were no arrangements for associates to support the FTSUG workload, and there was no cover for absence. The trust did not have FTSUG ambassadors who worked with the FTSUG although the trust did have ambassadors with access to resource folders that could be used if a member of staff approached them. They could then signpost them to the FTSUG. As there were no FTSUG ambassadors, any period of leave or any other absence was not covered. Due to the two acute sites and community service make-up of the trust, there had been discussion regarding a second FTSUG although this had not developed any further.

The trust was committed to improving care for patients with protected characteristics. For example, the sunflower lanyard scheme supported staff in identifying patients with a hidden disability who may need additional support. In April 2019 the trust introduced the interpreter on wheels with an app also available on trust owned tablets. This allowed audio and video interpreting to be readily available for those for whom English was not their first language, including users of British Sign Language (BSL). The use of video interpreting using BSL had been enthusiastically welcomed by members of the local deaf community as most appropriate communication method for users of BSL providing the potential to improve health outcomes. The equality and diversity manager had also set up a user group for deaf patients. This was started as deaf patients had feedback because there was little that assisted them in giving comments or making complaints. They now had a specific, dedicated email address where deaf people could raise their concerns. There were plans to provide staff with myth busting deaf awareness sessions in the coming months. These initiatives to improve communication with deaf people was also an indication of the trust’s commitment to the accessible communication standard they were required to implement.

All new human resources had an equality impact assessment. Policies were sent to the equality and diversity manager for comment and feedback to ensure that they were fit for purpose and did not discriminate against any protected characteristics.
Friends and Family test

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 96.5% and 98.1% from September 2017 to August 2019. The data appears to be stable with only random variation over the whole period.

Sickness absence rates

The trust’s sickness absence levels from July 2018 to June 2019 were mostly similar to the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2019 General Medical Council Survey the trust did not perform better than expected in any of the survey areas. Performance was worse than expected in two areas (Curriculum coverage and educational supervision) and the same as expected for the remaining 16 areas.

(Source: General Medical Council National Training Scheme Survey)
Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust “Accountability Framework - How individuals and teams are held to account for the delivery of the trust’s objectives” was produced in July 2019 and clearly set out the responsibilities and accountabilities for all trust leaders, managers and staff.

The organisation’s governance framework outlined the reporting structure and meetings; it also included a range of methods for monitoring performance and providing assurance. Having a meeting was not considered the sole means of assuring and managing performance. Managers and staff used a range of other means including improvement huddles, conference calls and working virtually whenever appropriate. The trust standardised agenda, report templates and action logs were used for all corporate meetings. The simplified governance structure is represented below:

The trust board received the integrated performance review report; the information included in these reports was validated with the divisions and used to develop the report which was presented to the board for their assurance. We saw copies of the trust integrated performance report in board minutes and noted there was discussion and challenge around the content. Reports were produced for quality and safety (covering metrics such as in incidents, infection control and patient experience), access and delivery (including metrics on patient flow and waiting times), activity, workforce (including metrics on expenditure, recruitment and staff absence) and finance. Reports were assigned to an appropriate executive director.

There was a system of monthly integrated performance reviews for divisions. Performance was monitored through monthly divisional integrated performance review meetings (IPRMs). Although a fairly new initiative, these were well embedded and divisional managers and board members spoke enthusiastically about the value of these. Reviews were chaired by the chief executive, or his deputy. The monthly divisional IPRM was the key forum at which the performance of the division was measured and monitored. The purpose of the meetings was:

- To assess actual performance against predicted plan under the five domains
- To assess risks to future delivery and agree and monitor mitigation plans.

The chief of division, associate director of operations and assistant directors of nursing had developed an integrated performance report which they presented to the monthly divisional IPRM.
This was the opportunity for the chief executive and executive directors to review and challenge divisional performance against all targets using the trust’s strategic domains.

It was the responsibility of the divisional leadership teams to hold their staff to account for performance within the division, promoting a positive performance culture and individual accountability within their areas of responsibility. The divisions held their specialities to account through the mechanism of specialty level review meetings which they held at appropriate intervals depending on the size and complexity of the specialty.

**Board Assurance Framework**

The trust provided their board assurance framework (BAF), which details five strategic objectives. A summary of these are below.

1. Safe patient care is the trust’s highest priority. The trust will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
2. The trust will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.
3. The trust will work closely with local commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of the local population in conjunction with other care services.
4. The trust will use their resources efficiently and effectively for the benefit of patients and their care to ensure services are clinically, operationally, and financially sustainable.
5. All East Sussex Healthcare Trust’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.

*(Source: Trust Board Assurance Framework – July 2019)*

We reviewed the latest iteration of the board assurance framework. It clearly defined risks to the delivery of the organisation’s delivery of its strategy and objectives. The risk was recorded in accordance with the trust’s statements of risk appetite. Controls to mitigate the risk were identified and sources of assurance made explicit. The framework was kept current with updates on further actions and time-scales recorded. The executive lead and monitoring committees were also identified.

From minutes we saw the framework was an agenda item for board meetings. Here changes to the framework were considered; for example, in December 2019 the following was noted. “There are two areas where assurance has increased 2.1.3 follow up appointments due to strengthened controls and 2.2.1 accountability framework as actions are progressing and this will be reported to POD. The Board will be asked to approve these moving to green. There is one area that remains red 4.2.1 due to capital constraints”.

The company secretary had responsibility for the BAF. She told us that the BAF had an in-depth review every six months and the format was evolving and improving following these reviews. For
example, the adding of risk tolerance to the framework. We could see evidence of the review process in the BAF documents supplied to us.

The non-executive board members we spoke with felt the BAF had improved in quality and they found it useful. They commented that it gave assurance, or an opportunity to challenge if not assured.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>387.9m</td>
<td>408.8</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(68.4m)</td>
<td>(44.4m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>456.4m</td>
<td>453.2m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(26.5m)</td>
<td>(45.0m)</td>
</tr>
</tbody>
</table>

The deficit reported in 2018/19 was lower than the previous year. Projections for 2019/20 indicated that the deficit will decrease further. The projected deficit for 2020/21 is £7.9m.

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

The trust exited financial special measures in July 2019. It had agreed a financial plan to deliver financial deficit of £34.03m in 2019-20 (£10.13m deficit including support funding of £23.9m). Its financial projections indicated it would deliver this plan. The trust told us that plans for its 2020-21 financial target of £29.28m deficit (excluding support funding which had not been confirmed) were well developed and that it had confidence that the plans would be delivered.

The trust had a track record of delivering its financial plans and its senior leadership had in-depth links with the local health economy and system partners. The system recognised financial risk as a key system risk for the emergent integrated care plan; and income risk had been reduced by the implementation of an aligned incentive contract with local clinical commissioning groups. The trust told us that it had agreed with system partners the income and activity assumptions for 2020-21 financial year, which were said to reflect appropriately over performance in the current year.

The director of finance has been in post since 2016. He had built strong relationships with finance leaders in the local health economy and Sussex health system. He was supported by a strong deputy whom we were told would act up as finance director when he left the trust in April 2020.

Divisional leadership teams were well-engaged with financial issues and described and gave examples of how they managed operational risk whilst delivering service transformation, including
innovative local solutions to workforce challenge. The executive team held divisions to account through integrated performance review meetings chaired by the chief executive. The development of financial plans emphasised the accountability of divisions to develop and deliver 2% annual cost improvements that were in addition to growth mitigation, quality improvement and transformation initiatives. In 2019/20 efficiency plans were 4.4% of expenditure and in 2020-21 efficiencies were planned at 3% of expenditure.

The internal auditors had given adequate assurance on the internal control environment; and, subject to “going concern” caveats reflecting the trust’s deficit, the external audit opinion was satisfactory.

Trust corporate risk register

The board assurance framework was augmented by a detailed risk register of significant risks. Progress on mitigation of risk was updated regularly but few had changed significantly over many years. It was unclear that people risks were considered by the people and organisational development committee, although the chair of finance and deputy chair of audit told us that these committees did undertake “deep dive” reviews for supplementary assurance.

The trust governance lead was confident staff knew the importance of governance and risk and there was increasing awareness of the divisional priorities.

The trust provided a document detailing their six highest profile risks. Each of these have a current risk score of 20 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Specialty</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/11/2015</td>
<td>1398</td>
<td>Capital projects and programmes</td>
<td>There is a risk to patient, staff and visitor safety due to the potential of falling debris from the external building cladding, facias, soffits and gutters.</td>
<td>20</td>
<td>1</td>
<td>09/08/2019</td>
</tr>
<tr>
<td>22/02/2016</td>
<td>1459</td>
<td>Diabetic eye screening</td>
<td>There is a risk to patient safety and patient data stored on software due to issues with IT performance and server.</td>
<td>20</td>
<td>4</td>
<td>22/07/2019</td>
</tr>
<tr>
<td>06/12/2018</td>
<td>1767</td>
<td>All specialties (risk register use only)</td>
<td>There is an increased likelihood of multiple hardware failures at one time as they reach the end of life due to the same or similar dates for when they were commissioned.</td>
<td>20</td>
<td>5</td>
<td>30/07/2019</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Department</td>
<td>Description</td>
<td>Score</td>
<td>Risk</td>
<td>Date</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>21/12/2018</td>
<td>1772</td>
<td>Anaesthesia</td>
<td>There is a risk to patient safety and non-compliance with national guidelines, caused by inadequate numbers of consultant intensivists to support critical care units on both acute sites.</td>
<td>20</td>
<td>4</td>
<td>25/07/2019</td>
</tr>
<tr>
<td>17/01/2019</td>
<td>1774</td>
<td>Estate and space utilisation</td>
<td>There is a risk that the continuing roof leaks within the boiler and generator house will lead to the failure of electrical services to the site.</td>
<td>20</td>
<td>5</td>
<td>07/08/2019</td>
</tr>
<tr>
<td>11/02/2019</td>
<td>1779</td>
<td>Obstetrics</td>
<td>There is a risk that staff who deliver care to women in labour who are using Entonox will be over exposed to the Entonox gases when the women expels them. It is caused by poor room ventilation and extraction of gases that does not allow for 15 air changes per hour and consequently breaches the acceptable Entonox levels.</td>
<td>20</td>
<td>6</td>
<td>16/08/2019</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register)

There was a systematic approach to identifying and managing risks. A new risk management policy had been introduced which meant the risk register was embedded from the ward up. Risks were reviewed at ward level and then reviewed again at the divisional meetings and specialist meetings, clinical outcomes and clinical effectiveness meetings. Staff identified a risk and this was then reviewed at local level, at a divisional meeting review and that meeting then escalated to clinical outcomes groups as appropriate. Highest scoring risks were captured on the corporate risk register.

The senior leadership forum reviewed the risk registers every three months. We were told leaders challenged to ensure all the risks are up to date and being managed and records captured all the actions taken. The trust risk lead and director of corporate affairs worked together to ensure that risk is captured in the board assurance frameworks.

The trust governance lead told us the organisation had some risks that could not be downgraded (for example, legionella). However, she was sure things are not “just logged and forgotten about”. From our review of risk registers we noted that entries were reviewed and updated.

The trust provided training for risk facilitators although it was open to all staff. There was further training available for health and safety training which was risk assessments specific.
Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The trust used an electronic incident reporting and management system. All staff were trained on induction on how to recognise and report an incident. On our core service inspections, we found staff had a good understanding of incident reporting.

There was a system that ensured leaders had oversight of incidents, their management and learning. Incident reports were completed at a local level. These were then reviewed by the governance team and categorised 1 – 5. Incidents rated 1/2 were subject to a local review and investigation and these represented no, or low, harm events. Progress on this was monitored by the central team.

If staff graded and incident 3 – 5 categorised (moderate harm) this triggered a formal investigation. These were managed through the divisional structure, then reviewed by the patient safety group and had final sign off by the director of nursing. All closed investigations were then passed back to the division to cascade the learning.

All 4/5 incidents were categorised as serious incident requiring investigation (SIRI) and reported on the national Strategic Executive Information System (STEIS) as required by national guidance. They were then allocated an independent investigator who had received training in completing these investigations. The governance team reported they worked well with the divisions to ensure there was good clinical input into the investigation process. Families and relatives were involved in the investigations for those categorised 3 – 5. Patient/family questions are incorporated into the investigation’s terms of reference and they were sent a copy of the report. The trust offered a family meeting after the investigations for further discussion and clarification. The trust provided support to staff during an investigation and this was recorded on the investigation template.

The board were sighted on the management of SIRI’s. All SIRI’s were reviewed at the weekly patient safety summit and the board supplied with a report. Governance and divisional staff had given individual presentations to the board recently after never event occurrence. There were systems for staff to triangulate incident data with that from complaints, incidents, compliments, and the patient safety report to ensure all staff had better oversight of issues themes and trends.

The trust had many ways of sharing learning from incidents. These included shared learning in practice (SLIP) forums and divisional learning at meetings safety huddles. Governance meetings agendas included a learning segment. “Grand rounds” and “Schwartz” rounds were also in operation and provided further opportunities for staff to share learning.

We reviewed eight serious incident reports. Overall the process was good with the template documents well completed. All had appropriate action plans, including the immediate actions taken to mitigate against reoccurrence. We did see that clinical input was used but felt the greater engagement of relevant clinical expertise to obtain relevant learning and recommendations for improvement to patient care was an area that could be strengthened. It was noted that families were involved and supported but it was not always well recorded as to how they had been supported and contributed to the investigation process in all its stages.
Learning from deaths

The trust had a process for reviewing and learning from patient deaths. The process is represented in the algorithm below:

The board received a quarterly report on learning from deaths to aid assurance that requirement from the CQC learning from deaths review were being implemented. We reviewed the learning from deaths dashboard presented to the board in December 2019. We saw that for the year to date 431 deaths were identified as being in scope for a structured judgement review, and that 393 (91%) had been reviewed. One death was considered to have been potentially avoidable.

There was a process for ensuring the accuracy of information. A quarterly quality review of randomly selected cases, looking at the accuracy of database entries, was undertaken by the assistant medical director and clinical improvement facilitator. The quality and quantity of the review entry on the mortality database was assessed against the record of patient care documented in the patient notes. Actions were taken at the quarterly mortality review meeting, chaired by the medical director, to ensure accuracy of mortality reviews and provide assurance deaths were reviewed accurately by individual consultants, and care ratings were correctly allocated. These actions included: serious incidents and amber incidents where death occurred cross checked against the care rating assigned, inquests and claims not identified as an issue through a complaint, serious incident or amber
incident cross checked against the care rating, complaints involving a patient death are cross checked against the care rating and where required the health records reviewed to determine if the rating was appropriate and a review of the cases where the family raised concerns about the care delivered checked against the care rating with bereaved relatives specifically asked if they had any concerns in care as part of the bereavement process.

We reviewed monthly reports from January to April 2019. There were a detailed summary of performance on the completion of reviews. We noted this report contained details of lessons learned. We also reviewed the mortality database for the intensive care unit and saw it was well completed and allowed for monitoring of the event chronology, speciality discussion and learning.

The trust was implementing the learning disability mortality review programme (LeDeR). Deaths of patients with a learning disability were being reviewed against the new criteria externally. However, feedback to the trusts from these external reviews was extremely slow reflecting the national situation. The trust process of conducting internal reviews was therefore being continued to mitigate against any risk. The deaths were reviewed by the learning disability nurse and head of nursing for safeguarding who entered their review findings on the mortality database. In the business year 2018/19 12 learning disabilities deaths were considered to be in scope and 9 were reviewed through the LeDeR programme or equivalent.

We reviewed 10 mortality reviews that did not proceed to structured judgement reviews. All contained a chronology of events. However, on decision making for the level of care, end of life care and clinical management only one has text evidence for the rating that care was good. It was not possible to determine the rationale for decision making especially relating to which cases were put forward for further review.

We reviewed five structured judgement reviews. We found the reviews generally gave good evidence for the ratings for each phase of care and had clear and measurable actions. There was also clear cross referencing to the serious incident process.

**Medicines**

The trust had systems and processes to safely prescribe, administer, record and store medicines. There was a hospital pharmacy transformation plan and this was continually updated in line with the department’s progress against it. Pharmacy was integrated into the governance structure of the trust, with a range of committees dealing with relevant medicines risks and issues. Pharmacy risks were registered; action plans were created to ensure that risks were managed in an active and ongoing way.

The trust was preparing for the installation and roll-out of an electronic prescribing and medicines administration system (EPMA). This included plans for reducing the risks associated with roll-out as well as business continuity in the event of an unintended IT failure.

Pharmacy staff supported medicines management training for some groups of staff within the trust. The trust medication safety officer showed there were processes to handle, review and share learning from medicines incidents across the trust. This included any dispensing incidents. There were also plans to produce a local action plan for aseptic services once the recommendations from the England pharmacy aseptic transformation board review are available.
A range of audits (such as those for the use of anti-microbials and the safe and secure handling of medicines) were undertaken. We also saw that some initiatives to promote medicines safety had been developed by the trust, including one relating to anticoagulants (medicines to prevent blood clots) which was shared with local primary care providers.

There were adequate systems to manage patient group directions, medical gases and the oversight of controlled drugs across the trust.

Medicines reconciliation is an important process that ensures people’s medicines are recorded correctly when they are admitted to hospital. The most up to date information on trust rates for medicines reconciliation were over 90% at 24 hours post admission. The national target for this is 75%.

Pharmacy staff told us that whilst training opportunities were on offer, they felt that they could not always take these up due to capacity in the team. Some staff felt that poor morale within the department was partly linked to work pressures. Some staff told us they were concerned that capacity to undertake dispensary duties was close to its upper limit. Work relating to improving support from managers, staff engagement and health and well-being was being undertaken, with a review date of March 2020. However, pharmacy staff told us they were proud of the service and care they provided.

There were plans to introduce weekend working. The viability of this had been researched and at the point of inspection, plans were being consulted upon. Staff told us they had concerns about the number of inexperienced staff this might involve. Within the consultation framework, we saw that there was flexibility in the planned approach to account for this.

**Infection prevention and control (IPC)**

The trust controlled infection risk well. There were suitable arrangements to ensure the trust had access to specialist advice, auditing arrangements and reporting structures which meant the board could gain assurance in relation to IPC.

The director of nursing was the executive lead/director for infection and prevention and control at the trust (DPIC) as required by national guidance. The trust had a dedicated IPC team as detailed below:
There was clear governance and reporting structure relating to IPC as detailed below:

The trust infection prevention and control group (TIPCG) was chaired by the director of nursing. The group met monthly and had wide representation from throughout the trust including from clinical units, occupational health, pharmacy, commercial division and also external membership from the local department of Public Health England (PHE). The TIPCG reported monthly to patient safety and quality group regarding performance and operational issues and also compliance against regulations.

Each of the clinical units reported directly to the TIPCG on compliance with regulatory standards for IPC. Clinical matrons and clinical managers had the responsibility for the prevention and control of
infection in their local area in line with national and local policies and guidelines. Each clinical department had appointed an infection control link facilitator who, with educational support and guidance from the IPC team was responsible for cascading and monitoring compliance with IPC practices at local level.

Externally, the lead IPC nurse reported directly on performance to the clinical quality review group held by two local clinical commissioning groups (CCGs).

The IPC team co-ordinated planned and unplanned audits throughout each year to monitor compliance with core infection prevention and control standards and any areas of risk or concern which may arise as a result of incidents.

The following audits were completed in the business year 2017/18

- Monthly staff hand hygiene audits
- Quarterly peer hand hygiene audits
- National Specification of Cleanliness audits
- Audit of compliance with Control of Carbapenemase Producing Enterobacteriaceae (CPE).
- Audit of compliance with Diarrhoea Assessment Tool Audit
- Re-audit of compliance with the trust MRSA policy for management of emergency admissions with a known history of MRSA.

In addition, the trust has systems for assessing the quality of cleaning throughout the organisation. These were audits to assess compliance with the national specifications of cleanliness (NSC). Results and actions were monitored through the TIPCG and the divisional integrated performance reviews.

The trust received an annual IPC report. We reviewed the report for 2017/18. The trust integrated performance report contained up to date in relation to IPC at the trust. We saw this in trust board minutes. We noted the trust was consistently achieving below its upper control limit for *clostridium difficile* (CDiff) cases per 1,000 bed days in the period from April 2017 to October 2019. The trust reported no MRSA cases for the month of October 2019, although a total of three had been reported to date for the current business year against a target of none.

**Recruitment**

It was widely acknowledged by managers and leaders that the inability to recruit and retain a skilled workforce was a prime risk to the delivery of the trust objectives and strategy. This was reflected on risk registers and board assurance frameworks. The trust was being creative to find longer term solutions to the national shortages of staff.

The trust integrated performance report for December 2019 noted the total workforce utilisation for October 2019 was 6,799.4 full time equivalents (fte) which was 412.4 fte below the budgeted establishment. It also noted: “The trust vacancy rate has increased by 0.7% to 10.5%. This is as a result of increases in budgeted establishment this month (+ 88.4 fte) including the Ambulatory Care Business case, funding of the Discharge Team workforce and new Information Security posts in Digital IT. Staff in Post numbers have actually increased by 29.7 fte. Current vacancies are 743.9 fte (an increase of 58.7 fte vacancies).”

The trust was recruiting internationally with some success. Eighty international nurses had joined the trust since May 2019 and six radiographers were to join the trust in December 2019.
Consultants remained the most difficult group to recruit, vacancy rates for the medical workforce ranged from 11% to 16% in the period from October 2019 to October 2019.

The trust were committed to looking at skills mix in an innovative way to ease recruitment and retention challenges. There was investment in new roles such as physicians’ and junior doctors’ assistants with competence assessed and lined to national guidance. The trust was investing in nursing associate roles and apprentices, and apprentices in other fields such as physiotherapy. However, some non-executives expressed the view that the trust need to “take stock” of these new roles and clearly articulate why they were beneficial and needed. They said they were working with the director of human resources to influence and refine the workforce strategy in this regard. From our discussions and review of documents we found there needed to be more assurance on the future workforce profile and needs, what roles encompassed in terms of skills, and plans to address present and future workforce risks.

We reviewed the wellbeing strategy and found it needed to more clearly evidence risks such as aging workforce and increasing stress and anxiety rates with assurance on how these would be addressed. These issues have potential to further affect the availability of key staff to deliver the trust’s work.

**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 trust had a structured safeguarding leadership with clinical and safeguarding expertise in line with national guidance. The director of nursing was the executive lead and strategically led the safeguarding agenda. The head of safeguarding reported into the director of nursing and had corporate responsibility for effective trust wide safeguarding, expertise, arrangements and reporting. She provided support to the divisional associate directors of nursing who were responsible for ensuring robust safeguarding arrangements and practice in each clinical division.

There was an effective governance structure in relation to safeguarding. The safeguarding operational group and divisional governance meetings were held monthly and reported into the bi-monthly strategic children and adults safeguarding group, which in turn reported to the board via its quality and safety committee. The board reviewed an annual safeguarding report; we reviewed the report for the business year 2017/18.

Trust safeguarding policies for adults and children set out the key arrangements for safeguarding practice, roles and responsibilities. We found these were reflective of national guidance and best practice.

The trust provided safeguarding training. Staff generally met the 85% target for completion.
Since 2017 safeguarding supervision has been provided formally to paediatric and maternity staff. The trust had recently launched its safeguarding supervision policy for nurses who predominantly worked with adults.

Trust staff actively made safeguarding referrals. Adult safeguarding referrals could be raised by staff, patients, family members or the public and were received by the local authority, who assessed if the concern raised met the threshold for a safeguarding concern. There was an increase in the number of concerns raised. However, the increased numbers of reports reflected “newer” safeguarding concerns e.g. modern slavery. Referral numbers for the business year 2017/8 are below:

Child safeguarding referral activity had remained unchanged over the last three years, as set out in the table below:

The trust collaborated with system partners in relation to safeguarding. The director of nursing was
a member of both the local safeguarding adults and the local safeguarding children’s boards in East Sussex. The head of safeguarding and members of the team fully supported the sub-committees, groups and processes of both safeguarding boards. The safeguarding teams felt this enabled the trust to drive forward both the national and local safeguarding agenda in partnership by supporting them to learn from safeguarding reviews, partner agency reports, national safeguarding challenges and local issues. Trust safeguarding staff were involved in the East Sussex Better Together (ESBT) programme, developing integrated health and social care for the residents of East Sussex. The team provided safeguarding advice and expertise to a range of colleagues.

The trust had arrangements to support staff in recognising and managing child sexual exploitation and abuse. The trust had undertaken audits of high-risk children, already known to the missing and sexual exploitation group, who attended the emergency departments. There was a weekly meeting, to identify specific high-risk children flagged, for updating information, discussion and planning. The named safeguarding nurse for community represented the trust at the missing and sexual exploitation group and shared learning. Child safeguarding training, policies, procedures and checks were reviewed in response to improve awareness and action in response to these risks to children.

The trust had effective arrangements to meet the requirements set out in the Home Office guidance for female genital mutilation (FGM). The FGM lead was responsible for all mandatory returns, monitoring local incidences of FGM and staff training and support. Staff identified and reported 11 cases of FGM from April 2017 to March 2018. All cases were reported to children’s social care for follow up.

Trust staff were aware of indicators of modern slavery and was compliant with its legal obligation to prepare staff to identify patients at risk of modern slavery and being trafficked. Trust staff had identified suspected cases, which were reported to the police.

The head of safeguarding was the trust lead for the PREVENT programme, which supported the local and national counter terrorism strategy. The trust was an active member of the local PREVENT board. Safeguarding training had PREVENT training embedded within it for both children and adults. There were no referrals under PREVENT in the business year 2017/18.

We reviewed nine safeguarding records. Generally, we found most were fully completed and were a record of the management of the concerns. This management was aligned with trust and national policies and guidance.

**Mental Health Act**

Staff knew how to support patients experiencing mental ill-heath. The trust had a service level agreement with a local NHS mental health trust so the trust could meet its legal requirements to ensure patients admitted to inpatient beds had their rights maintained and their mental health care needs met by the responsible mental health clinician. We reviewed this document. The director of nursing was the executive lead for the mental health act. The deputy director of nursing had instigated regular meetings to monitor trust compliance and to work collaboratively with the mental health team to address any issues with non-compliance. This work enabled the following:

- The site team were trained to undertake the duties of the receiving officer and maintain detained patients’ rights.
- Section 135/136 training for emergency department staff commenced
Revision of the Policy for the Mental Health Act to support staff

Audit agreements planned with the local mental health trust to measure compliance more systematically

Completion and submission of the KP90 return on mental health activity

Estates

There was a designated associate director of estates who reported to the chief executive. Thus, the board had access to expert advice on estates matters. The new trust strategy reflected the estate challenges. With system partners, the trust was an active participant in the “One Public Estate” group.

The trust faced significant challenges in maintaining and updating its infrastructure. All senior leaders agreed the trust estate was a major risk facing the organisation and this was reflected on the corporate risk register and board assurance framework. The board assurance framework stated there was a backlog of £95 million, although this was thought to have escalated to about £100 million. Estates risks entries were held on the risk register even if they could not be resolved so they remained a focus for the board. For example, the risk of legionella remained as a risk despite some remedial works that had decreased the risk, although piping was still in situ which meant the risk remained.

There had been no unknown or unexpected estates failures in the past four years.

The trust maintained an accurate asset register overseen by the medical equipment group which reported to the capital review group. Managers estimated £54 million was need in replacement costs over the next decade.

There were insufficient funds to cover the backlog of work. Therefore, the trust held a capital planning workshop annually. This covered analysis of current risks and the financial constraints. The progression of outcomes of this workshop was overseen by the finance and investment committee. This committee decided which projects would be taken forward for board approval. This process enabled the trust to focus its financial resources on those areas of the estate that presented the highest risks. The trust had received additional capital, including allocations to improve fire safety and also to undertake initial planning for site redevelopments. Further bids to access one-off sources of funding for other projects were in preparation. Other site developments and upgrades included installation of an MRI scanner, the development of a urology investigation suite and redesign of ambulatory care at the Conquest Hospital, and planned improvements in the emergency department at Eastbourne District General Hospital.

Business Continuity

The trust had clear plans for dealing with unexpected events. These were clearly set out in the Corporate Business Continuity Plan (including business continuity management system). This was current and due for review in 2020. The plan was on a bi-annual review schedule coordinated by the emergency planning team, unless there was organisational change or a change in national guidance which required this to be undertaken earlier. This plan met the trust’s obligations under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 and reflected national guidance such as the international standard for Business Continuity (ISO22301) and the NHS
The trust also had an Incident Response Plan (including command and control framework). This was reviewed at least bi-annually; the version control showed the plan was regularly updated and amended as needed. This plan provided one framework for command and control within the trust to meet the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006 as amended by the Health and Social Care Act 2012 (NHS Act 2006 as amended) and the NHS Standard Contract. It reflected other national guidance.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, sometimes reports were data rich but did not always provide sufficient analysis. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The board had strategic plans for the use and management of IT at the trust. The trust was working collaboratively with partners in the integrated care system and partnership and had developed a whole system information technology (IT) plan. The trust also had developed an IT strategy which had been approved by the board. This consisted of five strands of work all with associated milestones. Detailed plans on each of these strands was in development.

The trust had a clear process for ensuring information was collected, analysed and presented at the right level in the organisation. There was close, collaborative working between the performance and IT with clearly defined areas of responsibility and accountability. This is shown in the diagram below.

There were effective governance arrangements for the monitoring and steering of information governance. The trust had a designated senior information risk officer (SIRO) in line with national requirements, who was the director of finance. He chaired a board level information governance meeting and the information governance steering group was at executive level. Responsibility for information governance was delegated to the company secretary who led a dedicated team at the trust. The trust had a designated Caldicott guardian who was the medical director. The trust had commissioned internal audits in September 2018 and March 2019 to provide assurance of good
information governance at the organisation.

The trust took actions to make IT systems secure. All trust staff received mandatory training in information governance and compliance rates were reported to be improving. Overall mandatory training compliance at the trust was reported as 88.4% in the December 2019 trust integrated performance report. The SIRO believed the awareness and culture of information governance at the trust had improved, and that reporting processes were fit for purpose. We were told there had been no major information governance breaches in the past year, and “few” reportable incidents. The trust had a dedicated person responsible for cyber security, with expertise and experience in this field. It was reported that there was a robust cybersecurity infrastructure.

Divisional leadership teams received detailed integrated performance reports which were collated to provide the trust integrated performance report which was presented by executives at board meetings. The trust was seeking ways to improve the format and we saw an example of a different presentation which was due to be trialled at a future board meeting.

The integrated performance reports were comprehensive and covered a wide range of metrics. They identified targets, so leaders and managers could assess progress and performance. They contained historical data for comparisons, trend lines, histograms and RAG (red, amber, green) ratings and statistical process control charts (SPC) to help leaders identify area of improvement, deterioration or other trends and themes. However, although the reports were data rich, readers had to make their own analysis draw their own conclusions.

The trust shared data and made submissions to external bodies and regulators as required. For example, we received statutory notification as required by regulations, information about incidents was submitted to the National Reporting and Learning System (NRLS) and performance about access and flow was sent to the NHSI/E.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust’s vision of retaining two acute sites reflected strong local support in Hastings and Eastbourne. The trust recognised that it needed to transform services and refine its clinical strategies to deliver sustainable services that improve population outcomes and described steps to ensure patient and user engagement in these decisions through attendance at board of “Save our DGH” and “Hands off the Conquest” groups. Trust leaders and managers showed a deep commitment to and engagement with the development of integrated care partnerships and systems.

The trust had made a public commitment to engagement through its public engagement and patient experience strategy for 2017-2020. The board received an update of progress of this strategy in February 2019. We reviewed the update and saw progress had been made, despite changes to operating context and environment of the trust.

The trust had encouraged a larger number and greater diversity of people to get involved with the trust via the trust membership scheme. Members agreed to tell the trust a little bit about themselves, receive information about the trust and participate and give their views in surveys and other health and care related activities when appropriate. This included online questionnaires,
telephone or postal surveys, being invited to focus group discussions or workshops. Membership was free and open to all. Members needed to live locally or have been a patient in the past five years or the carer of a patient. Members received an e-magazine quarterly, were invited to annual general meetings, forums and open days, took part in surveys and became public panellists. Divisional leaders told us a citizen sat on the forum and partnership boards. There were about 2,000 members at the time of our inspection.

In 2017 the trust began to publish a patient newsletter, #OurMarvellousTeams. Feedback was reported as very positive. The focus of the newsletter was on trust news, public health campaigns and how to get further involved in the trust. The newsletter was distributed across the organisation’s acute and community sites, in areas with a high flow of outpatients.

Using the membership as a base, the trust had developed a group of “super” members who were willing get more involved in trust work. These members were mainly recruited as volunteers and as such had a formal role within the trust, took part in induction training and were checked via the Disclosure and Barring Service. In 2018, the trust had members involved in the excellence in care project (ward accreditation), the front entrance redesign, end of life care project and members who attended the patient experience and public engagement group. The trust also facilitated groups looking at the care of children with shorter lives and wayfinding around Eastbourne District General Hospital. The wayfinding steering group led the signage changes at Eastbourne. This steering group included representatives from the local area, patients and deaf and disabled groups.

In the two years 2017/8 the trust held four member forums attended by up to 50 members of the public where the trust discussed projects, asked for feedback about their design and next steps. Members had fed into the management of complaints, patient booklet, outpatients transformation, communication and discharge processes. In 2019, the trust held a member forum focussing on digital awareness, accessing health information online and outpatient transformation.

Staff organised a number of sessions with local people asking them to help them design the most effective discharge process. They undertook 20 face to face interviews with people who had recently left hospital and planned to undertake 100 telephone interviews to ask people about their experiences. Following this, the aim was to highlight key areas that needed improvement and to co-design solutions with patients.

With support from members, the trust developed a programme of “sit and see” sessions where a member of the public and a member of staff sat in an area of the hospital and recorded what they saw and made recommendations for the service. The trust had undertaken three sessions by the time of our visit.

In 2018 the trust held three very well attended open days in cardiology and ophthalmology and urology. Each of these public events received positive feedback and gave opportunities to engage members of the public.

The trust had undertaken substantial development work with the local deaf community, supporting them to communicate effectively for better health outcomes, and to support staff to recognise and support their particular needs. For further detail please see the culture section above.

The director of nursing was the executive lead for patient experience. The director discussed the need for greater engagement with hard to reach groups such as local ethnic groups or transgendered persons. In our discussions with managers and leaders we found that appreciation of the full extent of the trust’s patient engagement activities was not always present. A director told us they felt there was a need to re-focus the patient experience strategy and group to include wider
representation and better co-ordination.

The trust involved staff side organisations in board and committees. Staff side organisations told us that, generally, they were involved well in leadership meetings. We saw staff attendance from board meeting minutes. Staff side organisations felt they were engaged with the senior leaders in the trust but found that the links with managers at the middle manager level required developing. Staff side organisations were representative at the quarterly working policy group meetings. They also had representation on the disability network which met bi-monthly and the health and wellbeing committee. Minutes of all the meetings were sent to all of staff side representatives. It was reported that the leaders were supportive of the unions attending the committees but it could be difficult getting time away from clinical or other commitments.

Staff side representatives reported senior staff engaged with them when change was planned and they received proposals before any change was implemented. They described how consultation was genuine rather than a token gesture.

Staff side organisations held the executive to account by keeping an “action tracker” of issues they raised. The staff side organisations held a monthly joint meeting which was attended by the chief executive when available. If they were not available, the director of finance or director of human resources attended.

The trust leadership supported and participated in the various staff networks. This provided excellent opportunities for senior staff to engage with staff with protected characteristics, to learn about their experience and hear their views and ideas.

The board placed great value on the system of quality walks described in the leadership section above. The quality walks enabled front-line staff and both executive and non-executive directors to engage with each other.

The trust had refreshed its extranet to support better staff engagement and involvement, facilitate collaboration and initiate a shift in staff culture towards active knowledge. The focus of the new extranet was “How Do I”, and all new material was written with that question in mind. Analytics showed the extranet was well used, with an average 3,500 unique users accessing it every day. The extranet was also accessed over 24 hours, making it an important tool to communicate with staff out of hours.

There was a range of communications channels to ensure staff were kept informed of trust business and developments, in a suitable way for the target audience.

- Weekly ‘news’ email (all staff): Focused on short news articles, looking at what’s new or calls to action
- FocusOn: A more in-depth look at an area or policy, guidance or good practice
- Monthly team brief (trust leadership and cascaded to staff): Focussing on performance, and operational delivery, this communication offers information about the priorities for the organisation, and how the trust was meeting them
- Monthly Connect, staff newsletter (all staff): An e-zine is written by staff for staff. It focussed on #OurMarvellousTeams and the work that they are doing within the trust
- Quarterly chief executive message: Quarterly message to staff focusing on how the organisation is meeting its priorities.
- Staff handbook: Annual staff handbook, refreshing core information and standards that all ESHT people are expected to know.

The trust worked collaboratively with and routinely engaged with partners in the local health system.
Please see examples in the strategy section above. They worked in partnership with the local authority in relation to safeguarding vulnerable people in the local population and beyond. Please see the example in the safeguarding section above.

The trust infection and control team worked and engaged with the wider health system. They worked with the clinical commissioning group (CCG) and Public Health England (PHE) colleagues towards joint strategies for the reduction of healthcare associated infections which led to hospital admission. The IPC specialist nurses were members of the Infection Prevention Specialists Regional Network Meeting who shared and discussed local initiatives, innovations and work towards common goals across Sussex. Surveillance of community acquired E. coli bacteraemia was undertaken by the IPC team on behalf of the local CCGs under a service level agreement.

The pharmacy team worked collaboratively with the local clinical commissioning groups and had undertaken joint work in the clinical areas of diabetes, acute pain and transfer of care around medicines (TCAM).

The trust worked in partnership with East Sussex Healthwatch. This group carried observations of care and services using their powers of enter and view, especially in the emergency departments.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They were developing understanding of quality improvement methods and the skills to use them.

**Complaints process overview**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The trust had a current “Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (The 4C’s Model)”, which was underpinned by the principles of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the NHS Constitution.

This policy set out the timeframes for the trust responses to complaints. These were to acknowledge the complaint within three days and response rates of 30 days for non-complex and 45 days for complex cases. All complaints were recorded and tracked using the trust electronic incident reporting system.

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</th>
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What is your internal target for responding to complaints? | 3 | 100%
---|---|---
What is your target for completing a complaint? | 30 | 96%
If you have a slightly longer target for complex complaints please indicate what that is here | 45 | 100%
Number of complaints resolved without formal process in the last 12 months? | 2,697 (August 2018 to July 2019)

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

We reviewed complaints files during our core service inspection and looked at four more files as part of our well led review. We noted that there was a triage of complaints which ensured there were no elements that required a safeguarding referral, or needed to be reported and investigated as an incident. When acknowledging complaints, the complaints team provided complainants with factsheets and signposted local advocacy services. The fact sheet contained information on how the complaints was to be handled, and how it could be escalated if the complainant was unhappy with the response, including information about the Parliamentary and Health Services Ombudsman. Each complaint was assigned to a member of the complaints team and we saw that this case worker liaised with the complainant throughout the process.

We saw that complaints were thoroughly investigated at a level appropriate to the issues raised. Response letters offered apologies and explained in language that was easy for the lay person to understand. Letters also explained actions the trust planned to take as a result of the concerns raised. All complaints letters were read and signed by the chief executive, or in his absence, the director of nursing.

We noted that complaints did not always meet the time scales set out in the policy, although staff reported they had. We discovered this was because the complaints team worked on the understanding that the 30/45-day limit was interpreted as completion of the complaint investigation and writing of the letter for signing, not the date the complainant received the response. There was sometimes a delay of up to two weeks while the letters awaited signing, which was a scheduled activity for the chief executive. We believed that this was confusing for complainants and was not an accurate reflection of the stated policy. We raised this with members of the trust executive who began investigating this matter.

Generally, complainants were satisfied. The number of reopened complaints, a proxy measure for complainant satisfaction, had steadily decreased over the past three years. There were 132 reopened complaints in the business year 2016/7, 92 the following year and 80 during the business year 2018/19.

The trust had collected anonymous feedback from complainants on their experience of using the complaints process since September 2016. This was collected via a 12 question survey sent approximately four weeks after the complaint has been closed. From April 2016 to March 2019 the trust had sent out 753 surveys with a response rate of 31.7%.

The three question with the highest positive feedback were:
1. I was able to communicate my concerns in the way I wanted 67.0%
2. It was easy to find out how to make a complaint 64.8%
3. I was able to understand the response as everything was clearly explained, including names and terminology 58.0%

The three questions with the highest negative feedback were:

1. I felt the response answered all of the concerns I had raised 56.8%
2. I felt assured that the Trust would learn from my experience 47.7%
   I was satisfied with how quickly the Trust provided me with a response to my complaint
3. I felt the Trust understood my concerns and what I wanted from raising a complaint 39.8%

The trust received 20 contacts from the Parliamentary and Health Service Ombudsman (PHSO) during the business year 2018/19, and received 19 case outcomes (but some of the outcomes related to cases the PHSO opened in 2017/18). The PHSO decided not to investigate six cases, four cases investigated were not upheld, seven cases investigated were partially upheld and two cases investigated were fully upheld. Of the contacts made in respect of investigations, four were to provide decisions/outcomes (one case upheld, two cases partially upheld and one case not upheld).

**Number of complaints made to the trust**

From August 2018 to August 2019, the trust received a total of 550 complaints. The highest number were for outpatients, with 34.0% of total complaints, followed by urgent and emergency care (20.9%) and Medical care (14.5%).

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
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<tbody>
<tr>
<td>Outpatients</td>
<td>187</td>
<td>34.0%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>115</td>
<td>20.9%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>80</td>
<td>14.5%</td>
</tr>
<tr>
<td>Other</td>
<td>73</td>
<td>13.3%</td>
</tr>
<tr>
<td>Surgery</td>
<td>57</td>
<td>10.4%</td>
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<tr>
<td>Maternity</td>
<td>15</td>
<td>2.7%</td>
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<tr>
<td>Services for children and young people</td>
<td>12</td>
<td>2.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>7</td>
<td>1.3%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>4</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>550</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

The trust monitored the outcome of complaints. A summary is given below.
The trust board were well informed about complaints, their management, outcomes and lessons learned. They received a comprehensive annual report detailing complaints management at the trust. We reviewed the annual report for the business year 2018/19 and found it was a comprehensive overview, well supported with data, which enabled the board to have assurance.

**Patient Advice and Liaison Service (PALS)**

The PALS provided support for patients, their relatives and members of the public with general advice, questions, and concerns that could be handled quickly and locally without the need for a formal resolution approach. There was a PALS office based in, or very close to, the main reception areas at both Conquest Hospital and Eastbourne District General Hospital (DGH). These small teams were a regular source of advice to everyone accessing them, and often prevented concerns from needing to become a formal complaint by working with clinical divisions to resolve concerns as close as possible to the source. The PALS team were easy to contact in person, by telephone or by email. The majority of contact were by telephone with 3,862 telephone contacts in 2018/19 against 1,553 face to face ones and 1,110 email contacts.

The main reasons for contacting the PALS were:

**Compliments**

From August 2018 to July 2019, the trust received a total of 343 compliments which could be associated with a particular service area. The highest number were for other services, with 39.9\%
of total compliments, followed by urgent and emergency care (17.8%) and outpatients (14.6%). The trust reported a further 33,790 compliments received for provider wide services which were not attributed to a particular service area. Of these, 31,043 (91.9%) were described as "Friends & Family Test Plaudits" and 2,746 (8.1%) were described as "Thank You Letters/Cards/Emails/NHS Choices".

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>137</td>
<td>39.9%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>61</td>
<td>17.8%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>50</td>
<td>14.6%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>45</td>
<td>13.1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>39</td>
<td>11.4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>4</td>
<td>1.2%</td>
</tr>
<tr>
<td>Maternity</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Total</td>
<td>343</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Common themes from compliments received were:

- The kindness and professionalism of staff
- The quality of care and treatment provided
- The quality of the environment and services provided
- The kindness extended to the patient’s relatives and family.

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

**Quality Improvement**

All staff were committed to continually learning and improving services. There was an implementation plan to equip staff with a good understanding of quality improvement methods and the skills to use them.

The trust has decided to use the quality, service improvement and redesign (QSIR) as its methodology as a basis for quality improvement at the trust. The 10 objectives of this programme were felt to align well with the organisational plan and strategy. The trust leaders demonstrated a strong commitment and prioritisation to the implementation of this initiative. The trust leaders told us they viewed the rolling out and embedding of this methodology as pivotal in supporting the trust to make a step change in its performance and improving the quality, safety and patient experience of its services.

The QSIR had an associated training programme. These, in order of complexity, were pop-up QI, bitesize QI, QSIR fundamentals and QSIR practitioner. During the first two years of the project 1,150 staff had taken part in bitesize QI, and 60 staff had undertaken the QSIR fundamentals in the
first four months of availability. Thirty-seven staff had attended the five-day QSIR practitioner course, and 10 people had graduated as QSIR practitioners in November 2019. It was expected that 60 trust staff would take part in QSIR training in the following year.

**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>Joint Advisory Group on Endoscopy (JAG)</td>
<td>• Endoscopy department Conquest Hospital (February 2018)</td>
</tr>
<tr>
<td></td>
<td>• Endoscopy department Eastbourne District General Hospital (February 2018)</td>
</tr>
<tr>
<td>Clinical pathology accreditation and its successor medical laboratories ISO 15189</td>
<td>• Chemical biochemistry Conquest Hospital (December 2018)</td>
</tr>
<tr>
<td></td>
<td>• Chemical biochemistry Eastbourne District General Hospital (December 2018)</td>
</tr>
<tr>
<td></td>
<td>• Haematology Conquest Hospital (January 2019)</td>
</tr>
<tr>
<td></td>
<td>• Haematology Eastbourne District General Hospital (January 2019)</td>
</tr>
<tr>
<td></td>
<td>• Cellular pathology Conquest Hospital (January 2019)</td>
</tr>
<tr>
<td></td>
<td>• Cellular pathology Eastbourne District General Hospital (January 2019)</td>
</tr>
<tr>
<td></td>
<td>• Microbiology Eastbourne District General Hospital (February 2019)</td>
</tr>
<tr>
<td>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</td>
<td>• Audiology service (October 2018)</td>
</tr>
<tr>
<td>Other</td>
<td>• ISO accreditation of the Hospital Sterilisation and Decontamination Unit (HSDU) (July 2019)</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Accreditations tab).*
Services for children and young people

Facts and data about this service

The trust provides services for children and young people at both Conquest Hospital and Eastbourne District General Hospital.

At Eastbourne District General Hospital there is a Short Stay Paediatric Assessment Unit (SSPAU) and an outpatient unit (Friston children’s outpatients’ unit). Eastbourne District General Hospital carries out ear nose and throat (ENT) short stay operations, suitable for children to go home the same day. If a child needs an overnight stay, they will be transferred to Kipling ward at Conquest Hospital or other appropriate hospitals.

At Conquest Hospital, Kipling children’s ward, a 21 bedded inpatient ward, is the main ward for children who need an overnight stay. The hospital has a children’s outpatient unit (Kipling children’s outpatient unit), a short stay Paediatric Assessment Unit (SSPAU) and a Special Care Baby Unit (SCBU). Short Stay Paediatric Assessment Units (SSPAU) are used for treating children who do not need to stay overnight in hospital. The Special Care Baby Unit (SCBU) provides support to obstetric services for babies born prematurely or with underlying medical conditions.

The trust had 6,023 spells from March 2018 to February 2019.

Emergency spells accounted for 95% (5,710 spells), 5% (295 spells) were day case spells, and the remaining 18 spells were elective.
Percentage of spells in children’s services by type of appointment and site, from March 2018 to February 2019, East Sussex Healthcare NHS Trust.

Total number of children’s spells by Site, East Sussex Healthcare NHS Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>3,988</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>2,035</td>
</tr>
<tr>
<td>This trust</td>
<td>6,023</td>
</tr>
<tr>
<td>England average</td>
<td>1,146,418</td>
</tr>
</tbody>
</table>

(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 and there were processes to make sure everyone completed it. However, two out of eight modules for nursing staff and seven out of eight for medical staff were a little below the trust target of 90%.

Mandatory training for all staff groups was comprehensive. The training was a mixture of face to face and online learning system. Mandatory training modules included, fire safety, infection control, paediatric life support, mental capacity, and information governance. Other training was role specific for example, paediatric advanced life support (PALS) was mandatory for all staff dealing with emergency care or who had specialist roles.

There was a site-specific electronic staff record where all training attendance was documented. Staff we spoke with told us they felt their training was in line with national guidelines for healthcare professionals.
The service recently employed a paediatric practice educator to oversee mandatory training and staff development within the children’s and young people’s services, with a view to increase training modules to include medicines management competencies.

We saw the training matrix that was updated by the matron’s assistant who the trust employed to keep track of all training. The assistant booked staff training modules and sent out the relevant notifications, and staff we spoke to confirmed this.

There was an up to date policy for sepsis and staff knew how to access it. Staff received training in recognising and managing deteriorating patients including those with confirmed or suspected sepsis. Staff used the nationally recognised ‘Sepsis 6 bundle’ screening tool. This was in line with National Institute for Health and Care Excellence (NICE), guidance (NG) 51, recommendation 1.12, training and education.

All new nursing and medical staff had a structured four-day trust induction program. Nursing staff were supernumerary, which meant they worked with a senior colleague for the first two weeks of their employment to make sure they were safely orientated to the service.

Senior doctors were responsible for overseeing medical staff training and doctors attended paediatric advanced life support training. However, medical staff were slightly under the trust target of 90% for five out of eight and under the trust target for mental capacity training.

**Trust level**

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Health and safety</td>
<td>68</td>
<td>68</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>65</td>
<td>68</td>
<td>95.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>49</td>
<td>68</td>
<td>72.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>27</td>
<td>68</td>
<td>39.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>62</td>
<td>68</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services the 90% target was met for four of the seven mandatory training modules for which qualified nursing staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules. In addition, nursing staff did not meet the 95% trust target for the module information governance. Medicines management attendance was low as the service had only just recruited a new practice placement nurse who was redesigning this training module.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust
level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moving and handling</td>
<td>35</td>
<td>38</td>
<td>92.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>32</td>
<td>38</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>27</td>
<td>38</td>
<td>71.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>26</td>
<td>38</td>
<td>68.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>26</td>
<td>38</td>
<td>68.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>23</td>
<td>36</td>
<td>63.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>1</td>
<td>38</td>
<td>2.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services the 90% target was met for one of the seven mandatory training modules for which medical staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules. In addition, medical staff did not meet the 95% trust target for the module information governance.

**Eastbourne District General Hospital children’s services**

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified nursing staff in the children’s services at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>0</td>
<td>10</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Eastbourne District General Hospital children’s services, the 90% target was met for six of the seven mandatory training modules for which qualified nursing staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules. In addition, nursing staff did not meet the 95% trust target for the module information governance.
A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for medical staff in the children’s services at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and handling</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>1</td>
<td>8</td>
<td>12.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Eastbourne District General Hospital children’s services, the 90% target was met for one of the six mandatory training modules for which medical staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules. In addition, medical staff did not meet the 95% trust target for the module information governance.

**Safeguarding**

**Staff understood how to protect patients from abuse. Staff understood their responsibilities and the steps to take in the event of a safeguarding concern and the service worked well with other agencies to do so. However medical staff were a little below the trust target for safeguarding training.**

Medical staff attended a safeguarding training module as part of their induction, and during their paediatric placement to the service, attended the safeguarding level 3 ‘Think family’ training. As part of their learning and development the safeguarding team encouraged them to attend the weekly safeguarding meetings and case conferences. Staff rostering, and workload meant that these meetings were attended on an ad-hoc basis.

Safeguarding alerts were available via NHS digital Child protection information sharing project (CPIS), which was accessible on the trust’s internal internet system.

In the event of an out of hours concern, staff could bleep the duty social worker, consult clinical staff based at the Conquest site or call the on-call consultant if necessary.

Children who were subject to a child safeguarding plan or identified as being at risk had a red alert tick icon on the electronic patient records so all staff caring for them were aware of current issues.

There were two named consultants for safeguarding at the Eastbourne site. One consultant we spoke with told us they were responsible for training medical staff, attending high level safeguarding meetings, writing safeguarding reports and reviewing local policies.

Employment checks were carried out for new starters, which included identity checks, two references and disclosure and barring service (DBS) searches. The trust policy for making sure
staff DBS searches were re-checked during their employment was currently under review.

**Safeguarding training completion rates**

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

**Trust level**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>68</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>68</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>67</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>67</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>63</td>
</tr>
</tbody>
</table>

In children’s services the 90% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>38</td>
</tr>
<tr>
<td>Safeguarding children level1</td>
<td>38</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>31</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>30</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>17</td>
</tr>
</tbody>
</table>

In children’s services the 90% target was met for two of the five safeguarding training modules for which medical staff were eligible.

**Eastbourne District General Hospital children’s services**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for qualified nursing staff in the children’s services at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>38</td>
</tr>
<tr>
<td>Safeguarding children level1</td>
<td>38</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>31</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>30</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>17</td>
</tr>
</tbody>
</table>
### Safeguarding training compliance

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults’ level 2</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Eastbourne District General Hospital children’s services, the 90% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for medical staff in the children’s services at Eastbourne District General Hospital is shown below:

### Cleanliness, infection control and hygiene

The department controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. We saw that staff always cleaned their hands prior to patient care and kept equipment and the premises visibly clean.

The trust’s infection control policy contained the correct references to national standards for hand decontamination and antimicrobial stewardship. This is a national standard designed to improve the use of antimicrobial medications to enhance patient care and outcomes. There was also a local policy which made sure staff followed the safety standards for Invasive procedures, to reduce the transference of infection using the national safety standards for invasive procedures framework.

The trust employed an infection control lead, one band 7 and one band 6 infection control nurse for the Eastbourne site, who were responsible for training and compliance relating to infection control. There is a clear process for internal reporting of infection control concerns.

There were trust antimicrobial stewardship, patient environment monitoring and decontamination groups that oversaw infection control audits across the hospital.

Children’s outpatients and the SSPAU at the Eastbourne site were visibly clean and free from
clutter. All staff adhered to the bare below the elbows policy. Protective equipment such as gloves and aprons were available in all clinical areas to prevent contamination during clinical procedures. There was also a local policy which made sure staff followed the safety standards for Invasive procedures, to reduce the transference of infection using the national safety standards for invasive procedures framework.

Children who were thought to be infectious were cared for in one of the four side rooms. Barrier nursing was carried out for children who were known to be carrying infection. Staff described the process for deep clean area’s known to have been infected by contamination.

Antimicrobial hand cleaning gel was available outside the paediatric clinical assessment unit and the paediatric out patients’ assessment and throughout the ward area. Nurses carried a small hand gel on their uniforms and we saw them use this prior to patient contact.

Support staff undertook monthly hand hygiene audits in the outpatients and clinical assessment ward areas and we saw spreadsheet evidence that staff were 100% compliant.

In the reporting period Aug 2018 – July 2019 the SSPAU infection and cleanliness compliance was recognised with the Clean Care award. The department demonstrated compliance to infection control guidelines. The service had completed all required hand hygiene audits, there were no cases of preventable infections, and no avoidable Clostridium difficile or Methicillin-resistant Staphylococcus aureus infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design, upkeep and use of facilities kept people safe from harm. There were processes in place to inspect and monitor the maintenance and cleaning of equipment. The matron’s administrator kept a medical device log and up to date evidence of all cleaning audits, carried out for the cleaning of equipment within the unit monthly. The log was colour coded and easy to read. However, there was no toy cleaning policy for either site, toys were cleaned by support workers who used detergent wipes.

There was an up to date recently reviewed standard operating procedure for the children’s and young people’s service. The service had a supply of its own equipment, which included physical observation monitoring apparatus. Staff could also request medical devices from the trust equipment library, via a medical device’s asset register.

All equipment conformed to the relevant safety standards and had regular servicing, stickers on the equipment provided evidence that equipment had been serviced and had portable appliance testing (PAT) tested within the last year.

Housekeeping staff were responsible for daily cleaning and weekly cleaning of areas and equipment and documented this in a cleaning log folder.

The resuscitation trolley was easily accessible, thoroughly cleaned and included the correct paediatric equipment, including various sized masks. This was clearly labelled in line with the Resuscitation Councils national standards, which recommends all resuscitation trolleys should be laid out in a standardised way to ensure staff can quickly identify the correct equipment and drugs during an emergency situation. The drugs required for resuscitation were stored in a locked drawer.
and in date.

The correct paediatric defibrillator was available, clean, and checked daily in line with national standards, and nursing staff told us they were trained on its use during emergency situations.

There was also a local policy which made sure staff followed the safety standards for Invasive procedures, to reduce the transference of infection using the national safety standards for invasive procedures framework.

The department was only accessible via a buzzer and intercom system, and there were keycodes on doors to ensure children didn’t wander into high risk areas.

The environment was safe for children of all ages, with toilets, door hinges and slam protectors, children’s tables had rounded edges and were the appropriate height for smaller children. The play area was gated to ensure children did not wander off to other parts of the unit unattended. However, children had access to Lego and toys with small pieces that may cause a chocking risk if children are left unattended by carers or parents.

The unit was full of coloured laminated posters and sensory play equipment for children under 10 years old. The unit had television’s and a gaming console, although there was a lack of leisure equipment for adolescent children.

Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

There was also a local policy which made sure staff followed the safety standards for Invasive procedures, to reduce the transference of infection using the national safety standards for invasive procedures framework. Nursing staff ran pre-assessment clinics for routine surgery within the unit. Nursing staff used a paediatric assessment form to risk assess children for surgery, which covered all aspects of wellbeing, including medical history, allergies, social history, disabilities and weight and height. Risk assessments were carried out on a one-to-one basis. We observed two of these assessments, care was patient centred, methodical and unrushed. Nursing staff spoke clearly and gave parents clear instructions and there was time for parents to ask relevant questions.

The SSPAU had at least one member of staff on duty who was qualified in advanced paediatric life support, and all nursing staff were qualified in paediatric life support, this meant that staff were all up to date with these skills.

Patients handovers from theatre or the emergency department used the nationally recognised situation, background, assessment, recommendation (SBAR) technique, which was contained within the patient hand held assessment record. Patients were collected from theatre by a nurse and a parent. Theatre observation and drugs charts were transferred to the ward with patients. Patients received from ED were handed over in the same way.

Staff used the paediatric early warning score (PEWS) to identify deteriorating patients. Staff documented patient observations on an electronic observation tool. Staff we spoke with confirmed they understood the importance of reacting to the early warning signs and took immediate action to make sure children were put on the correct care pathway.

The service audited the correct use of PEWS observation tools and we were shown evidence of these via a spreadsheet data base and patients records.
The trust policy for the ‘management of critically ill children presenting unexpectedly at the Eastbourne site’ set out clear criteria for assessing, stabilising and monitoring any children that may have unexpectedly attended the Eastbourne emergency department or who may need further treatment following their routine operation. Paediatric doctors assessed patients before discharge, and transfer arrangements were made for children who required overnight stay transferred to the Conquest site.

Children experiencing mental health problems could be assessed using a child and adolescent mental health (CAHMS) triage form, which was accessible via the trust internal internet. Staff told us that all healthcare professionals used this tool to assess children’s mental health; this was then sent to the CAHMS service. The CAHMS team would make decisions on whether those children needed further mental health assessment from a mental health professional. However, CAHMS did not accept assessments after 3pm. This meant any child presenting at risk from complex mental health issues after this time, would be transferred to the SSPAU or Conquest site for overnight admission until assessment by a mental healthcare professional could be safely carried out.

When staff discharged children clear advice and relevant contact information was provided for parents. Staff gave parents a discharge notification and leaflets on relevant surgical procedures which included the contact details of healthcare professionals for advice and support following discharge.

CQC Children and Young People’s Survey 2016

In the CQC Children and Young People’s Survey 2016 the trust scored 9.6 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

CQC Children and Young People’s Survey 2016 questions, safe domain, East Sussex Healthcare NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>20</td>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.1</td>
<td>Worse than other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>36</td>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.6</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Nurse staffing

The service had adequate nursing and support staff with the right qualifications, skills,
training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers at senior level planned staffing levels, although they were not available on the dates of our inspection. The matron planned and reviewed duty rosters to make sure staffing levels were safe and the unit was covered by people with the right Skills.

The matron used an electronic rostering system to plan duty cover one month in advance. The app highlighted gaps in the service, annual leave, sickness and skills mix levels. There were systems in place to monitor staffing trends and manage the annual leave and sickness.

The matron reported no concerns and advised that there were three nurse vacancies across the site. There were systems in place to share staff cross-site when one site was short staffed due to unplanned events such as sick leave. However, staff told us that the unit had closed nine times during the reporting period August 2018 – July 2019 due to staff shortages.

Staff told us that recruitment of qualified paediatric nursing staff had been difficult, and applications to the service had been reduced in the last year.

On the SSPAU daily nursing cover was broken down to one band 7 Matron 7am – 7pm daily either on site or at the Conquest site. One band 6 paediatric nurse with advanced life support training covered 9am – 9.30pm. Two band 5 nurses, one of whom worked the 7am-7.30pm shift and the other covering 9am-9.30pm. The nurses were supported by one band 3 support worker on the ward. However, there was a shortfall of nursing staff between 7am and 9am. The Royal College of Nursing guidance: Defining staffing levels for children and young people’s services, recommends that there must always be a minimum of two registered children’s nurses on, in all inpatient or day case areas.

The matron was employed to work clinically for up to 50% of her contract, although this was not routine cover. Matrons were on site three or four long days per week. When she was on a day off, staff could contact the matron at the Conquest site for support if required and vice versa. However, the Royal College of Nursing guidance: recommends that each shift there should be one supernumerary shift supervisor/manager who can oversee the effective management, training and supervision of staff.

On Friston ward the outpatient service, one band 6 nurse covered the daily clinics Monday – Friday 9am to 5pm, with specialist paediatric nurses covering different clinics on different days. One full time support worker supported these nurses.

Two paediatric band 6 nurses trained in paediatric advanced life support, worked in the emergency department between10am – 10pm and 12 noon to 12 midnight. They were part of the paediatric nursing staffing levels and could be moved to other areas, for example SSPAU if required.

Nursing staff used a social media closed group to cover shifts, and most bank staff were contracted nurses from within the service who had full paediatric life support training, and knowledge of systems and processes. The service rarely used agency staff to cover shifts.

The trusts model for 24hr cover meant a senior nurse was always available cross site, with matrons covering each other. There was an on-call managers rota for out of ours which was clearly displayed in key areas. However, staff told us that cross site lack of staffing on the Kipling ward at Conquest has meant that Friston staff have been migrated to Conquest. Data provided by the trust demonstrated that the SSPAU had closed ten times since January 2019. Four closures were due to
lack of nursing or medical staff and six were related to children with complex needs who required one to one care, and no additional cover could be found to support the rest of the ward.

Trust level

The table below shows a summary of the nursing staffing metrics in children’s services at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8%</td>
<td>10%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>156.3</td>
<td>7.0%</td>
<td>7.4%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>72.3</td>
<td>11.0%</td>
<td>4.7%</td>
<td>5.3%</td>
<td>4,252 (3%)</td>
<td>160 (&lt;1%)</td>
<td>7,521 (5%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within children’s services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency use.

Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed an upward trend from February 2019 to July 2019. This could be an early indicator of
deterioration.

**Sickness rates**

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019. This could be an indicator of change.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank staff usage**

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019. This could be an indicator of change.

*(Source: Routine Provider Information Request (RPIR) - Nursing bank agency ta)*

**Eastbourne District General Hospital**

The table below shows a summary of the nursing staffing metrics in children’s services at Eastbourne District General Hospital compared to the trust’s targets, where applicable:

| Children’s services annual staffing metrics |
August 2018 to July 2019

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>32.2</td>
<td>23.6%</td>
<td>4.4%</td>
<td>4.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>15.6</td>
<td>38.7%</td>
<td>0%</td>
<td>4.6%</td>
<td>800 (4%)</td>
<td>000 (0%)</td>
<td>519 (2%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within children’s services at Eastbourne District General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, and agency use.

**Bank staff usage**

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019. This was due in part to sickness and nursing staff on maternity leave, and the matron did not feel this was a concern.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and
treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The Royal College of Paediatrics and Child Health’s report; Facing the Future standards for Acute General Paediatric Services (2010), sets out 10 standards. These standards include, a requirement for acute services to have a consultant on site at times of peak activity and 24-hour seven day a week paediatric consultant cover, which can be via telephone out of hours.

Consultants were responsible for planning recruitment, training and planning of medical staff cover across both sites. There were weekly on call duty rota’s for medics which were available for all staff.

The service had one named paediatric consultant available for liaison and immediate cover for children’s ongoing care following operative procedures or deteriorating within the department after arrival, in either the SSPAU or ED department, during the hours 8am to 6pm. Every child admitted to the paediatric department with an acute medical problem between 8am and 9pm would be seen by a consultant paediatrician within 14 hours of admission.

The trust adopted an attending consultant of the week system for both sites. Staff told us there was a cold ‘on-call’ consultants cover system at the Eastbourne site, which provided telephone advice out-of-hours. In the event of a serious incident out of hours, a consultant was required to attend the unit in person.

Consultants ran various daily clinics in outpatients for children requiring on going intervention for long term health conditions, supported by either, specialist nurses, or paediatric advanced nurse practitioners.

All anaesthetic doctors and paediatric registrar grade doctors were trained in advanced paediatric life support. Registrars were present on the ward during SSPAU opening hours. Registrars supported the paediatric senior house officers (SHO) and nursing staff in outpatients and the ED department.

In the event of acute emergency’s involving children out of hours, ED registrars were on site round the clock and were all trained in paediatric life support and were supported by the ED consultants and anaesthetic intensivist consultants when required. However, ambulances did not take acutely unwell children to Eastbourne, they were taken directly to the Conquest site.

Medical staff vacancy levels was just above the national average of 10% at 12.5%, the trust did not issue annual bank or annual locum rates for the Eastbourne site, however trust wide the use of bank staff was within national guidelines and the use of locum doctors was 1% during the reporting period August 2018 – July 2019. The vacancy rate at Eastbourne was 1% which was within national targets.

**Trust level**

The table below shows a summary of the medical staffing metrics in children’s services at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average</th>
<th>Annual vacancy</th>
<th>Annual turnover</th>
<th>Annual sickness</th>
<th>Annual bank</th>
<th>Annual locum</th>
<th>Annual unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>August 2018 to July 2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The table below shows a summary of the medical staffing metrics in children’s services at Eastbourne District General Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8%</td>
<td>10%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>23.6%</td>
<td>4.4%</td>
<td>4.3%</td>
<td></td>
<td>121 (&lt;1%)</td>
<td>336 (1%)</td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>1.1%</td>
<td>12.5%</td>
<td>2.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within children’s services at Eastbourne District General Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank or agency use.

**Staffing skill mix**
In May 2019, the proportion of middle career grade staff reported to be working at the trust was higher than the England average and the proportion of Registrar Group (Specialist Registrar) staff was lower. The lack of specialist paediatric registrars meant that the Eastbourne site could not provide 24 hour cover in the emergency department.

Staffing skill mix for the 46 whole time equivalent staff working in services for children and young people 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>43%</td>
<td>44%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>22%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>26%</td>
<td>43%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The records management code of practice for health and social care (2016) sets out clear guidance for NHS trusts to effectively manage patients’ paper or digital records. Access to patient records should only be accessible to those healthcare professionals providing care to the patient.

The service ensured that peoples individual care records, including clinical data, were written and managed safely. The administrative team and medical records managed paper patient records. Records were kept in a locked cupboard and accessible to the staff delivery patient care.

Information governance systems were in place including confidentiality of patient records. Since our last inspection, an electronic record tagging system had been created for patient records and staff had access to electronic patient records and on and off-site paper 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 rather than being piled up in various cupboards. However, the trust had not completely converted to
digital with paper records used for some aspects of care and digital records used for others which meant staff needed to make sure they checked both aspects of documentation

Electronic records were accessible to staff via their unique and private log in details which conformed to national information governance and data protection standards. Staff showed us how they accessed patient records and how details could be merged. Paper assessment documentation was scanned into the electronic system at the end of every episode of care. Paper copies were shredded and disposed of safely.

There were systems to flag records when a child had needs including any, mental health or child protection issue’s and this process was clearly understood by all staff. Not all information was available to all staff unless they were in direct contact with the child. Where appropriate, we saw records contained full details of children’s mental health, learning disability and autism needs.

Relevant child health information could be shared across the wider multi-disciplinary team, which included the GP’s, health visitors and school nurses, using nationally recognised digital information sharing systems. All staff carried log in access cards, which were issued under a strict checking criterion, that included identity checks.

Records we saw were clear, legible and accurate. All concerns and actions taken were recorded. Information relevant to keeping children safe was available for other clinicians providing care to them.

Parents or guardians would be advised to bring their Child’s Personal Child Health Record (PCHR) to each appointment. During their stay the ‘red’ book was updated by staff who stored them with paper copies of the hospital notes to ensure staff updated them appropriately.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Medicines were stored in a clinical room, with locked doors and key code access. Daily stock checks were made on ward medication, and controlled drugs were locked away safely. Staff were responsible for stock orders and check dates of all medication. However, our inspection team found that out of date medicines, although clearly labelled was stored on the same shelf as in date medicines. Staff told us this was because they were waiting for pharmacy to collect the out of date medicines in line with trust policy. Furthermore, there was no clear stock rotation, with several bottles of the same medicine open at the same time.

The wards used Patient Group Directions (PGDs) to provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber. However, the ward did not have accurate records of which staff had been trained and authorised to use these. We could not be assured that PGDs were always being used safely.

Medicines were appropriately prescribed by doctors and supplied and administered to people in line with relevant evidence and national guidelines. At the Eastbourne site we were told that doctors were responsible for all prescribing as only a few paediatric nurses across the two sites had gained their
certificates for the administration of patient group directive medicines.

Prescription charts we inspected included information on children’s allergies which were clearly legible. Furthermore, the child’s weight and height were included in the prescription chart to help with accurate medicine calculations.

Medicine rounds were carried out by nurses throughout the day. Parents were given specific advice about their medicines, and most medicine was available in oral liquid form. Medicine syringes were available for younger babies and children.

There was a folder in the clinic room for medicines policies. This had not been updated since 2004. The most up to date policies were available on the trust intranet. However, there was a risk that staff could use these out of date policies to make decisions. We highlighted this to the matron who made immediate changes and removed the out of date resources.

In the outpatient clinic children on long term medication for life changing illnesses had their medication reviewed at each appointment. Parents with younger babies and younger children were shown how and when to use medication. Children reaching adolescence were encouraged to start taking their own medication to help with their transition into adult services.

The Royal Pharmaceutical Societies new ‘Professional Guidance on the Administration of Medicines in Healthcare Standards’ (2019) replaced the NMC medicines management guidance for medicine administration this year. These national guidelines state “those administering medicines are appropriately trained, assessed as competent and meet relevant professional and regulatory standards and guidance”. However, we were told the trust does not provide regular medication assessments for nursing staff. We were advised that the new paediatric practice development nurse will be reviewing all training and this aspect of training may be introduced in the future.

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff understood their responsibilities to raise concerns. Examples given by staff included, medicine administration errors, incomplete documentation, inadequate staffing levels, and children inappropriately risk assessed.

The trust had a nationally recognised electronic incident reporting system. The patient safety team categorised incidents and the risk team rated them from minimal to major risk, so the appropriate staff could investigate them. We were shown examples of incidents investigated or under investigation by the patient safety team. These included children who were transferred from the ED department at Eastbourne to the conquest site, and children deteriorating after surgery. The documentation was clear and most of the incidents demonstrated a root cause analysis had been done by staff and lessons learnt.

Children’s services held a weekly patient safety summit, which looked at all incidents rated minor to moderate and categorised as level 1 or 2. Major and serious incidents were rated at Level 3 and investigated by senior management.
Consultants with the support of the senior leadership team would investigate serious incidents. All data was reported to the clinical commissioning group (CCG). Minutes of meetings had clear documentation and were stored safely. Nurses did not routinely participate in the review process, this was the responsibility of the matron who may ask staff for statement’s and review patient records.

External safety alerts came in via emails at trust level and were disseminated to the safeguarding team and the relevant nursing departments.

Staff we interviewed understood the principles of duty of candour and told us that once they became aware of safety incidents, they would report this to the matron and doctors and the relevant person. Parents and children would be informed, and records kept of this 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 July 2018 to August 2019, the trust did not report any never events for children's services.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) which met the reporting criteria set by NHS England from August 2018 to July 2019. There were no serious incidents at the Eastbourne site during the reporting period.

(Source: Strategic Executive Information System (STEIS))

**Safety thermometer**

The trust did not collect or submit data to the patient safety thermometer as many aspects of this model of data collection did not apply to this children’s unit.

(Source: NHS Digital)

**Is the service effective?**

By effective we mean: does peoples care, treatment and support achieve good outcomes, promote a good quality of life and based on the best available evidence
Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient’s subject to the Mental Health Act 1983.

There were policies to ensure children’s individual needs were thoroughly met. These included equality and diversity, type one diabetes, a clinical guideline for the holding of children and adults and children with learning disabilities, and a clinical pathway for treating children with downs syndrome which were all in date. Some policies we viewed on line for example the acute asthma in children, Abdominal pain in children: managing children with gastroenteritis and managing fluids in children needed review as they were up to two years out of date. However, the trust has supplied information to show these policies were in date but these were not displaying when accessed on the inspection.

The standard operating procedure (SOP) for observations on the short stay paediatric assessment unit was updated in July 2019 and the matron and practice educator were responsible for delivering training sessions to ensure the SOP was implemented correctly. Furthermore, regular quality walks were made by senior staff to make sure standards are being met.

The children’s service was in the process of introducing Excellence in Care audits and the tool included a regular paediatric early warning system (PEWS) audits. The practice educator reviewed 10 patient records on the SSPAU. Quality checks were carried out to make sure staff were clearly documenting observations on arrival and during children’s stay on the ward. Matrons and practice educators would cascade the results to staff during staff huddles, hand over, or theme of the month.

Children were assessed in both areas of the Eastbourne children and young people’s service. Staff created and used a children’s comprehensive integrated patient document (IPD), which made sure children’s physical, social, mental health and disabilities were identified and placed on the correct care pathway.

Clinics held in the outpatient department for children included diabetes, epilepsy, asthma, cystic fibrosis, rheumatology, cardiac and echocardiogram, and respiratory and endocrine conditions. Consultants worked alongside specialist nurses to provide holistic care for children. Regular audits undertaken by the specialist nurses and managers, ensured that outcomes were measured, and clinic consultations adapted to accommodate children with ongoing health conditions.

The children’s epilepsy team provided a bi-annual transition clinic cross site for those children approaching adult life. Health promotion was delivered with facts about safety, lifestyle, and coping with epilepsy as an adolescent. Vitamin D levels were measured. However, the service did not currently receive funding for a clinical psychologist.

The diabetic team also ran a transition clinic cross site for those children approaching adult life. Health promotion was delivered with facts about, lifestyle, diet and coping with diabetes as an adolescent. These clinics were well attended, and adolescent children had access to a diabetic clinical psychologist.

Staff acted upon previous CQC recommendations and undertook a GAP analysis relating to transition of children to adult services. One staff member created a ‘ready steady go’ transition assessment tool to prepare children between the ages of 15 and 17 years old.

The ward sister in outpatients identified a gap in the service relating to listening to the needs of children, adolescents and their carer’s. Funding was provided to deliver a ‘what matters to you’ study
day for key paediatric nursing staff and doctors. The paediatric nursing team worked with the principles highlighted by the Sweeney programme which enabled staff to step in the shoes of patients to identify gaps and improve care.

Staff had training on mental health which included aspects of the Mental Health Act 1983 in the trust safeguarding level 3 training days. Staff could identify children experiencing mental illness. The child and adolescent mental health (CAMHS) service devised a triage tool, for children at risk of self-harm or suicide to help nurses assess children in emotional crisis. The tool contained a colour coded matrix, with defined pathways and the relevant contact details of mental health staff. Children highlighted at risk of mental illness after 3pm on weekdays and during weekends could not be referred to CAHMS until the next working day. Arrangements would be made to admit children either to the children’s assessment ward at Eastbourne, or the paediatric ward at the Conquest site until they could be safely assessed.

**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. The service made adjustments for patients’ religious, cultural and other needs**

All new staff were given one-and-a-half-hour training session as part of the trust induction, by dietetics and speech and language therapy. The dietetics session promoted awareness on malnutrition, the use of the malnutrition universal screening tool (MUST), nutrition support strategies and assistance with patient feeding. The speech and language session covered aspiration; signs and symptoms, how to avoid and how to detect.

The integrated patient document assessment form prompted staff to weigh and measure children at each appointment. Staff assessed children’s nutrition and hydration including questions regarding food allergies via the integrated patient document. The assessment document made sure nurses were promoted to check that children who had undergone surgery could be assessed for their ability to swallow and had their urine and bowel movements monitored when required.

All food services staff were supported by the dietetics team when ordering food for specialist diets and plans on both hospital sites. Staff told us that they could call the kitchen and make special orders for children with special dietary needs.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

The service had a pain management policy in place which was accessible to all staff via the trust internal internet which was due for review.

Children returned from theatres were provided with adequate pain relief assessments and the anaesthetists and doctors wrote prescriptions for continued pain relief via a patient group directive (PGD) on the patient’s drugs chart.

The Integrated patient document included a pain scoring tool for children which included a smiley face chart from smiley to sad, so children could point to how they felt. Staff used the face, legs,
activity, cry, consolability, (FLACC) pain assessment tool for children who were either too young to communicate; or who’s communications skills were impaired.

Children experiencing acute pain were rarely seen at the Eastbourne paediatric day assessment unit so the inspection team could not observe any pain care. However, any child being assessed in the emergency department (ED) who were experiencing acute pain, would have their pain managed and stabilised by medical staff prior to transferring them to the paediatric unit at Conquest hospital.

**Patient outcomes**

*Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes*

The service reviewed the effectiveness of care and treatment through national audit. Information regarding outcomes was routinely collected and monitored.

There were two main aspects of care at Eastbourne, one was the paediatric outpatient service and the other SSPAU day surgery. This model of care allowed fully recovered children who have undergone minor surgery to return home on the day of their surgery. Nationally it has been recognised as best practice for those children to be cared for at home by their families. In the reporting period August 2018 – July 2019 a total of 25 children under the age of 18 were readmitted within 48hrs. These children included children who were prescribed daily intravenous medication.

The service had a Commissioning for Quality and Innovation (CQUIN) target for sepsis and a link nurse role was developed to ensure best practice and management. The SSPAU had a link nurse for sepsis, who collected and monitored data for all patients who had a PEWS score of three or more. When the ‘sepsis bundle’ pathway was triggered sepsis care and treatment was commenced.

The sepsis link nurse developed a ‘think Sepsis’ poster which highlighted monthly audit results and a ‘Stop’ sticker when the pathway was no longer appropriate, to ensure staff used the screening tool and cascaded results to the clinical leads and matron. The service recognised these measures as best practice and the staff member earned the trust ‘Sepsis award’. Any staff member found not to be following the correct pathway was notified; staff we spoke with had a thorough awareness of the signs and symptoms of sepsis and the ‘Sepsis bundle’ treatment protocol.

Audited outcomes were reported to the Clinical Commissioning Group (CCG) who analysed the data then set tariffs based on the needs of the population and the current outcomes. These tariffs determined what funding is available for each service, which meant some services had more funding than other’s for example there were limited facilities for adolescent children.

The Friston paediatric epilepsy clinical nurse specialist worked cross site with a case load of 350 children. A band 6 paediatric nurse had been recently employed to support the caseload. The specialist nurse contributed to a national audit. Established in 2009, Epilepsy12 was created by the Royal College of Paediatrics and Child Health, with the continued aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. Staff provided data which was collected nationally and used to measure children’s long-term outcomes.

The unit made sure the standards of the epilepsy 12 audit included, children with the symptoms of epilepsy need to be seen within two weeks of the first onset of symptoms, all children need to be
assigned a specialist epilepsy nurse were met. Children who attend clinic should see a consultant and a nurse at each appointment and be followed up yearly which is the minimum standard.

A diabetic specialist nurse and consultant ran a weekly type 1 diabetic clinic. The diabetic team followed national quality standards which involved participating in National Paediatric Diabetes Audit (NPDA) for children with type 1 diabetes, and their clinics had gained funding for a child clinical psychologist.

**Paediatric diabetes audit**

The table below summarises East Sussex Healthcare NHS Trust’s performance in the 2018 National Paediatric Diabetes Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion rate for key health checks for patients aged 12+</td>
<td>92.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted mean HbA1c</td>
<td>71.1%</td>
<td>Worse than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>(HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median HbA1c</td>
<td>66.0%</td>
<td>Clinically significant decline</td>
<td>No current standard</td>
</tr>
<tr>
<td>(This measure is provided to give an indicator of how performance has changed between the previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Paediatric Diabetes Audit)

**Emergency readmission rates within two days of discharge**

We saw data that which showed that a total of 25 children under the age of 18 were re-admitted to the Friston ward in the reporting period within 48 hours of discharge. Staff advise parents to telephone them if they have any concerns regarding their child’s recovery, and some children require further antibiotic treatment, which meant some discharges were unavoidable.
(Source: Hospital Episode Statistics)

**Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes**
### Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Children’s assessed needs, choices and preferences were met by staff with the right skills and knowledge. The learning needs of staff were identified through regular appraisals. We were shown evidence that 91% of staff had completed their appraisal within the reporting period and the data below confirms this.

All paediatric doctors and nurses are trained and maintain their training in paediatric life support (PILS). Band 6 paediatric nurses in all departments, doctors, and anaesthetists are provided with advanced paediatric life (APLS) support training cross site and this is reviewed annually. The matron’s administrator recorded when training had been completed and made sure invites were sent out for refresher training when they were due.

Anaesthetists and medical staff emergency rotas included cover for the children and young people’s services across the site which made sure they were available throughout the night because there was no night paediatric registrar cover at Eastbourne.

The service held resuscitation scenario training cross-site and one to one monthly supervision days for nursing staff. Staff were actively encouraged to attend and supported with their training needs.

During the hours of 7am-9pm there was paediatric medical staffing on site to give support and care for children who became medically acutely unwell.

Acutely ill children were seen at the Conquest site which was a recent change to the trust paediatric model of care. Children who became acutely unwell after surgery, would be stabilised by the medical staff at Eastbourne and prepared for transfer to the Conquest site.

Nursing staff told us they felt supported in meeting their training needs to ensure it covered their scope of practice. For example, one staff member has recently moved from a nursing role to become an advanced paediatric nurse practitioner. They were given the time to develop their role and developed a standard operating procedure for ward observations and a policy for lumbar punctures.

Another staff member started at the trust as a health care assistant and was encouraged to join a secondment into paediatric nurse training. They were encouraged to develop their career to be the specialist nurse for bladder care. We were told how specialist nurses were supported in outpatients by paediatric healthcare assistants who had the appropriate mandatory training and safeguarding level 2 competencies to support nurses and doctors.

Two healthcare assistants had been phlebotomy trained in the last year. They now run a blood taking clinic in outpatients once a week to help support paediatric community and inpatient services.
Appraisal rates

From August 2018 to July 2019, 90.3% of staff within children’s services at the trust received an appraisal compared to a trust target 90%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>29</td>
<td>30</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>64</td>
<td>72</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
<td><strong>144</strong></td>
<td><strong>90.3%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Eastbourne District General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>29</strong></td>
<td><strong>93.1%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care

There were systems which made sure children and parents had access to all the necessary multidisciplinary teams both within the hospital and the community setting. Doctors liaised with GP’s, health visitors, safeguarding leads and physiotherapists

Ward rounds on the Friston ward were attended by doctors, nurses and anaesthetists and dieticians. Other members of the multidisciplinary team (MDT) would be called upon when required. This was because only ear nose and throat surgery was performed at Eastbourne.
Parents of children who had elective surgery were debriefed by the ear nose and throat surgeon or the duty paediatrician and a children’s nurse who gave advice on the treatment and recovery process. In the event of complications parents were debriefed by a consultant.

Staff were clear about their roles and responsibilities and could identify all members of the multidisciplinary teams. Clinical assessments ensured that children and parents were referred to the relevant healthcare practitioners, who included physiotherapists, occupational therapists, dieticians, learning disability nurses, and mental healthcare professionals.

Monthly MDT meetings were arranged, and we saw minutes from these meetings, which were attended by consultants or registrars, specialist nurses and physiotherapists.

Discharge notifications were sent via the administrative team to the relevant health care professionals within the community these included GP’s, health visitors and community paediatric services. Parents are given information regarding their child’s condition or recovery and the contact details of community healthcare professionals. Follow up appointments are made, when required.

Children who failed to attend their appointments are sent a fresh appointment. If they do not attend for a second appointment the GP may be contacted to investigate why the child did not attend. Consultants were responsible for risk assessing children that did not attend and making decisions as to whether there may be safeguarding concerns. However, the unit did not audit the follow up of all children.

Seven-day services

Key services were available seven days a week to support timely patient care

Service at the Eastbourne site ran seven days a week for the SSPAU unit between 7am and 9pm and outpatients’ services ran Monday to Friday 9am to 5pm. The emergency department saw children with minor injuries or conditions during 8am and 9pm seven days a week. Acutely sick children were taken to the Conquest site if parents had called an ambulance.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Parents and children attending the outpatient specialist clinics for epilepsy, diabetes and other long-term health conditions, were given advice on how to manage their health condition. This included, dietary advice, blood sample investigations for vitamin D and other appropriate levels, medication advice and lifestyle advice.

All children had their height and weight monitored at every appointment this made sure they were within healthy limits. Any children found to be at risk of obesity or malnutrition were offered extra dietary support and where appropriate referrals were made to the dietician.

Parents of young children are empowered to support and manage their children’s health. Older children were encouraged to manage their own health and medication needs.

However, there were limited health promotion campaigns across the unit. Staff told us they had one during the summer on the use of sun creams. National guidance encourages trusts to promote health around breastfeeding, vitamin D use, obesity, adolescent mental health, and adolescent sexual
health.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

The service had a consent policy in place which was based on national guidelines around consent. Staff used this policy as a guide to help parents and children make informed decisions regarding their care.

Staff understood the relevant legislation and guidance regarding consent, including the Mental capacity act 2005. The Children’s Act 1989 and 2004 which were included in the safeguarding policy.

The integrated patient document (IPD) included a mental capacity assessment tool. Parents were supported to make decisions in line with current policy and we saw evidence of this during our observations.

Staff used assessment tools contained in their paediatric assessment document to assess adolescent understanding, known as Gillick competent to make sure children aged between 13 and 17 could make informed decisions regarding their care.

Parents and children would be asked for consent prior to any procedure and this was routinely documented in patient records. The service had a holding policy for children requiring clinical interventions such as blood samples, any parent who did not want to hold their own child during clinical procedures was asked for consent to proceed.

When parents lacked capacity to make informed decisions, staff ensured that best interest decisions were made with the multidisciplinary team.

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

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>64</td>
</tr>
</tbody>
</table>

Page 74
In children’s services the target was met for MCA/DoLS training for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>26</td>
</tr>
</tbody>
</table>

In children’s services the target was not met for MCA/DoLS training for which medical staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

Eastbourne District General Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Eastbourne District General Hospital for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>10</td>
</tr>
</tbody>
</table>

In children’s services the target was met for MCA/DoLS training for which qualified nursing staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Eastbourne District General Hospital for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>5</td>
</tr>
</tbody>
</table>

In children’s services the target was not met for MCA/DoLS training for which medical staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Other CQC Survey Data
CQC Children and Young People’s Survey 2016 Data

The trust did not perform better than other trusts for any questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. They performed about the same as other trusts for all four questions.

(Source: CQC Children and Young People’s Survey 2016)

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs

Staff we interviewed and observed, understood and respected the personal, cultural, religious and social needs of children and families who used the service. The service took all needs into account when planning and delivering care.

Staff took the time to interact with children and families who used the service in a respectful approachable way. Staff were friendly and always introduced themselves to families. The environment in both the paediatric outpatients and the SSPAU was very child friendly for children under the age of eight years old. However, the facilities were not as inviting to children reaching adolescence.

Staff we observed were supportive, encouraging, and they demonstrated positive patient centred attitudes towards the children and families. The service understood how to uphold the rights of children, young people and their families, and made sure it involved the whole family unit in decisions around care. Dignity was respected, curtains would be drawn, or older children admitted to side rooms.

Children with limited communication skills were encouraged to use picture boards to point to visual descriptions of how they were feeling. For example, happy or sad faces were used to identify the feelings of these children.

Feedback forms were given out to patients whilst they attended with the outpatients or the Friston SSPAU and we saw evidence of these. The inspection team viewed 14 patient feedback forms, 12 of which were very positive and included comments like, ‘kind friendly’ ‘staff explained care to us’ ‘caring nurses. The two negative feedback forms referred to the housekeeping and not patient care.

One parent we interviewed told us that she felt staff had catered for their child’s individual needs. When the operation had to be delayed due to the child’s sickness the hospital made sure the admission was moved and the child was readmitted. During the consultation, the parent told us that staff calmly explained the situation to the child in a language they could understand.

Another parent told us they felt staff had done everything possible to make their child’s admission ‘as stress free as possible’. Staff rewarded the child with a teddy to take home after having clinical procedures for example blood tests.

Parents of a child with a rare condition, highly praised staff for catering for their child’s unique needs in difficult circumstances. The child’s needs were readily accepted by all staff throughout the whole of
Paediatric nurses were compassionate and had a sound knowledge base regarding dealing with complex needs in a patient centred non-judgemental way. Thorough risk assessments at the first point of care, mean children with complex needs such as, autism, learning disabilities and mental health were flagged to the team, every effort is made to involve other members of the multidisciplinary teams for these children.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff understood the impact a child’s condition and treatment had on their wellbeing both emotionally and socially. Staff recognised and where possible supported the broader emotional wellbeing of children with long term or complex needs, which included support for their families and carers.

In the outpatient department the specialist nurses had extra training for complex long terms conditions such as epilepsy and diabetes. Staff we interviewed clearly understood how diagnosis and treatment of these conditions could have a negative impact on a child’s emotional wellbeing. The diabetes team had been awarded funding to employ a child’s clinical psychologist to help children cope with their feelings. The epilepsy nursing team hoped that in the future children with epilepsy could have access to the same services.

Staff demonstrated a real insight and a deep understanding of the complex feelings children with long term conditions may experience, especially when they reach the age for transition from children to adult services.

One parent told us, their adolescent child had recently been diagnosed with epilepsy. External healthcare professionals had made the appropriate referrals for the child to access epilepsy services. The child attended the outpatients four times over the last year. The child told us that the consultant at each appointment, gave good explanations about their care at every appointment. The parent told us staff not only supported their child’s emotional needs, but the parent felt supported whilst they adjusted to their child’s new health needs.

The play specialist who worked at the Conquest site, was called upon once a week to support staff in the outpatient department with the pre-operative assessments of children. Young children were encouraged to play whilst parents gave paediatric nurses full medical, social and emotional history prior to surgery.

Staff gave clear information to parents about procedures and thorough explanations in a language they understood. Parents were offered emotional support; nursing staff were compassionate and gave advice on feelings during the assessments. However, the service only had one play specialist cross site which meant many families with children with complex needs at Eastbourne were not able to access this important service.

Another parent was highly complementary of the service. His child had attended the department on several occasions with various injuries. The parent could not fault the staff, “everyone focused on my child’s fears and anxieties and went out of their way to reassure and support both my child and us as parents.”
Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure children and families understood their care and treatment and gave children and parents opportunities to ask questions. Staff would provide information to parents regarding external resources and support networks for a range of healthcare conditions.

During our inspection we did not witness care for children over the age of 12 or children with learning disabilities or mental health conditions. This means we are unable to comment on appropriate communications with young people, or whether older children are encouraged to contribute towards their care.

Discharge leaflets contained information on other available services for children and young people for many health conditions including diabetes and epilepsy. However, there was a lack of literature available for adolescent children, the service did not have any current literature for adolescent mental health, gaming addictions, drug or alcohol misuse.

Children were encouraged to provide feedback about the service during their stay on SSPAU. Staff employed a qualified in signer for deaf children, and where needed would access interpreters. Staff would use story boards for communicating with children, the learning disabilities team and play specialist could be called upon to support children with learning disabilities.

CQC Children and Young People’s Survey 2016

The trust did not perform better than other trusts for any questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. They performed worse than other trusts for four questions and about the same as other trusts for the remaining 16 questions.

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, East Sussex Healthcare NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>7.5</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 CYP</td>
<td>5.4</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>70</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 CYP</td>
<td>6.7</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016)

The service had been working on improvements since the survey, they were fully aware of the lack of transition services and planned to have this rectified by 2021.
Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Eastbourne hospital had a smaller children’s service and the model of care means that children did not stay overnight on site. Children were transferred to the Conquest site, for overnight stays. The short stay paediatric assessment unit, cares for children who have undergone minor surgery with a view for them to go home the same day. This is best practice as children normally recover better in their home environment. Children services provided at Eastbourne included outpatients, SSPAU and children bought in by parents to the emergency department, acutely ill children who required an ambulance were taken to the Conquest site which provided overnight care..

Clinical assessments, which identified children with protected characteristics under the Equality Act (2010) made sure everyone was treated equally and there was no discrimination throughout the unit. The equality policy had a clearly defined care pathway for children with learning disabilities and staff accessed mental capacity and deprivation of liberty training online and we were shown evidence that staff were 90% compliant.

The Department of Health’s, You’re Welcome: quality criteria for young people friendly health services (2011) recommends that children and young people’s experiences of health services are captured to help monitor and develop services. The unit engaged with families via their friends and family feedback forms, a feedback link via their public website and ran three public social media sites where patients and relatives could contribute to wider health conversations.

For example, the service had recently reviewed its arrangements for children and young peoples in transition between child and adult services. A gap needs analysis identified that services were limited when compared to national standards. Parents and young people had recently been consulted to help identify services that would support children with long term health conditions.

The unit at Friston saw children up to their 19th birthday dependent upon their health and social needs. Healthy children were transferred into adult services on their 17th birthday. However, children with complex needs or disabilities would remain in children’s services for a while longer.

The neurological disability team were involved with a medical supporting project, as past surveys identified services were listening to parents than young people. Senior managers helped raise awareness and provided support at trust board level to start transitional care for adolescents. With plans to initially start with the neurological disability service. The service aimed to transform transition to adult care services by 2021

There were play areas for children, with décor for children under 10 and lots of equipment and resources for them to use during their stay. Televisions were provided in the outpatient and SSPAU area. Parents could always stay with their children. However, the service had a lack of meaningful resources for children over the age of 10.

There were no tables for children over a certain height to draw or undertake crafts. Older children could use their phone’s or digital tablets to access the internet. However patient feedback we viewed
stated that the WIFI was not always available. Staff told us there was no funding for toys or play equipment.

Since our last inspection, the service employed one play specialist who worked cross site, to support nurses and the MDT with assessments and care. However, their base was at the Conquest site. This meant that children on the Friston ward had limited access to a play specialist. Parents were supported in the care of their children by health care assistants on the ward and in outpatients when they were speaking to staff.

Community staff had links with parents and carer’s forums, and feedback to the service regarding any concerns about service provision.

Parents had access to a patient kitchen and living room and could make themselves refreshments and relax. There was access to hot water and a microwave. Parents could make up formula milk for their babies in the kitchen but there was no separate storage facilities for expressed breastmilk.

Staff had paediatric training for caring and treating children with challenging behaviour, they understood that these children may be overwhelmed or frightened when they come into hospital. The pre assessment process made sure parents were well informed regarding what to expect from the SSPAU when children arrive.

There were four side room’s which were used for infection control, children with complex needs, children presenting with mental health illnesses or children with challenging behaviour.

**CQC Children and Young People’s Survey 2016**

The trust did not perform better than other trusts for any questions relating to responsiveness in the CQC Children and Young People’s Survey 2016. They performed worse than other trusts for two questions and about the same as other trusts for the remaining 14 questions.

**CQC Children and Young People’s Survey 2016 questions, responsive domain, East Sussex Healthcare NHS Trust.**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>6.8</td>
<td>Worse than other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>56</td>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>4.8</td>
<td>Worse than other trusts</td>
<td>R2</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016)

Since this survey, the trust had employed one play specialist and there were play area’s in outpatients for children under eight, which contained a full range of toys and activity equipment.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care
with other services and providers.

The children’s outpatient unit provided families with various clinics for children living with health conditions. There were systems in place that ensured children with long term medical conditions were seen by paediatric consultants with specialist interests, for example diabetes.

Children identified as having learning disabilities or autism, were referred from their GP or community health visiting teams. Children with complex needs were treated as equals within the service and when required a multi-disciplinary, meeting would be required to co-ordinate the child’s care appropriately.

The service set out an improvement plan which introduced the surgical pre-assessment and blood clinics. The outpatient's department created a clinic for babies with prolonged jaundice because data had suggested this may be a useful improvement for parents with young babies. However during the reporting period there had not been enough babies being referred by midwives or GP’s to warrant the continuation of the clinic. Therefore staff made sure they saw children on an ad hoc basis.

Clinics included, epilepsy, diabetes, cystic fibrosis, asthma, rheumatology, MRI reviews and ear nose and throat pre-assessments. In outpatients the healthcare assistants ran a phlebotomy clinic once a week, to assist with the medical staff with taking blood samples and shorten patient waiting times. Staff had more time to take bloods at these clinics and used distraction tactics which helped children stay calm during the procedures.

The SSPAU had a daily ‘huddle’ where staff would all meet to discuss, patient care and treatment which ensured that all staff had a good oversight of the individual needs and requirements of patients under their care.

Staff took the time to make reasonable adjustments to care, where possible. Staff ensured that children who had long term health conditions, visual impairment, hearing impairment or learning disabilities were supported by the multidisciplinary team. The learning disability nurse and physiotherapist would be asked to support care during a child's stay on the unit. However, children at Friston did not always have access to the children's play specialist as they were based cross site.

The waiting rooms in both areas provided lots of patient information leaflets which included, post-operative surgical care, information on epilepsy, diabetes, caring for your child with a cannula at home, children’s community nursing team, and short stay paediatric unit information.

The unit had wheelchair access ramps, and the lavatory and bathroom facilities were installed to make sure children had easy access.

Parents were given discharge notifications, with the relevant contact details of hospital staff and community services. They were provided with post-operative advice and given the option to call the SSPAU if they had any questions or concerns once home.

When the SSPAU closed calls were diverted to staff on the Kipling ward at the Conquest site, this made sure that parents had 24 hour contact. The inspection team noted that there were no telephone triage forms and calls were not documented, which meant that there was no paper trail of calls in the event of a serious incident. This was highlighted to the matron who told us they would follow this up to make sure a document was created on the electronic patient records.

Families who received bad news had access to the bereavement service, staff made sure every effort was made to reassure parents and signposted them to the appropriate healthcare professionals. Parents and children were treated with dignity and respect through their care and
Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The inspection team did not have access to referral rates figures during our inspection. Parents we spoke to told us that the wait was on average two to three weeks. Staff told us that referrals were received and reviewed by the medical secretaries and scheduling was planned from the conquest site.

Children referred by GPs or other healthcare professionals, with the signs and symptoms of epilepsy or diabetes would be seen within two weeks of the first onset of symptoms.

The matron kept monthly discharge rates, figures we were shown over a three-month period showed that the service had an 88% discharge on the day of surgery rate.

The Friston SSPAU had closed 10 times since July 2019, 6 of these closures were due to two children presenting with complex needs. For example staff identified one child as having developed a mental health concern and referred to social care; during their stay the child became a ‘looked after child’, which meant they had to await a specialist community placement. The service had to provide a 24hour care package which required one to one care, Staff had to be transferred from Friston to Conquest to support other acutely ill children and Friston had to be closed.

Children who required an overnight stay following day case surgery would be transferred to the Conquest site. The trust was aware that some transfers were delayed late into the evening, staff told us this is because they must wait for NHS ambulance or private patient transport services to transfer children safely. Based on the recommendations of our last report, the trust created a guideline which included a criteria flowchart for staff to make the right decisions on which mode of transport should be used to move children from the Eastbourne to Conquest site when required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

It was easy for children, families and carers to give feedback to the service. Complaints sent to the patient advice and liaison service (PALS) would be feedback to the ward matron, who set up an investigation. The electronic patient records took note of the patient’s bed number during their stay, and the matron would use rosters to identify key staff involved in patient care. When necessary staff would be asked to write statements to help with the investigation process. The matron would then write back to the PALS team with a response which would be sent to the patient. Staff clearly understood their legal duty with regards to duty of candour and were open and honest with patients, when things went wrong. The duty of candour guidelines were accessible via the trust website.
We did not see any complaints at the Eastbourne site because there were no current ongoing investigations, but the matron told us they would be responsible for responding to these.

Summary of complaints

Eastbourne District General Hospital

From August 2018 to August 2019 there were six complaints about children’s services at Eastbourne District General Hospital. The trust took an average of 29 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be completed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td>Patient care</td>
<td>4</td>
<td>66.7%</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

Trust level

From August 2018 to August 2019 the trust received 12 complaints in relation to children’s services at the trust (2.2% of total complaints received by the trust). The trust took an average of 29 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be completed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>8.3%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
<td>8.3%</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
<td>25.0%</td>
</tr>
<tr>
<td>Patient care</td>
<td>7</td>
<td>58.3%</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Number of compliments made to the trust

From August 2018 to July 2019 there were four compliments about children’s services at the trust. A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>3</td>
<td>75.0%</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
The common themes arising from compliments relate to:

- The kindness and professionalism of staff
- The quality of the care and treatment provided
- The quality of the environment and services provided (such as food)
- The kindness extended to the patient’s relatives and family
- The overall care and treatment provided to patients by the trust as a whole

All feedback received via the Friends and Family Test (FFT), thank you cards and letters, verbal compliments, feedback received via the trust website and NHS website reviews page is shared with senior managers for wider dissemination to staff.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

During the inspection visit to the Eastbourne children’s services, we met with the band 7 ward matron who had worked for the service for a long time. The matron had the knowledge and skills to ensure they had a good oversight of the service. We were given a flow chart that explained the leadership structure in full. However, we did not get the opportunity to meet the service manager or director.

The leadership team consisted of a chief of division, an associate director of operations, an assistant director of midwifery and nursing who was also the head of midwifery, and managed maternity and children and young people’s services. The service had speciality leads for acute and community paediatrics who were consultant trained, and oversaw obstetric, gynaecological and paediatric service managers.

The associate director of midwifery and nursing worked closely with the head of nursing and had an oversight of the deputy head of midwifery for acute services. The associate director of operations fed down to the health visiting, community paediatric service manager and the acute paediatric service manager.

The leadership team were highly trained and had the knowledge, skills, insight and integrity to deliver children and young people’s services across both sites. The leadership team understood the challenges to quality and sustainability.

There were clear priorities for ensuring sustainable, effective leadership. The ward matron was a valued member of the team at the Eastbourne site, who was supported by an administrative assistant. The matron had a good oversight of the service’s provided.

The matron worked on site full time, alongside medical colleagues, which included consultants,
registrars and anaesthetists. The team were visible and approachable, and the ward matron had an open door policy. Staff told us that the matron was supportive, compassionate and approachable.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The division’s vision included a mission statement which was ‘The very best start in life’. The focus was to combine community and hospital services in East Sussex to provide safe, compassionate, and high-quality care that improved the health and wellbeing of children, young people and their families. All staff we spoke to were aware of and upheld this vision.

Services were being transformed to make sure acute, outpatients, nursing outreach and community paediatric services holistically met the needs of children and young people. The leadership team were reviewing the following services:

- Care closer to home, to avoid unnecessary admissions.
- Effective transition into adult services for adolescent children with long term conditions.
- Health, education and social care working in unity.
- Codesign and coproduction with young people and their families.

Healthcare professionals across the service, were aware of departmental strategy, which was aligned to national recommendations for children and young people’s service provision.

Progress was monitored at board level, and since our last inspection some changes had been made to the provision of transition of young people. However, staff acknowledged there was still a lack of transition services within the unit for all adolescent children or children with mental health needs.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The head of midwifery recently organised coffee & croissants’ mornings for anyone working in the children and young peoples or maternity units to attend. These meetings were arranged to help with quality improvement and staff were able to feedback their experiences, concerns and ideas.

The culture centred around the needs and experiences of all people who used the services. Staff told us they worked as a team and were proud to work on the outpatients and SSPAU wards at the Eastbourne site.

Staff we interviewed had mixed feelings regarding the culture of the unit. Nursing staff felt they were well supported and valued and gave us examples of support regarding their personal development. For example, one member of staff had developed from health care assistants to specialist nurse in under 10 years, and the link nurse for sepsis was given time to audit staff compliance to the sepsis tool and publish the result. However, support staff we interviewed felt they were not always informed
of change or included in ward meetings.

Staff had access to three private social media groups, which included a team chatter group, a staff swap group and a share and care group. The team chatter group helped staff to debrief and discuss any concerns about their wellbeing or shift patterns. The staff swap group helped staff manage their own shift swaps and gave them the autonomy to manage their work life balance. The share and care group was designed for staff to share research and evidence-based practice amongst their peers.

There were clear policies and processes in place to monitor and assess staff performance. Appraisals gave managers and staff an opportunity to discuss career development, personal limitations and review of staffs work life balance. The matron had a clear oversight of sickness and special leave rates which were routinely managed in line with the appropriate policies.

A freedom to speak up guardian was available for staff cross site to support them with any concerns relating to care. The ward culture encouraged staff to be open and honest, staff told us that they felt the matron was open and approachable and listened to their concerns. Staff routinely used the online incident reporting system to report concerns over staffing, workload or risk, and all staff knew how and when to raise concerns at ward level.

The matron routinely held staff meetings, and video links were provided for cross-site team meetings. We were shown evidence of minutes from teams’ meetings, which demonstrated meetings were clearly structured and designed to engage staff with the everyday management of the ward. Furthermore, the matron sent email updates to staff regarding safety, changes to evidence-based practice or audit information.

The trust had lesbian, gay, bisexual, transgender, disability and cultural diversity networks in place. Staff told us everyone was treated as equal, and people recognised as having protected characteristics under the Equality Act (2010) were supported by managers.

Staff’s safety and wellbeing was a priority for the ward matron, who would make reasonable adjustments to shift patterns for staff who had children or vulnerable adults to care for at home. Extra support for staff was provided by the occupational health department and staff had access to six free counselling session’s if they were experiencing emotional issues.

All staff worked collaboratively, they were supportive, cooperative and appreciative of each other. Responsibilities were shared, which helped avoid conflicts. Staff told us they felt part of a family and stayed loyal to the service because of the relationships they had built overtime. We were told that many staff had worked at the unit for over 10 years.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear divisional governance structure, system and process of accountability which supported the delivery of sustainable, safe and quality controlled children and young people’s services.

The chief of division, associate’s director of operations, assistant director of nursing, head of
midwifery and deputy were accountable for practices and to commissioners of services across the catchment area of East Sussex.

The clinical governance lead, with administrative support, was responsible for leading daily risk meetings on the maternity unit and weekly governance meetings in the paediatric areas of the trust. All reported incidents were routinely fed up to the governance leads and there were clear processes in place to define, rate and investigate incidents across the unit.

The governance team was responsible for reporting to external agencies which included, the Perinatal mortality review board, the health service investigation bureau (HSIB) and the clinical commissioner group (CCG). The governance lead had a duty to oversee professional reviews, support staff with provision of evidence and produce reports from audited data across all children’s and young people’s services.

The service had a systematic programme of monitoring quality, operational and financial processes. The governance framework focused on five key areas these were:

- Quality and safety,
- Leadership and culture,
- Clinical strategy, access and operation delivery,
- Financial control,
- Capital development.

Monthly meetings were held which meant staff could cascade information back and forth. The systems made sure that all levels of governance and management functioned effectively and fed back to third party providers.

An “Excellence in care” model was 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. Staff told us they had seen changes implemented and were kept informed of planned changes.

Information about ward or clinical unit performance was displayed on whiteboards in each area. The ward dashboards showed the number of non-attendances over time, cleanliness audit results and the planned and actual staffing levels and the incidence of certain infections.

Minutes of meetings were of an acceptable standard and contained appropriate information. We reviewed the last three ward meeting and trust risk minutes. 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 chief executive officer report to board.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had clear and comprehensive assurance systems in place, which managed current strategic plan. The governance team were responsible for the regular reviews of these arrangements. The ward manager was satisfied that clinical and internal audits were sufficient to
provide assurance. Teams acted on results which were needed to develop future performance, these were regularly reviewed to help make adjustments to the service. Quality improvement measures were designed to involve staff in strategic and business planning.

The SSPAU and children’s outpatient service had a clinical and internal monitoring programme in place, which included regular internal audits for sepsis, infection control and theatre checklists. The service had a consultant lead for anaesthetics who was responsible for paediatric surgery. They were trained in advanced paediatric life support and critical care and responsible for the training and management of medical staff. There was a trust wide resuscitation team that would provide simulated training for staff, which made sure their skills were reviewed and updated.

There were arrangements in place to identify, record and manage risks, and mitigating actions. The service held monthly children’s risk meetings, where nursing and medical staff discussed incidents, risks, complaints and the patient experience. Other monthly meetings included, perinatal mortality and morbidity and guideline assessments and implementations.

The division held bi-monthly audit meetings for children’s services and paediatric morbidity and mortality meetings. These were attended by clinical and governance leads, and other clinical staff involved in patient care. Learning from outcomes was shared across the division.

There was a major incident policy and the matron knew what was expected of her and her team in the event of incidents that impacted on the service. Major incident plans included the redeployment of staff cross site and possible ward reconfigurations.

The inspection team found there were limited services for children and young people experiencing mental health problems because the system was complicated and integrated with third party community children and adolescent mental health (CAHMS) service. Community mental health services for children and young people were limited and mental healthcare professionals were not always available on site to advise on clear ways to get help or support. The lack of community mental health services for young people impacted on the trusts bed capacity, which meant that children with mental health conditions were being cared for in an acute setting, where staff had limited skills and knowledge in dealing with complex situations. Staff told us the current system was not responsive.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of the need to protect patient information with notes trollies being kept in secure areas and locked cupboards. Whiteboards in the public area of the ward, only had the patients initials and staff understood their responsibilities for information security.

Staff had access to a range of information to support them with their roles and were provided with a unique log in and protected password to ensure safe access to patient information. Management access included information on the performance of the service, staffing and patient care. Data was collated and used to populate a dashboard that was shared within the divisional meetings and fed up
to inform the IPR.

When we visited the ward and clinical areas, staff we spoke with were informed about how they were performing and how this compared to other areas of the division.

The matron spoke with us about improvements in key performance indicators and about action they had taken where data had identified a concern such as sepsis rates.

**Engagement**

_Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients._

Community stakeholder meetings were held quarterly, those invited to these meetings included, consultants, clinical leads, GP’s, the child safeguarding leads, social care representatives and health visitors. However, we were unable to see minutes from these meetings as they were accessible via the clinical leads.

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 used this information to make improvements.

The Friends and Family Test survey (FFT) provided results for the division and for individual clinical units. Team leaders used the results for discussion at team meetings benchmarked against other wards and services within the division. Results from the Friends and Family test were displayed on ward information boards.

Patients, staff and carers were able to meet with members of the trust’s leadership team and governors to give feedback. Patients, or their relatives could meet with the board to tell their stories. However, we did not see any evidence of these engagement meetings during our inspection.

**Learning, continuous improvement and innovation**

_All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research._

The trust actively sought to participate in national improvement and innovation projects. They used the NHS Right Care (a national NHS England supported programme) to create a strategy that would 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 Think Sepsis poster which had been launched in Eastbourne to help staff quickly assess and provide the appropriate interventions when dealing with sepsis.

The new ‘Family First’ level 3 safeguarding training was designed to support staff to understand the dynamics of family life and staff felt more confident to deliver care to children with complex social and emotional needs. Staff told us that this training had inspired them to deliver care that had the child’s needs at the heart of clinical decision making.
In the reporting period, the service had been awarded the clean care and sepsis improvement awards.

We were told that a serious case review flagged transition of children to adult care as a risk, because the service listened to parents more than young people. With support from the deputy director of nursing, who took ‘up the baton of support’, the service now plans to provide transitional care for all young people attending the neuro disability service by 2021.

End of life care

Facts and data about this service

The trust provides end of life care at a number of settings. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services.

End of life care is provided for people and those most important to them who are approaching the
end of their life and after death. This service is delivered across a number of settings, including acute and community hospitals and in people’s own homes supported by community teams. Mortuary, bereavement, chaplaincy, and volunteer services provide valuable services and support to patients and their families. Where additional expertise is required specialist palliative care teams are available in both acute and community settings.

The trust works in close partnership with local hospices to provide seamless care supporting patients to be cared for in their preferred place of death. Recently funding was approved to extend the team to enable provision of the service seven days a week.

End of life care is delivered either indirectly or directly by over 4,000 employees within the organisation. Education for staff is predominately provided by the supportive and palliative care team, local universities and through e-learning modules.

The trust has recently introduced ReSPECT, an alternative process for discussing, making, and recording recommendations about future emergency care and treatment, including CPR. This process encourages patients to focus on both the treatments they do want, those that they do not want and planning ahead for their care and treatment should they be unable to make decisions due to a future emergency.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The trust had 1,627 deaths from March 2018 to February 2019.

(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 and made sure everyone completed it.

Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training.

The trust set a target of 90% for completion of mandatory training, other than the information governance module where the trust set a target of 95%. Data provided by the trust indicated that there was a dedicated end of life care nursing team at Eastbourne District General Hospital only.

The trust did not provide mandatory training data for medical staff within end of life care.
A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at Eastbourne District General Hospital for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td></td>
<td>5</td>
<td>9</td>
<td>55.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for five of the six mandatory training modules for which qualified nursing staff were eligible. In addition, nursing staff met the 95% trust target for the information governance module. However, care should be taken when interpreting completion rates due to small numbers of eligible staff.

All new starters are given EOLC information at induction. Level 2 is patient facing staff who work with people at end of life – this is currently at 59% at the end of September. This training started in March 2018 and is in the second year of a three year trajectory to achieve 100% compliance.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust ran its own end of life training programme which was mandatory for all clinical staff. It was provided in three levels. All staff involved in end of life care completed level one training. This was delivered as part of the induction process. All patient facing staff completed level two of the mandatory training. This was a three-hour session. This was delivered twice a week and was alternated across the two acute hospital sites. Specialist staff working full time in the end of life care team were provided with level three 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.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

**Safeguarding training completion rates**
The end of life nursing team for the trust was managed as one team across their multiple sites which includes the Conquest hospital in Hastings. The data provided by the trust was identified as Eastbourne District General Hospital, but this information was for the team that covered all sites. However due to the way the information was submitted the data analyst below is identified as Eastbourne District General Hospital.

Eastbourne District General Hospital end of life care department

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at Eastbourne District General Hospital for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>9</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We asked the bereavement team what action they would take if they contacted any adults or children they deemed to be at risk, and how they would safeguard those people. We were given a clear description of the action that the team would take, how and where they would report their concerns. We were also given an example of an incident where they had needed to escalate their concerns to the relevant agencies. However, when we asked what level of safeguarding training they had received, we were told that they had not received any and had not been required to. This was raised with the bereavement office manager who confirmed that safeguarding training was not given directly or undertaken as part of their mandatory training.

Staff we spoke with that were based on the wards were able to describe the process they would follow in the event that they had any safeguarding concerns and how they may spot signs of abuse.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. They kept equipment and the premises visibly clean. Staff used infection control measures when visiting patients on wards and transporting patients after death.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The equipment used by mortuary staff appeared visibly clean.

When collecting a deceased patient from the wards, porters were responsible for ensuring ward staff had carried out the last offices and they were appropriately wrapped and covered before transporting...
them to the mortuary. This ensured that people were protected should a patient have had an infectious illness. After they had safely moved the patient to a space in the mortuary, they cleaned the trolley down and record on a cleaning schedule what they had done and when. The trolley was then deep cleaned once a week by the hospital’s own mortuary attendants. We were shown records to demonstrate the cleaning had been completed. We saw that staff used personal protective equipment when they needed to and we observed good hand hygiene practice both in the mortuary area and on the wards.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had enough suitable equipment to help them to safely care for patients.

The mortuary was situated on the ground level of the hospital. At the entrance, there were security cameras in place to monitor who was going in and out. There was a buzzer system that needed to be pressed so a bell could sound in the mortuary. The member of staff who was on duty at the time of our first visit established who we were before coming to the door to allow us entry. On entering they ensured that we signed as visitors and confirmed our identity again.

The mortuary itself was clean, uncluttered and tidy. There was capacity to store up to 118 patients there and they had never reached capacity. There were five spaces available for bariatric patients. The mortuary had a manually operated trolley that was used by mortuary staff to lift the patients into the higher and lower storage areas. There was one stretcher that was used to transfer the deceased patients from the wards or units to the mortuary. This was stored in a safe and easily accessible place.

At the rear of the mortuary there was a large corrugated metal door that could be opened when funeral directors attended to collect the patients. Behind the large door was a platform that could be moved up and down to move patients from the mortuary to ground level. The collection area was in a secluded area at the back of the hospital which was not visible to the public. However, the signage to clearly identified the area needed to be kept clear was itself, not clear. Hatched yellow lines that demarked the area where the undertakers would park were faded which meant that on occasion other vehicles had parked in the way. This in turn caused unnecessary delays for both the mortuary staff and the undertakers.

Staff across the wards we visited told us they were easily able to obtain syringe drivers from the equipment library. Those we saw were within their service date and were delivered with batteries and giving sets.

We saw records that demonstrated that mortuary fridge temperatures were recorded and monitored.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff shared key information to keep patients safe when handing over their care to others.
Comprehensive risk assessments were carried out, and risk management plans were developed in line with national guidance. Risk assessments such as falls, malnutrition and pressure ulcers were recorded in the patient record and included actions to lesson any identified risks. They had also introduced plans that were started with patients in the community to make advanced decisions and provided additional information for ambulance crews and hospital staff. This allowed the risk assessment to be a continual process and involved the patient as much as possible.

We saw an example of a patient that had been admitted to hospital with a non-reversible condition and had been started on the last days of life care pathway. The team saw that the patient then subsequently saw an improvement in their condition and had the last days of life care plan withdrawn. The ReSPECT form (The ReSPECT process provides health and care professionals responding to an emergency with a summary of recommendations to help them to make immediate decisions about that person’s care) was then updated and went with the patient when they were discharged to a nursing home.

Ward staff told us how they were confident with the information about the patient that was given to them before the weekend. They told us that the medical team were good at updating the care plans prior to the weekend. This ensured that all staff had up to date information about all their patients which enabled them to plan and deliver their care.

When a patient entered the last days or hours of their life, or were placed on a syringe driver, staff would use a different chart to monitor these patients. The standard checks of blood pressure and pulse were replaced with a form to assess comfort, such as assessments of pain, nausea, vomiting, breathlessness, agitation, mouth dryness and respiratory secretions. This form was completed at least every four hours and each symptom was categorised between zero and three with zero being the absence of the symptom. If the symptom was rated as one, two or three the form had advice on what to do. This included consideration of additional medication to control the symptom or to look for other causes of the symptom. These ratings were also used to advise nursing staff if there were two consecutive rating of two or a single rating of three then the patient should be reviewed by a doctor. Reviews of these charts demonstrated that these were being used well by staff.

There were arrangements to ensure deceased patients were correctly identified. When a patient was taken to the mortuary they were assigned an identification number from a book. The corresponding number was then placed on a large board that corresponded with the space that the patient had been put. In the mortuary a three-point check system was carried out to ensure that patients were not misidentified. This was driven by the information on the risk assessment form that was completed by the ward staff. The risk assessment form was placed on a clip board by the porters for review by mortuary staff. The mortuary staff then check the patient’s identity band against the details provided in the risk assessment. Patient notes were stored with the deceased patients and were also checked against identity bands.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The supportive and palliative care team was made up of eight specialist nurses and two support workers. This team worked across both of the trust’s main sites which included the Eastbourne
District General hospital. This team was also supported by palliative care link nurses based on each ward in the hospital. The link nurses attended additional training with the palliative care team and also attended regular link nurse meetings. Ward staff told us they found their link nurses very helpful and they were always around to answer questions. We looked at the minutes from three end of life care link nurse meetings and these showed that issues faced by the wards were discussed and solutions proposed.

**Eastbourne District General Hospital**

The table below shows a summary of the nursing staffing metrics in end of life care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>9.0%</td>
<td>12.8%</td>
<td>0.0%</td>
<td>3.7%</td>
<td>58 (&lt;1%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>7.4%</td>
<td>6.5%</td>
<td>0.0%</td>
<td>3.7%</td>
<td>58 (&lt;1%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Nurse staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and, bank use or agency use.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The supportive and palliative care team had five medical staff which was made up of three consultants and two specialty doctors. These medical staff had undertaken specialist training in symptom control and end of life care. This medical team also support the hospice and community end of life care.

The service always had a consultant on call during evenings and weekends. This out of hours cover was provided by the local hospice.

The trust did not provide data for medical staffing within end of life care. So, we did not have rates of sickness, agency usage, turnover rates, or vacancy rates. However, staff reported the service had
enough medical staff to supply effective support to patients.

Other Staffing
The bereavement office was staffed by one bereavement officer who worked four days per week and one that worked three days per week. At times when one was on leave, support was provided by the bereavement team from the Conquest Hospital. Although it was sometimes very busy, there had been no occasion where they were not able to provide a service.

The mortuary service had a mortuary manager and two mortuary attendants. Staff in the mortuary service occasionally had to work across both hospital sites if they were short of staff.

Records
Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

On the critical care unit, we saw all patients had a ReSPECT form completed. ReSPECT stood for Recommended Summary Plan for Emergency Care and Treatment. This was a process that allowed people to record their wishes about how they would like to be treated in a medical emergency when they may not be able to communicate. This was the first unit, or ward to adopt the ReSPECT form in the hospital. We saw that these were completed well and displayed clear details of escalation and ceilings of care where necessary.

Conversations took place about the patient’s care at the end of life. In total we visited a total of 12 wards or units, including critical care. As part of the visits to the wards we carried out a comprehensive review of the records of seven patients that were in the last days of life. These records all contained a last days of life care plan which had been completed according to the patient’s needs and wishes. We also saw each of the patients had a comprehensively completed ReSPECT form.

We saw staff ensured that paper notes, where used were locked and re-locked after each use. Records in the bereavement office were only placed outside of secure storage when they first arrived in the office for the staff to record them and when they were being used by a member of the medical team to record details of the death on the system. The office where the administration of the records was processed was a separate room away from the relatives’ area, which itself could not be accessed without a member of staff letting you in.

Medicines
The service had systems and processes to safely prescribe, administer, record and store medicines.

The wards had access to a team of specialists from the Supportive and Palliative Care Team who attended individual wards if a patient was deemed to be entering the last days of life. They provided support to the clinical and nursing staff on the treatment regime to be started to ensure patients were given the right medication to keep them comfortable, as well as providing support to the patients and their families.
Medicines were stored safely and securely on all the wards. Access to medicines was limited to authorised staff only. Controlled drugs were stored safely and securely. All medicines were stored securely in line with the provider’s policy and national guidance. Access to medicines was limited to authorised staff only.

Patients’ medicines were reviewed by the ward and supportive and palliative care teams regularly. Each morning the ward teams reviewed the symptoms and needs of each patient on end of life care. The pharmacy team provided specific advice to patients and carers about their medicines.

Each ward had access to end of life care observation and prescribing charts as well as ReSPECT forms (ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices).

A full medicines reconciliation was completed on admission to the wards by the pharmacy team. Records of this were passed onto the doctors to ensure continuity of care.

The trust operated an incident reporting system on which staff could record incidents and medicines safety concerns. Staff were aware of recent medicines safety alerts and the actions that had been taken around these.

Midazolam was commonly prescribed when required to help manage agitation and restlessness. It was not held as ward stock, not used excessively and was prescribed in line with trust and national guidelines.

Staff were trained on the use of syringe drivers (A small battery-powered pump that delivers medication at a constant rate throughout the day). Medicines were prescribed on a separate syringe driver prescription chart that also prompted staff to perform checks on the device every four hours to ensure it was working correctly and we saw consistently completed charts.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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.

Incidents regarding end of life care came from all divisions. The service drew information from the electronic incident reporting system and any elements that related to end of life care were reviewed by the palliative care team. The incidents were fed back to the end of life improvement group to identify any key themes. The incidents and the themes drawn from them formed part of the mandatory training that was provided to all staff across the trust.

Staff reported incidents and took action to ensure they were investigated. During the inspection there was an incident where a patient that had died had been misidentified by ward staff and the label placed on the risk assessment form was for another patient. A member of the mortuary staff completed the three point check they carried out to establish that the patient had been correctly identified. Having done this they realised that the label on the form did not correspond with the patient’s details they had. They acted immediately and called ward staff and the bereavement officer to attend the mortuary. We then saw that the incident had been recorded on the electronic incident reporting system. We spoke with the mortuary team and the bereavement officer and were provided
assurance that once the incident had been investigated, the learning would be fed back to all wards and steps would be taken to prevent any future recurrence.

Each instance of any error was incident reported. We were shown the mortuary error log where any issues were recorded and collated to identify themes. We reviewed the log and although the number of errors that were reported were low, there were consistent themes around the quality of the information being provided on the risk assessment forms by the wards.

We were also provided with the end of life care incident log and reviewed the content of that. We saw that there were 31 incidents reported in the previous 12 months prior to the inspection. These were categorised by harm and risk. Descriptions of the incidents and actions taken were also clearly explained.

Staff received feedback from investigation of incidents. All staff we spoke with, including those in the mortuary and on the wards told us that they received feedback when an incident had been investigated. Learning from incidents was used to help improve the service and prevent repetition.

Staff we spoke with were also aware of the duty of candour or, letting people know when things have gone wrong. All could explain the process they would follow if they realised that something had happened that shouldn’t have, who would need to be notified and how. Staff could not give any recent examples where this had happened specifically in the provision of end of life care.

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 July 2018 to August 2019, the trust did not report any never events for end of life care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

From July 2018 to August 2019, the trust did not report any serious incidents for end of life care.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service was using personalised care plans for those in the last days of life which was in line with the National Institute of Clinical Excellence (NICE) standard NG31 “care of dying adults in the last days of life”. These had consideration to the six recommendations of this which were; recognition, communication, shared decision-making, hydration, pharmacological interventions, and anticipatory prescribing. The service had recently released version three of this care plan along with new guidance to support staff in the use of these new care plans. These care plans included individual’s preferences regarding the type of care they would wish to receive and where they wanted to be cared for. We saw these priorities of care were also displayed on end of life care notice boards on the wards and departments we visited.

The trust was aligned with the five priorities for care of the dying person. This was in line with guidance from the national institute for health and care excellence (NICE) guidance 31; Care of the dying adults in last days of life. During our inspection we saw that patients in the last days or hours of life had been started on the trusts “last days of life personalised care plans”. These care plans included individual’s preferences regarding the type of care they would wish to receive and where they wanted to be cared for.

Audit data provided by the trust showed that despite repeated education and support to ward areas the documentation within the LDOLPCP has consistently remained below the standard that the trust would have liked. As part of the action plan to improve the documentation, a small task and finish group was developed to redesign the LDOLPCP to make it easier to use, with more prompts and increased education about the importance of completing it. A number of changes were made to the LDOLPCP, including a more detailed family support section, with prompts for completion; a more structured individualised care plan again with prompts to support its use. The most significant change was a section that looked at care at the time of and immediately after death as this was often not clear from the documentation within the LDOLPCP.

**Nutrition and hydration**

The service supported patients through regular assessments for nutrition and hydration. Staff supported patients to make sure they had enough food and drink to meet their needs. Patients were encouraged to eat and drink normally for as long as possible despite this need reducing as people approached the end of their life.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed.

When reviewing patient notes we saw that patients at the end of their life were receiving the necessary nutrition and hydration. However, when non-symptom medication had stopped, we saw that food and drink was noted as no longer being taken.

We saw patients were encouraged to eat and drink normally for as long as possible despite this need reducing as people approached the end of their life. In the last days of life personalised care plan there was a section that prompted staff to think about nutrition and hydration including what the patient would want after they were unable to eat and drink normally.

The service had completed an audit on patient end of life care plans which included looking at recording of hydration status. The trust had compliance of 53% in April 2019, 68% in March 2019, 58% in February 2019, 50% in January 2019, and 84% in December 2018. The trust’s audit
acknowledges that this is below where they would like this to be and they have formed a task and finish group to improve and simplify the end of life care planning document. This group has also produced a completed example of an end of life care plan to guide staff that has been placed on the trust’s intranet.

**Pain relief**

*Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.*

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw records showing that for patients in the last days of life staff used a non-verbal pain score. This included consideration for facial expression, body language, physiological changes, physical changes and vocalizations such as crying. This allowed staff to continue to assess a patient’s pain level if the patient was unable to say how much pain they were in.

‘Just in case’ or ‘Anticipatory’ medicines (medicines prescribed preemptively to provide relief from symptoms if needed) were used on the wards. The trust used drug dispensing charts for end of life care which would support prescribers to provide medicines in line with national recommendations for the management of symptoms in the last days of life.

Staff were trained on the use of syringe drivers (A small battery-powered pump that delivers medication at a constant rate throughout the day). Medicines were prescribed on a separate syringe driver prescription chart that also prompted staff to perform checks on the device every four hours to ensure it was working correctly.

When a person is entering their last days of life the ward stopped vital observations and instead used a ‘symptom observation chart’ to record and manage symptoms. This chart helped prompt staff to use PRN (when required) medicines to manage symptoms as they appeared. Patients were given timely pain relief when required.

The wards reviewed current medicines as a person entered their last days of life and stop the medicines that were not providing relief from symptoms. Medicines were given as liquids where appropriate, as this was easier for patients to tolerate.

**Patient outcomes**

*Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.*

The service participated in the National Audit for Care at the End of Life (NACEL). The information provided was at trust level and not broken down to individual hospitals. The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the five priorities for care set out in ‘One Chance To Get It Right and NICE Guideline (NG31) and Quality Standards (QS13 and QS144)’. A Case Note Review, completed by acute and community providers only, which reviewed all deaths in
April 2018 (acute providers) The audit of the trust acute hospitals included a review of 80 sets of records.

There were nine indicators tested during the audit, with the trust being compared to the national summary scores. The indicators were:

- Recognising the possibility of imminent death
- Communication with the dying person
- Communication with families and others
- Involvement in decision making
- Needs of families and others
- Individual plan of care
- Families and others experience of care
- Governance
- Workforce / Specialist palliative care

The summary scores for the trust were marginally worse in all indicators other than governance, where the summary score for the trust was better than the national score.

In many of the indicators from the review of the records, the trust’s performance was similar to the national average. However, the review highlighted that in areas where the trust scored below the national average, this was in large part because the information had not been recorded. This was raised with the leadership team who acknowledged that this was the reason for the indicator being below the national average. However, they were confident that with the introduction of the ReSPECT form and the last days of life care plan, recording of conversations and decisions would improve.

The service provided a fast track discharge process for patients that were approaching the end of their life and had a preferred place of care outside of the hospital. Data from the end of life care dashboard showed that between November 2018 and August 2019, the service referred 270 patients to the community healthcare service for rapid discharge. Of those, 203 were successfully discharged to their preferred place of care. In this period, patients were able to be discharged within two days from the date of referral for all months except for June 2019 (three days) July 2019 (three days) and August 2019 (five days). In the same period, a total of 58 patients died in the hospital before they could be discharged.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff we spoke with in the bereavement office and the mortuary told us that they had regular supervision meetings with their direct managers. These were noted to be useful means of discussing many issues including any training needs for them or other members of their teams where they also had management responsibility.

Ward based end of life care link staff were provided with regular updates from the members of the supportive and palliative care team to assist them with aspects of their role that related to end of life care.
Mortuary staff also held ad-hoc training events about the work of the mortuary and the importance of accurately recording information about all of the patients that had died. One of these took place during the inspection and was observed by one of the inspection team. It was noted to be well attended and all staff were active participants.

**Appraisal rates**

Data provided by the trust indicated that there was a dedicated end of life care nursing team at Eastbourne District General Hospital only.

The trust did not provide appraisal data for medical staff within end of life care.

From August 2018 to July 2019, 88.9% of eligible nursing staff in end of life care received an appraisal compared to the trust target of 90%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some staff groups.

### Eastbourne General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
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<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>8</td>
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</tbody>
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(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Records we reviewed for patients that were noted as receiving end of life care showed input from the multi-disciplinary team, including palliative care consultants, nurses and ward based nursing staff.

The hospital had an acute oncology nurse that visited any patients that were on wards away from the specialist oncology wards.

We observed board rounds on wards that discussed each patient’s condition. The wards were led by the medical team with nursing staff, occupational therapists, social care staff and physiotherapists all in attendance. These were seen to be well organised with all members of the multidisciplinary team having an equal voice.

Eastbourne District General Hospital had a ‘Hospital Intervention team’ (HIT) who made arrangements for patients that were being discharged home to their preferred place of care. The team was formed of medical staff, nursing staff, occupational therapists and physiotherapists. They worked together to arrange for equipment, medicines and care packages to be available to the patient.
The hospital had a ward that was available for private patients, but also cared for patients that were not private. Staff told us that the medical team did not routinely visit and that a visit had to be requested. Although the ward did have an end of life care link nurse, there was no multi-disciplinary board round held on the ward. This meant that on occasions, decisions about patient care were delayed.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

The supportive palliative care team provided a service between 8am and 4pm, Monday to Friday. Outside of these times support and advice could be sought from the local hospice. Staff we spoke with on the wards told us that the support they received both in and out of hours was comprehensive and easily accessible.

The chaplaincy service was available for patients 24 hours a day, seven days a week. The chaplain was present on site during the day Monday to Friday and also held a Sunday service. Out of hours there was a on call rota so that if a patient needed chaplaincy services someone would come into the hospital to see them.

The mortuary was accessible 24 hours a day. Out of hours the porters would take a patient to the mortuary, record which refrigeration bay they had been put in and leave the risk assessments on a file for the mortuary staff to process in the morning.

Out of these hours the ward staff were supported by telephone advice from the local hospice and staff on wards told us they found this worked well. Managers told us they had a plan to expand the palliative care service to cover out of hours support but this had not been started when we visited.

### Health promotion

**Staff gave patients practical support to help them live well until they died.**

The service had relevant information promoting healthy lifestyles and support on wards. We saw posters with information on smoking cessation with phone numbers of other agencies to call for advice.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw in patient records risk assessments were completed, and support was offered where needed. The last days of life personalised care plan contained a section prompting staff to offer information leaflets to relatives about coping with dying.

In the end of life care newsletter, we saw an article telling staff about a club in the community for patients at the end of life can join. This club was set up to educate people of what options they had for their funeral.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. During the inspection we saw an example of a recommended summary plan for emergency care and treatment (ReSPECT) document completed and end of life care initiated where the patient did not have capacity to make the decision themselves. Staff had discussed the situation with the family and they had come to the decision together to work in the best interests of the person.

When reviewing patient records we saw that capacity assessments were taking place, decisions were being made and care plans were being adapted to ensure that patients received the best care. We also saw that they were recording discussions about capacity with the relatives of patients.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff showed us how they would access the policies on the trust’s intranet and told us they would seek advice from their manager.

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

Data provided by the trust indicated that there was a dedicated end of life care nursing team at Eastbourne District General Hospital only.

The trust did not provide training data for medical staff within end of life care.

**Eastbourne District General Hospital**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

At the time of the inspection, only 82% of eligible staff in the supportive and palliative care team had received DoLS training. However, existing SPCT team members were 100% compliant. Four new team members had recently started which may have impacted on the compliance levels.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Eastbourne District General Hospital level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
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<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>7</td>
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(Source: Routine Provider Information Request (RPIR) – Training tab)
Compassionate care

Staff providing end of life care truly respected and valued patients as individuals. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff were dedicated to making sure patients received the best individualised patient-centred care possible, at the end of their life.

Throughout the inspection we saw staff interacting with patients and their loved ones in a respectful, considerate and empathetic manner. This was staff in all areas we visited including the wards, the bereavement office and the mortuary. Staff we spoke with and observed during their everyday practice clearly showed that they understood that there was one chance to get the provision of end of life care right.

The bereavement suite provided an environment that promoted the privacy and dignity of the deceased and bereaved people. We visited the bereavement suite where relatives and loved ones would attend when they had been bereaved. The suite was situated close to the entrance, by the reception desk which meant that visitors would not need to walk through the hospital to find it. The room itself was clean and comfortable and was separate from the rest of the bereavement office.

Staff were discreet when managing sensitive situations. For example, when a patient died on a ward or unit, the ward staff called the portering service to arrange for the patient to be moved from the ward. The staff used a description of the job they needed to do using a phrase that visitors or patients on the ward would not recognise as describing that someone had died. This phrase was again used when the porters attended to collect the patient.

Staff maintained patient’s dignity after they had died. If a patient died in a bay, the wards staff would ensure that the curtains would be placed around the bed until they could be removed. The porters would ensure that the correct bay was identified before entering.

The interactions we witnessed were calm, professional and considerate of the feelings and emotions of those on the other end of the line. We observed staff and volunteers speaking with bereaved relatives in this manner.

Where possible, ward staff cared for patients approaching the end of their life in side rooms. This meant that the patients would be away from the busiest areas of the ward and it gave friends and family space and privacy.

Staff on one ward gave us a recent example of where they had a couple that were both approaching the end of their life. The team arranged for them both to be cared for in the same room, with their beds together. This allowed them to be together in the last days of life.

Staff on the told us they were able to accommodate family members overnight by moving a temporary bed into the large side room. This ensured that family members would be able to have immediate access to see their loved one if they were in the last hours or minutes of life. It also provided comfort to the patient knowing that their loved one was close by.

Comments were recorded on the survey forms completed when families or loved ones visited the bereavement office. The responses we saw were overwhelmingly positive.

Examples that were given included:
“All the staff were amazingly supportive, patient, friendly, understanding. They enabled family members to spend precious last moments with my husband and being accommodated in a side room ensured dignity and privacy”.

“I cannot thank you enough, to every staff member on Sovereign stroke ward from the lovely catering girl who brought us coffee every day to the wonderful caring support from the staff nurse who was my shoulder to cry on. I know my mother was loved and cared for in every way and felt safe when I left to go home that she could not be in better and safer hands, which gave us all great peace of mind. Thank you all from the bottom of my heart”.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal and cultural needs. People’s emotional and social needs are highly valued by staff and are embedded in their care and treatment.

The critical care unit at the hospital had employed a psychologist to provide support to patients, family and friends of patients and staff. They were available to speak to those that wanted to speak with them about the situation they or their relative was in and to help them cope with bereavement or the possibility of bereavement. Although the psychologist was primarily based in the critical care unit, they were able to provide support across the hospital.

The critical care unit also had musicians visit to provide music therapy to the patients and visitors. The chaplaincy service was available to provide support to both patients and their relatives or loved ones. The chaplain could, if requested to, say a prayer for the patient and / or family or if they were not religious, offer words of comfort. They were also able to offer, where requested chaplaincy services from non-Christian religious faiths.

The chaplaincy service would do all they could to respond to specific requests for support. We were told about an occasion where the relatives of the patient wanted the chaplain to arrange for the patient to be given the last rites. However, the patient died before it could be arranged. However, they attended the patient and offered prayers and were subsequently able to relay to the family that they had not been able to give the last rites but had offered prayers.

Staff on the wards had received training in how to break bad news. This ensured that when a patient had died, the families and loved ones would receive the information in a respectful and considerate way. Where possible they would ask the loved one or relative to come to the hospital before breaking the news. We were given examples of how staff had gone to great lengths to provide emotional support. For example, staff told us about an occasion where a long-term patient was assisted by ward staff to attend their son’s wedding. The team arranged for a private ambulance provider to collect the patient and take them to the wedding. They provided a trained nurse and a healthcare assistant to accompany the patient to the wedding to ensure they still received the care required while away from the hospital. Staff involved in making the arrangements were proud of what they had been able to achieve and kept photographs of the wedding as a reminder of the day. The effort the team went to was recognised by the patient and their family.

The bereavement staff were able to see relatives of a patient that dies in a comfortable room in the bereavement suite. They were able to offer advice as to what the next steps would be, provide
support and guidance regarding how to arrange a funeral and explain the processes for registering a
death and obtaining a death certificate.

Mortuary staff offered the loved ones of patients that had died the opportunity to see them at the
hospital if they wanted to. They would arrange to meet the family in the reception area and
accompany them to the mortuary area. They would then guide them through the viewing area,
allowing them to be with their loved one.

On one ward we visited we saw that there was a patient approaching the end of their life who had a
large family visiting. The team had managed to get the family a separate room on the ward to use
when visiting.

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

Staff supported and involved patients, families and carers to understand their condition and
make decisions about their care and treatment. Relationships between people who use the
service, those close to them and staff were strong, caring and supportive. These
relationships were highly valued by staff and promoted by leaders.

On Pevensey ward we saw that the clinicians ran a ‘face to face’ chemotherapy helpline where
patients could raise questions and discuss issues relevant to their own treatment. This ensured that
any questions or queries that they had could be addressed at the earliest possible opportunity and
provide clarity to the patients at a time when they could have been confused about what was
happening to them.

Records we reviewed demonstrated that conversations had been had with both patients and their
families when planning for the last days of life. Our own observations saw that staff were aware of
the sensitivity surrounding these conversations and were able to take into account the thoughts and
feelings of all parties.

Bereaved relatives were able to make appointments through the bereavement office if they wanted
to view their loved ones before they went to the undertakers. This was arranged on a person by
person basis, taking account of the individual circumstances of the bereaved. When relatives did
attend, they were met at the bereavement office by mortuary staff who would then be able to take
the visitor to the mortuary. In most cases however it was more practical for relatives to arrange this
with the undertaker to view their relative once they had left the hospital.

The service had a property and valuables policy to ensure that when a patient died, the relatives and
loved ones would be able to keep it. Property was kept on the ward until it was collected by the
bereavement officer or when the ward staff took it to the bereavement office. Copies of property
records were given to relatives, one was given to the bereavement office, one was kept in the patient
notes and one in the property central record book. Valuables were kept in a safe while the patient
was on the ward then transferred to the cashiers’ office after the deceased is moved to the mortuary.
This policy helped ensure that personal possessions, and possessions with a financial or sentimental
value could be collected by the correct person and minimised the risk of them being lost.

Staff understood the needs of the relatives of those that had died. In one example, family stayed with
a patient that had died during the night and while the death could have been verified, the family
wished to stay with their loved one for some extra time. This allowed for them to collect some of the
patient’s own clothes before the death was verified and the patient moved to the mortuary.
Relatives of patients that were in the last days of life had unrestricted visiting times to ensure that those that wanted to visit their relatives would be able to do so. Relatives were provided with refreshments.

### Is the service responsive?

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. There was a proactive approach to work with others in the wider system and local organisations to plan care. The services were flexible, provided choice and ensured continuity of care.

End of life care provision at the hospital was seen by the service as being part of the wider end of life care provision across East Sussex. The service had a well-developed relationship with the local hospice, the local general practitioners and the local NHS ambulance service.

The service was an active member of the Kent, Surrey and Sussex end of life care networking group, the NHS improvement end of life care practitioner network and the East Sussex end of lifecare Clinical reference group. This ensured the team had a system wide overview and were able to develop the services provided to the local population.

When speaking with staff about the provision of accommodation for the relatives of patients that were at the end of their life, we were told about accommodation on site that was made available specifically for this purpose. On the site, near the staff residences, there was an apartment that had five bedrooms, a lounge / living room and a kitchen. In all there was accommodation for up to six people. When visiting this apartment, we saw that it was clean, comfortable and in a quiet part of the site. Relatives were able to use this accommodation overnight, sometimes for more than one night, and it was provided free of charge. There was also parking provided free of charge for anyone staying there.

Relatives or loved ones visiting patients that were approaching the end of their life were able to use recliner chairs in the family rooms to rest if they required. They were also provided with comfort boxes which contained a few toiletries so that people would be able to make themselves comfortable.

Although wards tried to do everything they could to accommodate the relatives and loved ones of those approaching the end of their life, they were not always able to provide the space that they would have liked to.

Managers and staff worked to ensure accessibility to the service. There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. The hospital was accessible by a variety of methods including a number of bus routes, visitor car parking and blue badge spaces. Friends and relatives of those in the last days of life were given tickets for free parking.

The service had comfort boxes for the relatives of those in the last days of life. These boxes included item such as; lip balm, a bag to keep a lock of hair, and forget me not seeds for planting as an act to remember their loved ones. These also contained information leaflets about coping with dying, the chaplaincy service and organ donation.
The end of life care team worked closely with service in the community. The palliative care team had a close working relationship with the local hospice as this provided out of hours cover to the trust for end of life care support. We saw records that showed this relationship was working well to also facilitate efficient unexpected discharges to the hospice.

Meeting people’s individual needs

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility and choice. The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people’s needs. The service was inclusive and took account of patients’ preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff aimed to ensure patients in the last days of life were not alone when no family or friends were present. They sat with patients when this happened. However, we were told by staff on one ward that they are occasionally moved to cover other wards when they have patients that are in the final stages of life. This meant they were not always able to sit with the patient on a one to one basis when there are no relatives or a loved one present.

We saw an occasion where a patient that was on active treatment, which was not working had a last days of life care plan initiated and was moved to a side room. This meant that the staff were able to support the family more closely. The family told us that they were pleased with how the process had been handled and the care that had been shown to them and their loved one.

The chaplain had been looking to develop links with local faith leaders. Although most patients were Christian or had no faith there had been the need for the chaplain to call on other faith leaders to attend the hospital.

There was a chaplain’s office in a corridor in a quiet part of the hospital. Next to the office was a chapel that would accommodate up to 40 people. There was also a multi faith prayer room however, there were no washing facilities nearby that people could use before using the prayer room.

A Sunday service was given at the chapel every week. There was a weekly mass every Friday and morning prayers were held at 9:45 every day and a midday prayer service was held every day. These services were attended by patients, friends and relatives and hospital staff. They also recorded the Sunday service which was then played on hospital radio so patients that could not come to the chapel for the service could still be involved.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us there was not a high demand for languages other than English but some leaflets were available on the trust internet in other languages. Interpreting services were available through a telephone interpreting service.

Special arrangements could be made for early release of a patient’s body to meet the cultural and religious needs of the community. Where possible, the staff could allow for family members to wash the body of their relative in order to fulfil their cultural or religious obligations.

Guidance literature was available for patients and their relatives. This included a booklet about the end of life care and what they might expect to happen. The service supported family’s choice in collection of the deceased. The bereavement office had information about how to organise this. Staff
told us some relatives wanted to organise a funeral without a funeral director and they told us they had supported families that had chosen this option.

Staff told us they were using the proactive elderly advance care (PEACE) documents in partnership with the local hospice and community end of life care team. These were more detailed plans of what the patient would want to happen given different circumstances, such as if they wanted to die at home then they may consider situations that may result in them being admitted to hospital and make an advanced decision that they do not want to go to hospital.

Access and flow

Patients could access the supportive and palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

The supportive and palliative care team would be able to take a patient onto their caseload with just one phone call to their service. The team had two categories of referral to the service. They were priority one and priority two. Priority one would mean they sent one of the team to see the patient on the same day. Priority two patients would be seen within 24 hours. The trust set a target of seeing 95% of priority one patients within those timeframes. Between November 2018 and August 2019 (the most recent month for which data was provided) the service met the target in four of the months. In the six months it did not meet the target the team achieved 90% in January 2019, 94% in March 2019, 94% in May 2019, 94% in June 2019, 94% in July 2019 and 84% in August 2019.

The target for priority two referrals was 90%. In the same period, this was achieved in six of the 10 months. January 2019 the team saw 85% within the target timeframe, in March 2019 it was 82%, May 2019 81% and August 2019, 85%. In this period, the service responded to a total 1341 referrals across both acute hospitals.

When patients were approaching the end of their life, staff would take into consideration the patients preferred place of care. These would be met wherever possible, but we were told that on rare occasions there were delays in providing a rapid discharge to patients because of delays caused in pharmacy.

Where possible, staff helped patients to be rapidly discharged from hospital so that they are able to die in a place according to their wishes. The wards worked with district nurses and families to provide end of life support after discharge.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The EoLC team received a report from the complaints team regarding any complaints that related solely to the provision of end of life care or if they contain an element that links to the care provided at the end of a patient’s life. The senior nurse from the palliative care support team oversaw the investigation of all complaints. The outcomes of all investigations were fed back to the end of life
care improvement group to review. We reviewed minutes of the most recent meetings and did not see specific information about complaints. However, there was information about patients’ stories and given the relatively low number of formal complaints, this was not unexpected.

Details of the numbers of complaints received and investigated were recorded on the end of life care dashboard. This kept complaints, and possible service improvements at the forefront of the service leaders’ minds.

As there were relatively few formal complaints made solely about the provision of end of life care, the service used the comments from the survey carried out with families and loved ones to look at ways to improve the service. We saw an example where concerns had been raised by visitors that there loved one had been cared for at the end of their life on a busy ward. As a result, the supportive and palliative care team spoke with the family to listen to their concerns. This was reported back to the Bereavement and Chaplaincy Services Manager who presented the concerns to the Last Days of Life Improvement Group, where it was discussed and agreed that whenever possible side rooms are made available to these patients, or alternatively the end of bay window beds when side rooms are being used for medical reasons, which give a degree of privacy and feeling of space.

**Summary of complaints**

**Trust level**

From August 2018 to July 2019 the trust did not receive any complaints in relation to end of life care at the trust.

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

**Number of compliments made to the trust**

From August 2018 to July 2019 the trust did not receive any compliments about end of life care. Although there was no specific figures kept regarding compliments made to the end of life care service, we saw evidence from the survey carried out by the bereavement team that there were frequent compliments paid to the service that was provided across the trust.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

**Is the service well-led?**

**Leadership**

Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The end of life care service was led by a palliative care consultant and a senior palliative care nurse. Staff we spoke with across all areas of the hospital that were involved with the provision of end of life care.
care told us that the leaders of the service were visible and would involve all staff in what was happening in the service. They also spoke of how the service had transformed in the last two to three years since there had been a shift in emphasis towards providing good end of life care.

Staff told us clinical leaders operated an open-door policy and they could discuss concerns. The palliative care team worked closely with other service providers and had a good understanding of the priorities for the service and the challenges faced. The palliative care team reported to the deputy director of nursing.

The mortuary service had a mortuary manager who led by example. They set themselves high standards and ensured that the rest of the team, and the portering staff they worked with also met those standards. The mortuary manager was, at the time of the inspection leading on an education programme being rolled out across the wards concerning the role of the mortuary team and what they expected from the wards.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. These were aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The vision for the end of life care service was to ensure that across East Sussex, high quality individualised end of life care is effectively coordinated, integrated and provided to all those that need it, regardless of diagnosis or age. Where appropriate, they would have conversations about death and dying at an early stage, supporting people to make plans and communicate these with those who are important to them. This care extends beyond death to include bereavement and support for families.

The aims of the strategy were to improve the quality of end of life care for people in East Sussex by coordinating care and integrating pathways and services where possible, they would do this by:

- improve access to individualised end of life care by improving identification of people in their last year and having conversation about death and dying early and recording these for use by the whole system.
- Improve palliative care through the identification of those living with life limiting conditions and providing appropriate services for individuals and their families.
- Improve the skills, confidence and capability of those who care for people at the end of life by providing learning and training opportunities to staff across the whole health system.

Part of the strategy was for the service to complete the recruitment of another consultant whose remit would be to drive the service forward by providing training to more ward-based staff. This would ultimately lead to the wards and units taking greater ownership of the care of patients approaching the end of their life and enhance the provision of support to the divisions seven days a week.

The services current vision and strategy was based on the five national principles set out by the Leadership Alliance for the Care of Dying People. These priorities were:
1. Recognising those people that may die within the next few days or hours.
2. Communicating with those that are dying and those close to them in a clear and sensitive way.
3. Involving the person dying in planning their care as much as the wish to.
4. Supporting the needs of family and others that are important to the person that is dying.
5. Plan and do. Complete a personalised care plan and carry this out.

The end of life care dashboard was used as a means of providing real time data to demonstrate performance and progress against the strategy. This meant that senior staff could monitor the service provision and use the information to further improve it.

At the time of the inspection, the end of life care service did not have any performance data displayed on the overall trust performance dashboard. However, the leaders of the service anticipated that they would be able to get some measure of their performance incorporated into the trust dashboard at some point in the future.

**Culture**

There was a strong culture that was centred on the needs of patients at the end of their life. Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values to deliver high quality person-centred care. Staff could raise concerns without fear. Staff were proud of the organisation as a place to work and spoke highly of the culture.

Staff across the wards told us they felt very well supported in the delivery of end of life care. Link nurses and healthcare assistants told us that they had received training that enabled them to undertake that part of the role. They worked closely with the supportive end of life care team and could call on them for assistance and support whenever they needed it.

The leaders of the end of life service told us how they were proud of how cohesive the supportive palliative care team had become and how proud they were of what the ward staff did, through the work of the link nurses and healthcare assistants. They believed that this had led to an improvement to the care provided at the end of life.

We spoke with a range of staff across 12 different units and wards. Staff on each ward told us how end of life care was now part of their everyday working lives and not something that was someone else’s responsibility. We were told how the leaders of the service would regularly visit different areas of the hospital and that they felt comfortable raising any concerns or making suggestions. It was evident that all staff had a voice.

The open culture between colleagues of all disciplines and seniority was reflected in the culture that staff developed with patients, families and loved ones. We saw that staff were considerate in their interactions with those they came into contact with and would do what they could to support them.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
The end of life care service was jointly represented on the trust board by the director of nursing and the medical director. There was a non-executive director on the trust board that had responsibility for end of life care.

The end of life care governance system had nine workstreams that feed into the end of life care improvement group. This improvement group then reports to the trust’s clinical outcomes group which in turn reports to the quality and safety committee. This committee then conveys information onto the trust’s board.

We looked at the minutes of a supportive and palliative care governance and team meeting which showed they had discussed their plans to start a seven-day service from the beginning of the year 2020. This also included details on new recruitments and barriers that were still to be overcome. We then looked at the minutes of the following end of life care improvement group which showed this information had been passed on to this group to keep them updated. At this meeting there were trust hospital and staff from the local community end of life services.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified relevant risks and issues and identified actions to reduce their impact however did not always keep records of these updated. However, the service did not have plans to cope with unexpected events.

The service had started to conduct an audit of the completion of ReSPECT forms. This was carried out by a consultant anaesthetist. This had highlighted concerns around the quality of information being provided at the time of discharge. At the time of the inspection the supportive palliative care team were about to start a project to work on the quality component and conduct further audits into the practices that took place at the time of discharge.

The end of life care service had its own risk register that fed into the wider trust risk register and was reviewed at board level. We saw the risk register that showed the risks were identified, given a risk scoring which fed into a rating. There were five entries on the risk register that we were shown. Four of the risks were rated as high, and one was rated as extreme. These were all related to clinical matters however, when we spoke with the service leads, they also identified that recruitment, staff wellbeing and accommodation were all risks to the end of life care service. These were not however recorded on the risk register.

The mortuary service did not have a major incident plan specific to the mortuary area. We were told that a team responsible for emergency preparedness, response and resilience had started work on producing one. A review of the trust’s major incident plan did not specifically mention the mortuary services.

Information management

The service collected a wide range of reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
The hospital shared information with the local hospice through an electronic portal. This enabled the hospice to see the hospital’s notes on the patients and the hospice could also see the patient’s hospital notes.

The trust collected, analysed, managed and used information well to support all its activities. The hospital shared information with the local hospice through an electronic portal. This allowed the hospice to see the hospital’s notes on the patients and the hospice could also see the patient’s hospital notes. The service had secure electronic systems with security safeguards including individual usernames and passwords for each member of staff. The service had a dashboard that they used to track trends and monitor their performance against their targets. This included the monthly totals of patients seen within their target timeframe. This also included information on total numbers of; incidents reported, relatives surveys sent and returned, along with information from the mortuary and the community end of life care service.

Staff were aware of how to use and store confidential information. Patient confidentiality arrangements were in place, for example, on all the wards we inspected we saw medical records were stored in a locked trolley or kept in an area where staff were able to observe who was accessing these records. Staff on all ward we visited checked our identity cards before allowing us access to patient records.

The issue that concerned the leaders of the end of life service related to the National Audit for Care at the End of Life 2018

Engagement

Leaders and staff use innovative approaches to gather feedback from people who use services and the public, including patients with a diverse range of needs. This was then used to plan and manage services. They collaborated with partner organisations to help improve services for patients. There were consistently high levels of constructive engagement with staff.

The service leads had been working with local general practitioners to promote the use of the Respect form (The ReSPECT process provides health and care professionals responding to an emergency with a summary of recommendations to help them to make immediate decisions about that person’s care) for those patients with long term conditions that may be approaching the end of their life. The service leads told us that this had led to an improvement not just in the numbers that were being completed but also in the quality of the information being provided.

The service conducted surveys with bereaved families and friends regarding the care that they and their loved ones received. Between May and October 2019, the service gave bereaved families and friends a questionnaire when they met the bereavement officers to collect the Medical Certificate of Cause of Death, property and all information they needed following the death of the patient.

Two-hundred questionnaires were given to the bereaved and 43 were received back. The response rate for the period was 21.5%

Results

Some respondents did not complete all questions, therefore there is a percentage deficit in some of the following results:
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you given the opportunity to speak with nursing or medical staff about any concerns you may have had?</td>
<td>84%</td>
<td>8%</td>
</tr>
<tr>
<td>Did a member of staff tell you that your relative/friend was coming to the end of their life?</td>
<td>84%</td>
<td>12%</td>
</tr>
<tr>
<td>If yes, did you feel you had enough privacy when you were told?</td>
<td>80%</td>
<td>12%</td>
</tr>
<tr>
<td>Did staff discuss with you where your relative/friend wished to be cared for in their last days?</td>
<td>60%</td>
<td>32%</td>
</tr>
<tr>
<td>Did you feel the personal wishes of your relative/friend were respected by those caring for them?</td>
<td>88%</td>
<td>0%</td>
</tr>
<tr>
<td>Did you feel that the religious/spiritual beliefs were taken into consideration by those caring for your relative/friend?</td>
<td>96%</td>
<td>4%</td>
</tr>
<tr>
<td>Did you feel that you were involved in the decisions made about the care of your relative/friend?</td>
<td>84%</td>
<td>12%</td>
</tr>
<tr>
<td>Did you feel that the hospital was the right place for your relative/friend to spend their last days?</td>
<td>76%</td>
<td>12%</td>
</tr>
<tr>
<td>Your relative/friend had a personalised care plan focusing on their care. Did you feel that every element of the plan was met?</td>
<td>76%</td>
<td>4%</td>
</tr>
<tr>
<td>How much support did the ward and medical staff provide for you?</td>
<td>Less than needed</td>
<td>Right amount</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>68%</td>
</tr>
<tr>
<td>Were you offered support from the Chaplaincy and Pastoral Care Service?</td>
<td>72%</td>
<td>16%</td>
</tr>
<tr>
<td>Were you given the ‘Guidance Following Bereavement’ booklet by the ward staff following the death of your relative/friend</td>
<td>96%</td>
<td>0%</td>
</tr>
<tr>
<td>If no, were you given advice about the Bereavement Office?</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>If you accessed the Bereavement Office, how would you rate your experience?</td>
<td>Poor</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Overall, how do you rate the staff on the following points of care:</td>
<td>Communication</td>
<td>Poor</td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Emotional support | 4% | 8% | 12% | 76%
Respect and dignity | 0% | 8% | 4% | 88%

Staff told us how they conducted a memorial service twice a year for the relatives and friends who had been bereaved. Staff who cared for patients at the end of life also attended. The services were led by the chaplains.

The service produced a staff newsletter to keep staff up to date with projects and changes within the end of life care service. We looked at the September edition that included information about recent audit results, the updated last days of life personalised care plans, recommended learning opportunities, and a local palliative community support group. This newsletter was used to share stories of good practice from across the service.

Learning, continuous improvement and innovation

The leadership team drove continuous improvement. Staff were committed to continually learning and improving services. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service leads told us how the previous CQC report into the end of life care service had given them the impetus needed to look at the whole service again and rebuild the culture. It brought end of life care to the attention of the trust. They changed the palliative care team to be known as a supportive team rather than a specialist team in order to make the work they did more open to everyone to get involved with. They explained that they no longer look back on the report now but that it did inform their work plan.

The service was looking to move to a seven-day service from the early part of 2020. The recruitment process to appoint a second whole time equivalent to the team was well advanced and the service expected an appointment in the new year. Once this appointment had been made, the service planned to increase the education provision to all areas, ultimately leading to divisions and wards being more pro-active in the provision of end of life care and auditing their own work in this area.

Acute services

Conquest Hospital
The Ridge
St Leonards on Sea
East Sussex
TN37 7RD
Tel: 01424 755255
Services for children and young people

Facts and data about this service

The trust provides services for children and young people at both Conquest Hospital and Eastbourne District General Hospital.

At Conquest Hospital services are delivered on Kipling children’s ward, a 21 bedded inpatient ward, this is the main ward for children who need an overnight stay. The hospital has a children’s outpatient unit (Kipling children’s outpatient unit), a short stay Paediatric Assessment Unit (SSPAU) and a Special Care Baby Unit (SCBU). Short Stay Paediatric Assessment Units (SSPAU) are used for treating children who do not need to stay overnight in hospital. The Special Care Baby Unit (SCBU) provides support to obstetric services for babies born prematurely or with underlying medical conditions.

At Eastbourne District General Hospital there is a Short Stay Paediatric Assessment Unit (SSPAU) and an outpatient unit (Friston children’s outpatients’ unit). Operations which are suitable for a child to go home the same day are carried out at Eastbourne District General Hospital. If a child needs an overnight stay, they will be transferred to Kipling ward at Conquest Hospital or other appropriate hospital.

(Source: Acute Routine Provider Information Request (RPIR) – Context tab, trust web site: www.esht.nhs.uk)

The trust had 6,023 spells from March 2018 to February 2019. Emergency spells accounted for 95% (5,710 spells), 5% (295 spells) were day case spells, and the remaining 18 spells were elective.

Percentage of spells in children’s services by type of appointment and site, from March 2018 to February 2019, East Sussex Healthcare NHS Trust.
Total number of children’s spells by Site, East Sussex Healthcare NHS Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>3,988</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>2,035</td>
</tr>
<tr>
<td>This trust</td>
<td>6,023</td>
</tr>
<tr>
<td>England average</td>
<td>1,146,418</td>
</tr>
</tbody>
</table>

(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**

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received and kept up-to-date with their mandatory training.

The trust set a target of 90% for completion of mandatory training, other than the module for information governance, where the trust set a target of 95%. There was a comprehensive system for highlighting when staff were due to undertake their mandatory training. Staff were sent three reminders by the matron’s assistant, the first being four months prior to their deadline. If the staff had not undertaken training after these reminders the matron was informed and followed up with the staff member directly. The matron’s assistant had a clear understanding of staff training and we felt reassured that compliance was being monitored.

**Trust level**
A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Health and safety</td>
<td>68</td>
<td>68</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>65</td>
<td>68</td>
<td>95.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>49</td>
<td>68</td>
<td>72.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>27</td>
<td>68</td>
<td>39.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>62</td>
<td>68</td>
<td>91.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services the 90% target was met for four of the seven mandatory training modules for which qualified nursing staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules. In addition, nursing staff did not meet the 95% trust target for the module information governance.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>35</td>
<td>38</td>
<td>92.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>32</td>
<td>38</td>
<td>84.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>27</td>
<td>38</td>
<td>71.1%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>26</td>
<td>38</td>
<td>68.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>26</td>
<td>38</td>
<td>68.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>23</td>
<td>36</td>
<td>63.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>1</td>
<td>38</td>
<td>2.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services the 90% target was met for one of the seven mandatory training modules for which medical staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules. In addition, medical staff did not meet the 95% trust target for the module information governance.

Conquest Hospital children’s services
A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified nursing staff in the children’s services at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Health and safety</td>
<td>57</td>
</tr>
<tr>
<td>Infection control</td>
<td>56</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>56</td>
</tr>
<tr>
<td>Fire safety</td>
<td>55</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>39</td>
</tr>
<tr>
<td>Mental Health act</td>
<td>1</td>
</tr>
<tr>
<td>Medicines management</td>
<td>26</td>
</tr>
<tr>
<td>Information governance</td>
<td>52</td>
</tr>
</tbody>
</table>

At Conquest Hospital children’s services, the 90% target was met for four of the seven mandatory training modules for which qualified nursing staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules. In addition, nursing staff did not meet the 95% trust target for the module information governance.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for medical staff in the children’s services department at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>27</td>
</tr>
<tr>
<td>Health and safety</td>
<td>25</td>
</tr>
<tr>
<td>Infection control</td>
<td>20</td>
</tr>
<tr>
<td>Fire safety</td>
<td>19</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>17</td>
</tr>
<tr>
<td>Mental health act</td>
<td>0</td>
</tr>
<tr>
<td>Information governance</td>
<td>21</td>
</tr>
</tbody>
</table>

At Conquest Hospital children’s services, the 90% target was met for one of the six mandatory training modules for which medical staff were eligible. In addition, medical staff did not meet the 95% trust target for the module information governance.

Until recently all modules for both medical and nursing staff were completed during a face to face training day. A recent change had meant that staff completed paediatric and adult basic life support, health and safety including manual handling, blood transfusion within the face to face training day and the rest had moved to online training. This meant the training figures were not quite in line with staff completion as the data had not been processed.
Staff were given two hours paid and protected time to complete the online mandatory training.

We saw that staff mandatory training was mostly in line with trust targets on the updated spreadsheets. However, the figures above were a true reflection of the figures from the period requested prior to our inspection.

Previously staff had completed Mental Health Act mandatory training every three years. This had now been introduced as a yearly mandatory training module, this has meant a slight backlog while staff realigned their training needs and is reflected in the below target figures.

Alongside the mandatory training, the division had a policy for sepsis management which all staff we spoke with were aware of. Staff received training on sepsis management and there was a sepsis lead who undertook regular notes audits to screen for completion of the sepsis six screening tool.

The most recent audit showed staff had completed the screening tool correctly in only 66% of notes reviewed in September. As a result, staff had been reminded during departmental meetings and safety huddles. The matron said the majority of these cases reflected staff not correctly reporting any further actions when the paediatric early warning signs (PEWs) score was recorded as three, as there was no formal trigger on the bedside electronic recording system in use.

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.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The safeguarding team were visible on the children’s wards on both days of our inspection and staff told us that they came to the wards most mornings, to assist with any safeguarding issues.

Staff received training specific for their role on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

We spoke with the safeguarding lead for the trust. She had a clear vision and passion for the role and had many lead staff members to support them. There was direct access to the leadership team in regard to any safeguarding matters and a clear and comprehensive policy which could be accessed by all staff.

We saw minutes of structured safeguarding meetings included a monthly multi-agency meeting with social care, and a quarterly strategic meeting which was attended by social care, health visitors and general practitioners (GP). The safeguarding team contributed to external reports which included contributions to serious case reviews, six monthly dashboards, deep dive audits and section 11 audits. Section 11 audits are completed by the Local Safeguarding Children Boards, who have a statutory duty to assess whether agencies in their area are fulfilling their statutory obligation to safeguard and promote the welfare of children as described in ‘Section 11 of the Children Act 2004’. This showed that the trust understood their commitments to safeguarding and it was given sufficient priority to keep people safe.

The division had a lead consultant and nurse for safeguarding who attended regular meetings and fed back to all staff through divisional meetings. Staff throughout the division commented on the lead
being visible and approachable and they had an open-door policy and were very responsive to questions.

Staff also undertook supervision on safeguarding matters, although this was not formal, staff said the ad-hoc manner in which it could be accessed was helpful and meant it felt more relevant as it could be organised, very quickly, following a specific incident.

The trust had an up to date Safeguarding Children Policy, which was available to guide staff on how to protect people from abuse and referred to relevant legislation and guidance. The policy included flow charts providing a quick reference guide to staff on what to do should a concern be identified. The policy was available in the internal computer system. The policy included specific sections on female genital mutilation (FGM), different aspects of abuse, and maltreatment. There was a reference to ‘PREVENT’ (identifying when vulnerable people may be exploited and drawn into terrorism).

Safeguarding alerts were available via NHS digitals Child Protection Information Sharing project (CPIS) which was accessible on the trusts internal internet system. In the event of an out of hours concern, staff could bleep the duty social worker, consult clinical staff based at the Conquest site or call the on-call consultant, if necessary.

There was a red 'alert' icon on the digital patient record system, which was created to make sure staff were aware of any ongoing safeguarding concerns regarding a child under their care.

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

**Trust level**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults’ level 1</td>
<td>68</td>
<td>68</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>68</td>
<td>68</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>67</td>
<td>68</td>
<td>98.5%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults’ level 2</td>
<td>67</td>
<td>68</td>
<td>98.5%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>63</td>
<td>64</td>
<td>98.4%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

In children’s services the 90% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults’ level 1</td>
<td>68</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>68</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>67</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults’ level 2</td>
<td>67</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>63</td>
</tr>
</tbody>
</table>
In children’s services the 90% target was met for two of the five safeguarding training modules for which medical staff were eligible.

**Conquest Hospital children’s services**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for qualified nursing staff in the children’s services at Conquest Hospital is shown below:

<table>
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<tr>
<th>Training module name</th>
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<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults’ level 1</td>
<td>57</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>57</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>56</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults’ level 2</td>
<td>56</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>52</td>
</tr>
</tbody>
</table>

At Conquest Hospital children’s services, the 90% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for medical staff in the children’s services at Conquest hospital is shown below:

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<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults’ level 1</td>
<td>30</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>30</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>25</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults’ level 2</td>
<td>24</td>
</tr>
</tbody>
</table>

At Conquest hospital children’s services, the 90% target was met for two of the five safeguarding training modules for which medical staff were eligible.

There were weekly meetings held with named doctors and nurses to discuss patients who may be at risk including child sexual exploitation (CSE), high risk patients and to discuss ongoing investigations and serious case reviews.
All clinical staff dealing with children were trained at level 3 safeguarding children and all support staff were trained at level 2 safeguarding children.

We saw evidence of changes to safeguarding practices following concerns raised, for example, clinical staff told us that this year the trust had run a level 3 ‘think family’ safeguarding study day. Topics covered included dealing with difficult family dynamics, FGM, forms of abuse including sexual abuse and the impact of parental mental health conditions. The safeguarding lead nurse developed scenarios for clinical staff to help embed good safeguarding practice.

We also saw a change to the discharge letters which now included a box to indicate if safeguarding concerns had been seen. This gave a clear indication if follow up in regard to safeguarding was needed.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

There had been no E-coli or Methicillin-resistant Staphylococcus aureus (MRSA) infections in Children and Young Peoples’ services from October 2018 to October 2019 and one reported instance of Clostridium difficile (C diff). This was reported at the GP within 28 days of being on the children’s ward, so may not be attributable to the hospital.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The most recent cleaning audit (October 2019) on the special care baby unit (SCBU) was reported at 100%. The same audit score was reported as 97% on Kipling ward.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed consistent and correct processes for washing hands between patients and after patient contact. Hand hygiene scores across the division were consistently between 97-100% compliant from January to October 2019.

Throughout the inspection we saw all staff were bare below the elbow and had no jewellery, long nails or other items which could increase the spread of germs. We witnessed that staff were routinely reminded of this during safety huddles. Regular audits were carried out by the link infection control nurse and reported to the infection control lead. The link nurse also attended regular infection control meetings.

Staff cleaned equipment after patient contact, however equipment was not labelled to show when it was last cleaned. This could lead to a piece of equipment not having been cleaned and staff using it without assurance that this cleaning had occurred.

We saw sharps bins were available in treatment areas where sharps may be used. This was in line with Health and Safety Regulations 2013 (The Sharps Regulations), 5(1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed, by whom and on what date.
Staff disposed of clinical waste safely. We saw the correct classification, segregation, labelling and handling of waste throughout the inspection. For example, no domestic waste bins we checked contained any clinical waste, the bins were clearly labelled, and bins were foot lever operated. This was in line with Health Building Note 00-09: Infection control in the built environment which states: 3.154 Space at the ward/unit level is needed for suitable waste receptacles to segregate the waste in line with the approach described in Health Technical Memorandum 07-01. The storage should be sufficient for different waste streams to be segregated pending collection; that is, domestic waste should be separate from clinical waste, and clinical waste with different disposal routes should not be mixed (for example, sharps waste not mixed with orange-bagged waste).

Side rooms were available on Kipling ward for patients who had an infection which needed isolation. We spoke with staff who could explain circumstances when the rooms would be used. These rooms had en-suite facilities. There were also two further side rooms that could be used for isolation, however they had a separate toilet outside of the room, which meant total isolation was not possible.

If babies were transferred to the SCBU from other trusts they were held in isolation and swabs taken to ensure there was not risk of infection.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.4 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had made improvements to the layout and environment of Kipling Ward. Previously the environment was cluttered, with equipment stored in the corridor, we also saw one bay was also crowded with too many beds for the available space. During this inspection we saw the bay capacity had been reduced from six beds to four, however, the general environment still felt a little cluttered and clinical.

There was well equipped bright and welcoming play room but during our two-day inspection we did not see this being fully utilised. Play equipment was available in all areas where children were seen. This included outpatients and SCBU.

Kipling ward had funding to transform a side room into a quiet room and parents’ room. This would enable difficult conversations to happen in a suitable and separate area. At the time of inspection these conversations would happen in either the side rooms or isolation rooms, or any other available quiet space. An example being the seminar/handover room. This does not provide the best environment for what could be potentially very difficult news to be relayed.

The service had enough suitable equipment to help them to safely care for patients. We saw age specific equipment for children and young people, for example hoists, specialist cots, resuscitation equipment, and smaller blood pressure monitors.

Kitchen and areas where children could be hurt had high door handles that restricted access to smaller children.
Patients could reach call bells and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment which were documented and reviewed for compliance. We saw beds with rails to support older children with complex needs, however, there were no larger changing tables in bathrooms for older children if needed.

The theatres had a separate recovery area to adults in-line with The Association of Anaesthetists of Great Britain and Ireland, Guidelines: Immediate post-anaesthesia recovery, 9: There should be a specially designated area for the recovery of children that is appropriately equipped and staffed. Age appropriate equipment such as a dedicated paediatric airways trolley was also available.

The SCBU had two parents’ rooms with access to a toilet and shower. There were two further areas that parents could stay in if these were not available. Although these areas were not ideal and did not offer full privacy it did allow parents to stay with their children if they wished.

There were resuscitation trollies available which were regularly checked. These contained equipment for children including an age appropriate defibrillator. We also saw hoists were available for older children.

Entrances to the children’s ward and SCBU was restricted. All visitors had to be let in by staff members to ensure no unauthorised access.

We checked 27 pieces of equipment from across the division, all equipment had an asset barcode and log number which ensured it had been registered onto the trust’s medical devices log. This then indicated to the facilities team when equipment was due to be serviced or replaced.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

We saw a comprehensive and easy to read initial assessment of all children and young people who were seen in the unit. This included a prompt to ask for the child’s personal child health record or ‘red book.’ The Personal Child Health Record, also known as the PCHR or ‘red book,’ is a national standard health and development record given to parents/carers at a child's birth. This gave all staff a clear introduction to the children and young people and minimised risk.

Staff used a nationally recognised paediatric early warning signs (PEWS) to identify deteriorating patients and staff escalated as appropriate. We reviewed eight patient records and saw the PEWS scores were recorded and escalated as necessary. Staff knew about and dealt with any specific risk issues, for example sepsis risk. Risks were highlighted during handovers, safety huddles and documented in patient records.

The World Health Organisation (WHO) published the WHO Surgical Safety Checklist and Implementation Manual in 2008 to increase the safety of patients undergoing surgery. We observed The World Health Organisation (WHO) surgical checklist was fully completed during our inspection. The five steps were audited regularly with an average compliance rate of 98-100% from January 2019 to October 2019. The compliance for these audits were discussed at the monthly trust WHO & National Safety Standards for Invasive Procedures (NatSSIPS) group. Any non-compliance was reported to the group as an exception report.
There was a trust ‘Policy for 5 Steps to Safer Surgical Interventions (Incorporating World Health Organisation Safety Checklist (WHO) & National Safety Standards for Invasive Procedures (NatSSIPS)’. The pre-team and post team briefs were audited locally by each area using the checklists and any trends monitored and discussed at the WHO & NatSSIPS meeting.

Children in recovery were monitored by two staff members who had specific paediatric training and were trained in paediatric life support. This training provided the knowledge and core skills required to intervene to prevent further deterioration towards respiratory or cardiorespiratory arrest. The recovery was separate from the adult recovery and screened to ensure children had separation from adult recovery.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health. We saw evidence staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide in patient records we reviewed. We saw evidence of risk assessments placing children at risk to themselves or other patients in side rooms with one to one care in place.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 7.1 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was worse than other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.6 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

**CQC Children and Young People’s Survey 2016 questions, safe domain, East Sussex Healthcare NHS Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>20</td>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.1</td>
<td>Worse than other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>36</td>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.6</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

The division used the sepsis six care bundle for the management of patients with suspected sepsis. Staff had a good knowledge of this, we saw numerous posters around all areas highlighting the dangers and raising awareness for both staff and parents/carers. We saw a clear escalation policy
and saw this review process documented in patient notes we reviewed. The service had a Commissioning for Quality and Innovation (CQUIN) target for sepsis and a link nurse role was developed to ensure best practice and management.

We saw patients and their families were given clear information on discharge from the service and given contact details for help and advice following discharge. Oncology patients had open access to the department ensuring they could be seen promptly if any issues arose. We also saw written information about any new medications a child may have been given.

Staff shared key information to keep patients safe when handing over their care to others. We witnessed two handover meetings, two ward rounds and two safety huddles during our inspection. Shift changes and handovers included all necessary key information to keep patients safe.

We reviewed the Risk Management Policy and Procedure, dated March 2017. The detailed document covered several areas of risk including health and safety and identified staff roles in relation to this. There were clear process’ for identifying and categorising risks and who reviewed these.

The Operational Policy for Acute Children’s and Neonatal Services, July 2019, outlined what staff should do in relation to day to day running of the department including patient transfers, stabilisation and transfer to critical care, safety and security in the paediatric and neonatal units and staffing amongst any other associated risks.

Staff had been trained in the care of children with a tracheostomy we saw this documented in staff files. We also saw specific competencies for the care of children with Non-invasive ventilation.

**Nurse staffing**

Nurse staffing was on the divisional risk register and staff reported that there were often staff shortages that needed to be filled with bank and agency staff. There had been times when these staff were not specialist trained in paediatric care.

Establishment reviews were in place and set planned staffing levels using nationally validated tools. Paediatric wards conducted a 20-day audit on each ward using Safe Nursing Care Tool (SNCT) to assess nursing care hours based on patient factors, ward factors and staffing factors. Staffing was recorded and discussed twice daily to determine the acuity of patients and if further staffing was required.

Current staffing levels were five trained nurses and one healthcare assistant on day shifts on Kipling ward and two trained nurses and one healthcare assistant on the Short Stay Paediatric Assessment Unit (SSPAU). Although staffing levels were often achieved by using bank and agency nurses the department had a robust induction and competencies check and tried where ever possible to use regular agency to mitigate the risk. There were no occasions where there were not at least two specialist paediatric trained nurses on any shift.

However, we saw there were 19 times from 1 January 2019 to the 1 October 2019 where the ward, beds, or cubicles were shut to new referrals overnight. Eleven of these closures were due to insufficient paediatric nursing staff/skill mix of staff. In the other eight closures capacity was the cause. This meant children had to be diverted to neighbouring hospitals for care. In all but two of these closures the ward was reopened at 7am when the day shift staff started work. This could have a negative impact by placing children away from their family home and support network.
The SSPAU unit could be used to increase capacity if needed, but the department often did not have the staff to allow this to happen. The SSPAU closes to new patients at 5pm each evening and children in beds were moved to the ward or discharged by 7pm. This meant that if children were admitted to accident and emergency after 5pm and there was no capacity on the ward that they would need to be transferred elsewhere or held in accident and emergency paediatric beds until a bed became available. If the department had more staffing the SSPAU could be opened to accommodate these children.

The department had recently employed two new ward sisters who would be starting in post over the few weeks following inspection. Once they were in place there were plans to increase the opening hours of the SSPAU to 9pm and the long-term plan would be that the unit would open 24 hours a day. This aimed to address some of the capacity issues and decrease the number of times the unit needed to close.

We also reviewed the staff rota leading up to December 2019 and saw that there were 58 shifts which were not filled between the 5th November and the 3rd December 2019. This could indicate difficulty filling shifts with the current staffing numbers.

Leading up to our inspection staffing had caused significant issues across the division. This had been primarily due to two patients with complex health issues needing one to one care whilst on the ward. Staff throughout the department described this as a particularly hard time as staff reported there were often not enough staff. The division had raised this with the chief executive and it was taken seriously, and action taken. The staffing issues over this period had meant that the SSPAU was not able to be opened out of hours to accommodate more patients if the need arose.

Trust level

The table below shows a summary of the nursing staffing metrics in children’s services at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>156.3</td>
<td>7.0%</td>
<td>7.4%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>72.3</td>
<td>11.0%</td>
<td>4.7%</td>
<td>5.3%</td>
<td>4,252 (3%)</td>
<td>160 (&lt;1%)</td>
<td>7,521 (5%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)
Nurse staffing rates within children’s services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency use.

![Vacancy rate - qualified nurses, health visitors and midwives](image1)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed an upward trend from February 2019 to July 2019. When asked the matron explained that this was not due to any theme or trend, and staff had left for varying reasons including retirement, maternity leave, promotion and moving out of the area. The division had employed three new band five nurses who were all due to start within three weeks of inspection to ease staffing pressures.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

![Sickness rate - qualified nurses, health visitors and midwives](image2)

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019. Although this figure seems high we analysed the past three months of rotas and saw that there had been significant use of agency and bank staff because of children requiring one to one care. As there was a shortfall of permanent staff the service often had to use agency and bank to ensure one to one care was maintained. We saw that the actual versus planned staffing was met most of the time including the two days of inspection and over the past three months.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Conquest Hospital

The table below shows a summary of the nursing staffing metrics in children’s services at Conquest Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>2.1%</td>
<td>6.3%</td>
<td>4.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>3.4%</td>
<td>5.6%</td>
<td>5.3%</td>
<td>3,265 (3%)</td>
<td>160 (&lt;1%)</td>
<td>6,829 (7%)</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within children’s services at Conquest Hospital were analysed for the past 12
months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency use.

![Vacancy rate - qualified nurses, health visitors and midwives](image)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed an upward trend from February 2019 to June 2019. When asked the matron explained that this was not due to any theme or trend, and staff had left for varying reasons including retirement, maternity leave, promotion and moving out of the area. The division had employed three new band five nurses who were all due to start within three weeks of inspection to ease staffing pressures.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

![Sickness rate - qualified nurses, health visitors and midwives](image)

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*
Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019. The upward trend accounting for the two long term patients that required one to one care at the end of the reporting period. Although this figure seems high we analysed the past three months of rotas and saw that there had been significant use of agency and bank staff because of children requiring one to one care. As there was a shortfall of permanent staff the service often had to use agency and bank to ensure one to one care was maintained. We saw that the actual versus planned staffing was met most of the time including the two days of inspection and over the past three months.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing
The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends. A consultant paediatrician was available 24 hours seven days a week, on both the ward, SSPAU and the SCBU. Every child admitted to the paediatric department was reviewed by a consultant paediatrician within 14 hours. Consultants were on site between the hours of 7am and 7pm, and on call outside of these hours.

Consultants worked on a weekly rotation to ensure good continuity of care for children and young people and their carers. Consultants were expected to attend handovers at 8:30am and 4pm. We witnessed two medical handovers on inspection and saw they were attended by consultants. The division had recently introduced twilight consultant shifts between 3pm and 7pm to ensure that decisions about children’s care was made by doctors with sufficient seniority to ease the pressure on beds and reduced the length of stay safely.

There were plans to increase the consultants shift to 9pm to ease winter pressures showing that staffing was continually reviewed and considered.
The division also had two senior house officers (SHO) and two middle grade doctors on the unit from 8am to 9pm daily. After 9pm the unit was staffed by one middle grade doctor and two SHOs. Registrars and SHOs were available twenty-four hours seven days a week on site. Acute paediatric consultants were available either via phone if on call or in person if on site. They were available to attend the hospital, if required, when on call.

The department had access to a child psychiatric consultant 'In hours' via CAMHS on landline numbers at Hastings or Eastbourne for 9am to 5pm. Outside of these hours from 5pm to 8pm staff could access a local urgent help service which could also be accessed on the weekends between 10am and 6 pm. Outside of these hours telephone consultation was available via the local tier 3 unit (CAMHS consultant on call).

**Trust level**

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The table below shows a summary of the medical staffing metrics in children’s services at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>156.3</td>
<td>7.0%</td>
<td>7.4%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>43.1</td>
<td>3.2%</td>
<td>9.7%</td>
<td>1.2%</td>
<td>984 (2%)</td>
<td>121 (&lt;1%)</td>
<td>336 (1%)</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)*

Medical staffing rates within children’s services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank or agency use.

**Conquest Hospital**

The table below shows a summary of the medical staffing metrics in children’s services at Conquest Hospital compared to the trust’s targets, where applicable:
Children’s services annual staffing metrics
August 2018 to July 2019

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate (%)</th>
<th>Annual turnover rate (%)</th>
<th>Annual sickness rate (%)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>112.3</td>
<td>2.1%</td>
<td>6.3%</td>
<td>4.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>33.4</td>
<td>3.8%</td>
<td>7.9%</td>
<td>1.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within children’s services at Conquest Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank or agency use.

In May 2019, the proportion of middle career grade staff reported to be working at the trust was higher than the England average and the proportion of Registrar Group (Specialist Registrar) staff was lower.

Staffing skill mix for the 46 whole time equivalent staff working in services for children and young people 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>43%</td>
<td>44%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>22%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>26%</td>
<td>43%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records.

The trust used a mixture of electronic and paper records. Electronic records were accessible to staff via their unique and private login details which conformed to national information governance and data protection standards. Staff showed us how they accessed patient records and how details could be merged. Paper assessment documentation was scanned into the electronic system at the end of every episode of care. The paper copy was then safely shredded and disposed of.

Records were stored securely, patients individual care records, including clinical data were held securely in trollies. We saw several trollies across the department and they were always locked when not in use. There was an online notes system in place meaning other departments in the hospital could access notes and diagnostic information instantly.

There were specific systems to flag if a child had particular needs for example, safeguarding or mental health issues. We spoke to four members of staff who confirmed this was well established and widely understood. There was a prompt on the initial risk assessment to the use of children’s personal child health record (referred to as “red books”) and we witnessed one being completed for a patient on Kipling ward.

Relevant child health information could be shared across the wider multi-disciplinary team, which included the GP’s, health visitors and school nurses, using nationally recognised digital information sharing systems. All staff carried log in access cards, which were issued under a strict checking criterion, that included identity checks.

We saw documented evidence that the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guideline was in use in patient records we reviewed. There were clear nursing care plans and all levels of nursing and medical staff used the same set of notes. This enabled a quick review of the whole care of the patient.

When patients were moved between departments, services or back into the community we saw that discharge summaries and letters were available and distributed to the appropriate team. We witnessed a patient discharge and saw the relevant information was passed effectively between teams and the families.

Records we saw were mostly clear, legible and accurate. All concerns and actions taken were recorded. Information relevant to keeping children safe was available for other clinicians providing care to them. However, we did see some illegible handwriting in three out of the 8 paper records we reviewed. If notes are not clearly written it could lead to a delay in care or wrong delivery of care.

Medicines

Medicines were stored safely and securely on all the wards. Access to medicines was limited to authorised staff only. Staff did not always keep accurate records of medicines administered.
The wards made use of patient group directions (PGD) to administer medicines to patients without seeing a prescriber, the ward however kept no records of who was trained and authorised to do this. Some staff members held individual copies of their authorisations, but this was not the case with all staff. A new practice development nurse had been in post for two weeks and had identified this as an issue and planned to re-do all the PGD competencies as soon as possible. With no record of who holds the correct patient group direction authorisations we could not be sure that they were being used safely and correctly in line with trust and national guidance.

We reviewed six prescription charts and care records. There were several gaps in prescription charts which had not been identified by staff on the wards. This showed that current checks were not effective in identifying potential missed doses. We could not be assured that people using the service were getting their medicines as prescribed.

A full medicines reconciliation was not always completed on admission to the wards by the pharmacy team. Staff would however obtain information about medicines from carers and through referral letters and access to electronic records.

Doors to medicine rooms had a digital lock and only authorised staff had access. There was a digital record of all medicines that were taken from the drug cupboard and fingerprint recognition was in place to ensure no unauthorised access. The controlled drugs needed two members of staff to use fingerprint recognition to access. There was also a log book for the controlled drugs which indicated dose.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients' medicines were reviewed at the multidisciplinary team meetings (MDT) as well as daily reviews of all patients on the ward. Patients and carers were involved in decisions about their medicines where appropriate. Patients could request to speak to the pharmacist for help and advice or discuss medicines with their nurse or doctor.

The trust operated an incident reporting system on which staff could record incidents and medicines safety concerns. Staff were aware of recent medicines safety alerts and the actions that had been taken around these.

The wards did not use medicines to control people's behaviour excessively or inappropriately.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Staff could access medicines supplies and advice throughout the day and out of hours. Staff could access an up to date guidance and references relating to medicines such as British National Formulary and Medusa (injectable medicines guide) to administer medicines safely.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. We asked several members of staff across the division and all said they had reported incidents and received feedback from them if needed.
All incidents were categorised between one and five (five being the most serious and one being the least). Any incidents that were categorised as level three or above were reviewed at the weekly Patient Safety Summit. Any incidents could also be discussed at the daily divisional risk meeting. This was a multidisciplinary meeting which included consultants, doctors, nurses (including paediatric) and matrons. This meant any immediate concerns, or issues with classification or escalation of incidents could be dealt with quickly.

We heard of changes occurring as a result of incidents. Following a higher number of reported medicine errors on Kipling ward, the decision was made to move the medicines and controlled drugs to a separate room where medicines and drugs could be prepared without distraction. Previously this was carried out behind the nurses’ station. As a result of the change the numbers of incidents related to medicine errors has improved.

Staff understood their duties in regards to the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed the trust policy on this and managers were confident in the situations where the duty of candour would be applied.

Staff received feedback from investigation of incidents through the ‘theme of the week’ huddles and departmental meetings. If staff were involved in the incident directly they would receive feedback personally. This showed a positive, no blame reporting and feedback culture.

There was evidence that changes had been made as a result of feedback. On Kipling ward, we saw a ‘you said - we did’ board. This detailed that patients had complained about the televisions were not working on the ward. This had been escalated and new televisions had been purchased across the department.

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 July 2018 to August 2019, the trust did not report any never events for children’s services.

(Source: Strategic Executive Information System (STEIS))

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) which met the reporting criteria set by NHS England from August 2018 to July 2019. The incident took place at Conquest Hospital and involved sub-optimal care of the deteriorating patient meeting SI criteria. We reviewed the action plan and investigation into this and saw it involved multiagency input and involved discussion and input from a wide range of multidisciplinary staff.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The trust did not submit data to the patient safety thermometer, however, the service was in the process of introducing a more formal method of continually monitoring safety across the division. Staff collected safety information however this was not formally shared with staff or patients.
The Children and Young People's Services Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with children and young people's services. The tool focusses on: Deterioration, Extravasation, Pain and Skin Integrity.

It’s a point of care survey that is carried out on a single day each month which supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines.

Some other divisions within the trust undertake an ‘Excellence in Care’ audit which covers several aspects of care including falls, medicine errors, and patient feedback. The women’s and children’s division did not currently have ‘Excellence in Care’ data to share with us. This was because it was currently being trialled in the departmental areas and evaluations undertaken to determine what adaptations are required so that the tool met the needs of paediatrics.

We saw some information on boards within paediatric areas, including hand hygiene audits, staffing numbers, and infection numbers. However, there was not a formal collation of this information available to benchmark against other areas and improve scoring at present.

Is the service effective?

Evidence-based care and treatment

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. The Clinical Effectiveness team distributed details of every new NICE guideline published to each division on monthly basis for a review of applicability and then compliance. If current guidelines need updating an action plan is produced which was tracked by the Clinical Effectiveness team. Progress with NICE action plans are reported and monitored via the monthly Divisional Governance meetings and the Clinical Effectiveness Group who escalated and acted upon any concerns raised, for example to mitigate risk. The Clinical Effectiveness Team undertake regular 'Quality Improvement Reviews' whereby actions noted as 'complete' were independently assessed to determine if the actions have been effectively embedded in practice.

We saw work was being undertaken in the special care baby unit (SCBU) towards gaining the BLISS accreditation, Bliss is the leading UK charity for babies born premature or sick. It supports families with a baby in neonatal care, works with health professionals to provide training and improve care for babies, this was something the unit was striving to achieve but finding difficult with the restraints of being such a small unit.

Children and young people received a comprehensive assessment which included a history of any past or current mental health problems on their initial risk assessment. We also witnessed the physiological and emotional needs of patients being discussed at handover, this included any need for children and adolescent mental health services (CAHMS) referral or if care at home would be more appropriate.

The division took part in national audits including National Neonatal Audit Programme (NNAP). They also undertook several internal audits including infection control, Paediatric Early Warning System (PEWS) audit, and sepsis six compliance. This ensured they could benchmark against trust targets, and national comparisons. We also saw the trust had taken part in the NHS Benchmarking Network Outpatients, Bespoke Report 2019. We saw an overarching model of care
report following on from this which was reviewed for completion quarterly at the trust oversight group meeting.

On Kipling ward there was a cupboard containing information for staff including policies and procedures set by the trust. We reviewed these documents and found some had past the date set for review. For example, the ‘Clinical guideline for the care of surgical patients (adults and children) with learning disabilities and/or dementia’ was issued in April 2015 and due for review 2018. However, when we looked on the trusts intranet, the same policy had been reviewed and did not need re-review until 2021. This could mean staff may not be referring to the most up to date policy. It is also clearly stated on all policies we reviewed that the trust discouraged retention of hard copies as it would not guarantee that it would be the most up to date.

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. The service made sure that patients’ religious, cultural and other preferences were taken into account.

Staff were proactive in monitoring the nutrition and hydration needs of children and young people admitted to wards. All children admitted were assessed using the screening tool for the assessment of malnutrition in paediatrics (STAMP). The STAMP assessment was completed in all eight patients records we looked at.

Staff ensured patients who required fasting before a procedure were timed and closely monitored in order that the patient would not go for too long a period without food or fluids. We saw this recorded in patient records.

All children we spoke with on the wards advised they liked the food and were regularly asked by staff if they had enough to eat and drink. Facilities were available for parents to make drinks and snacks. Families were welcome to bring food for their child, if they wanted.

There was a dietitian who worked on both the wards and within the SCBU. They were available for advice and carried out assessments on children if required.

Milk rooms were located on Kipling ward and SCBU. Staff could provide numerous alternatives to breast and formula milk if a baby was lactose intolerant or had allergies. There were systems to ensure expressed milk was stored correctly and given to the appropriate baby in SCBU. Each baby was in a bed marked with a letter of the alphabet. This letter then formed part of identifying the milk stored in the fridge. It was clearly marked however; the fridge wasn’t locked. The danger of tampering was mitigated by restricting access to the unit.

On Kipling ward, we saw the milk fridge could be accessed by anyone within the ward, children’s outpatient, and Short Stay Paediatric Assessment Unit (SSPAU). There could be a risk of tampering and We couldn’t see any measures to reduce the risk of tampering.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
Pain assessment formed part of the Paediatric Early Warning System (PEWS) chart which we observed being recorded during a patient review. We saw pain documented in all patient records we reviewed.

The department used many ways to determine pain levels including The Face, Legs, Activity, Cry, Consolability scale (FLACC) scale. This is a measurement used to assess pain for children between the ages of two months and seven years or individuals that are unable to communicate their pain. The scale is scored in a range of zero to 10 with zero representing no pain. The scale has five criteria, which are each assigned a score of zero, one or two. The department also used The Visual Analogue scale (VAS) used to self-report pain to assess a patient’s experience of pain. It can be used in children aged eight years and older, depending upon their cognitive ability.

Patients and carers we spoke with reported that pain was well managed. We observed pain management prescribing and administration of analgesia which was appropriate to patient need and staff were confident in the approach to pain management.

There was not a specific pain nurse for pediatrics, but we were told that if a patient required more complex pain management the pain service would review and support the team to ensure they had the competencies required for example patient-controlled analgesia pumps.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

We saw a rolling audit schedule on Kipling ward, SSPAU and SCBU which included hand hygiene, PEWs completion and medicines management. Results of these audits were discussed at both ward level and fed up into divisional meetings. Audits we reviewed showed when the division did not meet trust targets that an action plan was implemented. An audit from July 2019 showed that although all children had a set of observations on arrival, documentation was poor. It was reported that 40% of children aged zero to 11 months, 45% of children one to four years, 19% of children five to 12 years and 33% of children above 13 years old did not have the PEWs was not recorded. Following the PEWS audit an action plan had been implemented. The Standard Operating Procedure (SOP) for observations on the short stay assessment unit was updated and the practice educator and matrons have been delivering training sessions to ensure the SOP would be implemented correctly. Evidence of this implementation and correct practice was being followed up by further audits and safety huddles. The division had more recently completed (November 2019) a further audit of 10 records of children that were both inpatients at the time and discharged from SSPAU. The results showed that there is a notable improvement in documenting PEWS both at admission and discharge. The most recent hand hygiene audit on Kipling ward achieved 100% compliance.
The table below summarises East Sussex Healthcare NHS Trust’s performance in the 2018 National Paediatric Diabetes Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion rate for key health checks for patients aged 12+ (There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually)</td>
<td>92.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted mean HbA1c (HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year)</td>
<td>71.1%</td>
<td>Worse than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Median HbA1c (This measure is provided to give an indicator of how performance has changed between the previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant)</td>
<td>66.0%</td>
<td>Clinically significant decline</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Paediatric Diabetes Audit)

A diabetic specialist nurse and consultant ran a weekly type 1 diabetic clinic. The diabetic team followed national quality standards which involved in National Paediatric Diabetes Audit (NPDA) for children with Type 1 diabetes. and their clinics had gained funding for a child clinical psychologist.

The table below summarises Conquest Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to neonatal care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do all babies &lt;32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºC-37.5ºC? (Low body temperature on admission is associated with increased complications, such as hypoglycaemia, jaundice and respiratory distress, and death in pre-term infants)</td>
<td>58.3%%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of</td>
<td>99.2%</td>
<td>Positive Outlier</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
admission?
(Timely consultation with parents/carers is crucial to allaying fear and anxiety and improves the parent/carer experience)

| Do all babies < 1501g or a gestational age of < 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP) (ROP is a preventable cause of blindness in pre-term infants provided it is detected and treated in a timely way) | 91.8% | Within expected range | Did not meet |
| Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age? (It is important that the development of pre-term babies is monitored by a paediatrician or neonatologist after discharge from the neonatal unit) | 64.3% | Within expected range | Did not meet |

(Source: National Neonatal Audit Programme)

The division was working with National Neonatal Audit Programme results and had made changes to practice as a result, for example the appropriate screening for retinopathy of prematurity data now suggests 100% compliance after the pathway changes.

Other recent audit results showed improvement including temperature recorded within 1 hour <32/40 between 36.5-37.5 degrees C was now 90%, inline with the NNAP target of 90%.

The total emergency readmission rate from the whole division (including maternity) was 20%.

More than half of the readmissions were children that have open access (for 48 hours) or children who had to return for intravenous antibiotics.

(Source: Hospital Episode Statistics)

The rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes was 14.1%. That indicates that 40 of 284 patients across children and young people had multiple emergency re-admissions.

(Source: Hospital Episode Statistics)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

There was a detailed induction protocol for both bank and agency staff to ensure they had the correct levels of skill to deliver safe care. All new nursing and medical staff had a structured four-
day trust induction program. Nursing staff were provided with supernumerary status for the first two weeks to ensure they were safely orientated to the service. We also saw an induction and development programme which included ward-based competencies that all staff completed.

The division had two dedicated practice development nurses, one to support SCBU and the other to support the wards, outpatients and SSPAU. We saw evidence of mentorship, education review, appraisals and one to one clinical supervision. Staff reported they felt supported to develop and opportunities were available if they wanted to take them.

Staff had completed relevant competencies and training on specific skills related to children’s and young people. For example, several nurses had undertaken a children’s tracheotomy course recently to support a regular long-term patient who was often in the department.

We saw all the competencies and training were logged on a database which could be easily accessed to ensure completion and for assurance. Sufficient staff were trained in advanced paediatric life support (APLS). Staffing was managed to ensure a band six APLS trained nurse was available on each shift. We saw all staff undertook paediatric immediate life support (PILs) training. This training provided healthcare staff with the necessary knowledge and skills needed to provide immediate life support to paediatric patients. Medical staff attended paediatric advanced life support training and were supported by their seniors with all their training needs.

From August 2018 to July 2019, 90.3% of staff within children’s services at the trust received an appraisal compared to a trust target 90%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>29</td>
<td>30</td>
<td>96.7%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>64</td>
<td>72</td>
<td>88.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>130</td>
<td>144</td>
<td>90.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Conquest Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
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<tr>
<td></td>
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<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>20</td>
<td>21</td>
<td>95.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>54</td>
<td>60</td>
<td>90.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
We reviewed five appraisals which were in-depth and included specific training details and discussion about progression. Many staff we spoke with had been internally promoted and gained extra qualifications and skills through discussions with their line managers. Staff followed a clear competency framework which worked towards achieving their personal professional development.

We saw specific competency frameworks in units within the division, for example paediatric nursing staff in operating theatres had specific competencies which were updated annually. We saw this documented and logged for updates. The service held resuscitation scenario training cross-site and one to one monthly supervision days for nursing staff.

There were lead and specialist nursing staff in some areas for example diabetes but not for other key areas such as asthma, mental health, and continence.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

There was embedded multidisciplinary working throughout children and young people’s services. We witnessed effective communication between teams and two multidisciplinary team meetings during our inspection. The meetings considered everyone’s views and staff could access patients’ x-rays and outcomes of investigations which were used for feedback and training purposes; alongside evaluating the patients’ health. Staff were universally positive about the relationship between consultants and the wider team and we saw that there was mutual respect for each profession.

There was a formal process for the transition of children and young people with diabetes into adult care, but no other formal transition process’ were in place within the division. We saw that there was a good system however, with joint consultant clinics being held wherever possible and positive liaison between consultants was reported. The division had identified that there was a need for better transition for children who were approaching adulthood when transferring to adult care. In response the trust was in the process of recruiting a lead practitioner to oversee the transition process across the trust.

There is no paediatric intensive care unit (ITU) at the Conquest Hospital, however, the department had a good relationship with the intensive care unit (ITU) and the ITU outreach team were accessible and will see paediatric patients if the need arose. If children were transferred to ITU then a paediatric advanced nurse practitioner (PANP) attended and stayed with them.

We heard about good access to paediatric services in and out of hours, we heard from staff there was a very positive relationship between services within the hospital. We saw this in practice during a handover where a cardiologist was needed for review which was organised immediately for the same day.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.2 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.
Allied health professionals supported the wards according to demand for their services. Physiotherapists attended wards regularly, occupational therapists were involved with discharges and speech and language therapists and dieticians could be contacted when required via telephone.

There was no registered mental health nurse working within the department. The division had access to Child and Adolescent Mental Health Services (CAMHS) however there were pressures on the service which meant children were not always seen in a timely manner. We also heard about recent issues with a child who was medically fit but was unable to be discharged due to not having an appropriate placement offered to them via social services. There were also reports of children suffering with eating disorders not being reviewed appropriately. A consultant we spoke with said it was a frustration and that inter-hospital relations had been strained as a result. This issue was on the divisional risk register and staff worked well with the resources they had to accommodate children and support each other.

The service had good links with local GPs who could call a consultant five days a week with any questions or for referral.

**Seven-day services**

*Not all services were available seven days a week to support timely care for children, young people and their families.*

Although diagnostics, pathology and pharmacy provision were available at all times, there was no seven-day service for physiotherapy, occupational therapy and play specialists. All of which were only available Monday to Friday. This could mean children who attended at the weekend were not receiving the same level of care as children who arrived on a weekday. For example, if a child needed the play specialist to calm, distract them or help them feel more settled, before a blood test, this would not be available and could cause unnecessary distress to the child.

There was no mental health provision in hospital out of hours, which was on the divisional risk register. There was a mental health nurse based at Hailsham who could be contacted for urgent mental health needs 24 hours seven days a week. A CAMHS consultant was available on call and via phone as needed.

**Health promotion**

*Staff gave children, young people and their families practical support and advice to lead healthier lives.*

Parents and children attending the outpatient specialist clinics for epilepsy, diabetes and other long-term health conditions, were given advice on how to manage their health condition. This included, dietary advice, blood sample investigations for vitamin D and other appropriate levels, medication advice and lifestyle advice.

All children had their height and weight recorded during an initial assessment which made sure they were within healthy limits. Any children found to be at risk of obesity or malnutrition were offered extra dietary support and where appropriate referrals were made to the dietician.
Parents of young children are empowered to support and manage their children's health. Older children were encouraged to manage their own health and medication needs.

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

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

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 over 16 who lacked the capacity to make decisions about their care.

We spoke to several members of staff including consultants and nurses who understood their responsibilities in relation to paediatric mental health and capacity. We witnessed an example where staff had recently had to alert the safeguarding team and held a multidisciplinary meeting which included the parents in relation to a child’s capacity to decide, which showed a good understanding.

The process for consent was monitored and reviewed to ensure it met legal requirements. There were age appropriate consent forms for under and over 16’s and we witnessed all signatures were checked in the wards and in anaesthetic rooms prior to surgery. The check was completed between trained staff, parents and carers or the patient themselves depending on their age.

We saw that young people were encouraged to involve their families or carers in decisions around consent, this was standard practice and was noted in the consent process. Parents were supported to make decisions in line with current policy and we saw evidence of this during our observations.

We saw in guidelines and were assured from speaking with staff that they knew their responsibilities in relation to Gillick competencies and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent.

Parents and children would be asked for consent prior to any procedure and this was routinely documented in patient records. The service had a holding policy for children requiring clinical interventions such as blood samples, any parent who did not want to hold their own child during clinical procedures was asked for consent to proceed.

Staff had training on mental health which included aspects of the Mental Health Act 1983 in the trust safeguarding level 3 training days. Staff could identify children experiencing mental illness. The trust had devised a child and adolescent mental health (CAMHS) triage tool, for children at risk of self-harm or suicide. The tool contained a colour coded matrix, with defined pathways and the relevant contact details of mental health staff.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for qualified nursing staff in children’s services is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>64</td>
</tr>
</tbody>
</table>

In children’s services the target was met for MCA/DoLS training for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>26</td>
</tr>
</tbody>
</table>

In children’s services the target was not met for MCA/DoLS training for which medical staff were eligible.

**Conquest Hospital**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Conquest Hospital for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>53</td>
</tr>
</tbody>
</table>

In children’s services the target was met for MCA/DoLS training for which qualified nursing staff were eligible. Deprivation of liberty safeguards (DoLs) and MCA doesn’t apply to children under sixteen.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Conquest Hospital for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>21</td>
</tr>
</tbody>
</table>

In children’s services the target was not met MCA/DoLS training for which medical staff were eligible.

In children’s services the target was met for MCA/DoLS training for which qualified nursing staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.
Other CQC Survey Data

The trust did not perform better than other trusts for any questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. They performed about the same as other trusts for all four questions.

(Source: CQC Children and Young People’s Survey 2016)

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

The caring attitude of staff was evident throughout the division and we saw thank you cards and comment books which were positive about the care received.

Throughout our inspection, on Kipling ward, short stay paediatric assessment unit (SSPAU) in outpatients and in the special care baby unit, we observed patients and families being treated with care, compassion and understanding. The parents we spoke with praised medical and nursing staff for the way they communicated with them and we were repeatedly told that “Staff do the best for us”. Parents told us that they felt staff cared for them as well as their children; one commented “The doctors are good at explaining thing to him (their child) in a way that he understands.”

All the parents we spoke with told us they were very happy with the care their child was receiving, saying they felt “safe” and that the service was “great”. The inspection team observed examples of compassionate caring by staff throughout handover. We found that the 6 C’s used by the NHS in Britain were embedded in ward culture: Care, Compassion, Competence, Communication, Courage and Commitment.

Patient and family feedback was obtained through the Friends and Family Test (FFT), using both hard copy and a text system. Children could provide feedback through pictorial charts. To the core FFT question, “How likely are you to recommend our ward to friends or family if they needed similar care or treatment?” an average of 98% responded positively.

Parents told us how they had been encouraged to get involved with care, for example being taught by staff how to hold their babies, wash them and change the nappy in the SCBU. Mothers said they were encouraged to express breast milk and helped with this by staff. The SCBU team ran parentcraft sessions to help parents undertake daily tasks such as bathing with their babies to help them feel more secure and confident undertaking these both on and off the unit.

The trust performed about the same as other trusts for the 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

The trust did not perform better than other trusts for any questions relating to compassionate care in the CQC Children and Young People’s Survey 2016. They performed about the same as other trusts for all 10 questions.

(Source: CQC Children and Young People’s Survey 2016)
Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

We witnessed staff checking that information was understood and asking if patients had any further questions to ask.

Staff demonstrated an understanding of how both parents and children were affected emotionally by the need to spend time in hospital, and they ensured that support was available to reassure parents and calm patients. We saw that the pre-admission assessment included asking if the child had a particular toy or comforter that they would like to bring with them. Children having surgery could bring toys with them to help them feel at ease.

Bereavement was well managed with multi faith chaplaincy support. Staff helped parents to create memory boxes, taking photos and doing hand and foot prints. Parents could spend as much time as they wanted with their children. A recently bereaved family donated memory boxes called “Louie boxes” for all bereaved families, they included several meaningful items such as two soft teddies, one to be placed with the child and one for the parents to keep. The division worked alongside two local hospices who provided further support and counselling to recently bereaved parents.

The division had recently undertaken a survey of patients that had accessed the bereavement services within the department between May and October 2019. The questionnaire was given to next of kin, an identified family member or friend when they meet the bereavement officers to collect the medical certificate of cause of death, property and all information they need following the death of the patient. Two hundred questionnaires were given to the bereaved and 43 were received back. The response rate for this period was 21.5%. Overall patients that accessed the Bereavement office, rated their experience as good or excellent 90% of the time. With communication rated 88%, emotional support 88%, and respect and dignity 92% either rated good or excellent individually.

We saw useful information for parents was visible on boards in SCBU and folders were provided in the parent’s room which contained information on a range of support and helpful information.

The trust did not perform better than other trusts for any questions relating to emotional support in the CQC Children and Young People’s Survey 2016. They performed about the same as other trusts for all four questions.

(Source: CQC Children and Young People’s Survey 2016)

There was only one play specialist who was based on Kipling ward to work with patients around anxiety and distress and helped to prepare them for procedures. They were available Monday to Friday during the daytime and worked one day at Eastbourne hospital.

Parents felt listened to, we heard from a mother who had requested that staff do her child’s observations less frequently at night as it was distressing the child to be woken. She felt she had been listened to and as a result less intrusive observations were being undertaken.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.
We saw evidence of staff understanding the importance of parent involvement and in the SCBU there was a period of quiet time each day where parents could spend time with their children without interruptions. Skin to skin contact was encouraged we saw this promoted on noticeboards and in information leaflets in the parents’ room.

On wards, we observed staff going down to the child’s level when speaking to them to discuss what the procedure was, what they were going to do before doing it, and asking the child for permission. Conversations were kept at a low level, we noted that staff did not use medical terminology when explaining procedures to parents, and saw that staff took time to play with patients and interact with parents.

All parents told us that they knew which nurse was looking after their child, and all said the consultant had introduced themselves to them. Consultants and nurses gave parents regular updates on their child, especially after they had been away for a few hours to rest. Parents commented this was much appreciated and reduced the stress they were feeling about missing important information. In SCBU parents were provided updates via the online record system which could include photographs and comments from any missed ward rounds. Ward rounds times were advertised throughout the division, so parents could ensure they were present if they wanted to be.

Staff we interviewed clearly understood how diagnosis and treatment of these conditions could have a negative impact on a child’s emotional wellbeing. The diabetes team had been awarded funding to employ a child’s clinical psychologist to help children cope with their feelings. The epilepsy nursing team hoped that in the future children with epilepsy could have access to the same services. Staff demonstrated a real insight and a deep understanding of the complex feelings children with long term conditions may experience, especially as they reach the age when they transition from children to adult services.

The trust did not perform better than other trusts for any questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

They performed worse than other trusts for four questions and about the same as other trusts for the remaining 16 questions.

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, East Sussex Healthcare NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>7.5</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 CYP</td>
<td>5.4</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>70</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 CYP</td>
<td>6.7</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
</tbody>
</table>
We saw staff asking parents the best way to communicate with children to ensure that they understood what was happening. Children were able to talk to clinicians without parents present, we saw an example of this during inspection and the correct process of consent was followed and a chaperone offered.

Parents were offered food on the wards if they needed to stay the night and could stay with their children at all times. Interviews with parents made it clear that children’s needs were considered, for example a toy piano was purchased for a long-term patient who loved to play.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service was not always able to deliver care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Services for children and young people at the Conquest Hospital included the short stay paediatric assessment unit (SSPAU) which opened 7am to 7:30 pm with last admission at 6pm. The unit opened weekends however, children could be seen from the SSPAU or Kipling Ward dependent on staffing levels. There were nine SSPAU beds, including one isolation cubicle. The nine beds were used for day case surgery, medical day cases and assessment of which one cubicle was available for children needing isolation. There were four additional beds (D Bay) available for the SSPAU if not occupied by overnight patients from Kipling Ward.

Elective day case surgery was undertaken Monday to Friday, the SSPAU will be open from 7am or 8am (depending on the surgical list). Medical cover for these patients was the responsibility of the admitting surgical team under a joint care arrangement with the paediatricians.

Kipling ward was open 24 hours a day seven days a week. It had 17 beds of which eight are open bay beds and eight were general purpose single cubicles. There was a self-contained oncology isolation room, with bathroom facilities. There were four additional beds (D bay on the SSPAU) making the total capacity 21 beds. In business continuity circumstances, for example, pandemic flu, the number of overnight beds can be increased to 30 including the oncology room if required but this was dependent on available staffing. If overnight beds are increased, booked admissions may need to be cancelled. The responsibility for making this decision and subsequently cancelling these patients lies with the Service manager/ Associate Director of Operations.

Children were admitted under the care of a consultant paediatrician for all medical and mental health conditions and under the care of a consultant surgeon for all planned and emergency surgical admissions. The surgical teams were responsible for the care of paediatric surgical patients. The paediatric team supported surgical teams in paediatric medical management when this need was identified.

In total 413 sessions had seen Paediatric activity since January 2019 with an expected further 224 sessions to include paediatric activity by December 2019 (forecast from 2018 Activity).
The Paediatric consultant of the week were available for advice and assistance for surgical and gynaecological patients in children’s outpatients. The outpatient area was open Monday to Friday. There were consulting rooms for the exclusive use for children and young people’s clinics which included general and specialist paediatric clinics, community paediatric clinics and other specialties for example, dermatology, paediatric dietetics and visiting consultants. All GP referral letters requesting an outpatient appointment at either hospital were triaged Eastbourne Hospital.

The Special Care Baby Unit (SCBU) was a Level 1 unit caring for babies of 31 weeks gestation and above and had 12 cots. Babies were admitted directly from delivery suite, postnatal ward, tertiary units(repatriation), community midwife (Homebirths) services, transitional care, and stabilisation of a critically ill neonate awaiting transfer to a Neonatal Intensive Care Unit. The service had operational policy for the transfer of critically ill children who would be transferred using local retrieval services.

There was no specific area for children or young people who required stabilisation on Kipling ward or the SSPAU. Staff told us that children would be stabilised in side rooms in available or cubicles, before being transferred to the intensive care unit (ITU).

Children over the age of 16 were referred or admitted to the adult services, unless they have a long-term condition and are under paediatric outpatient follow-up or have a recognised disability or learning difficulty.

Monthly avoiding term admissions into neonatal units (ATAIN) meetings were held. The ATAIN programme aims to reduce avoidable causes of harm that can lead to infants born at term (over 37 weeks gestation) being admitted to a neonatal unit. We observed one of these meetings which was multidisciplinary and cross site via video link.

We saw that young people presenting with mental health issues who needed in-patient admission to a medical ward were admitted to Kipling ward for medical management under the care of a paediatrician. They would be referred to Child and Adolescent Mental Health Services (CAMHS) as part of their admission. The decision for discharge was made by the paediatrician, when the child was medically fit for discharge. However, CAMHS had to authorise the mental health discharge either back home or to an alternative facility. This had recently caused a problem with staffing on Kipling ward as there were patients requiring one-to-one care, who were medically fit for discharge, but CAMHS and social service were unable to find an appropriate care setting which meant that the child had to remain on the ward to ensure their safety. Staff reported that it was not the right environment for these children and that staying on the ward long term could have health implications and that the children would become bored.

The trust did not perform better than other trusts for any questions relating to responsiveness in the CQC Children and Young People’s Survey 2016. They performed worse than other trusts for two questions and about the same as other trusts for the remaining 14 questions.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>6.8</td>
<td>Worse than other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>56</td>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>4.8</td>
<td>Worse than other trusts</td>
<td>R2</td>
</tr>
</tbody>
</table>
During inspection it was noted that the environment felt clinical with little to engage children on the ward. The play room was inviting but we seldom saw children or parents playing in there. We did not see any advertised activities on the ward, although we were told activities had taken place recently to celebrate Halloween. During our previous inspection there was no play specialist to lead and develop play services at the hospital. The hospital had now introduced a play specialist into role however, the play specialist was working on their own to support the wards, SSPAU, children’s outpatients and support Eastbourne Hospital one day a week. They felt it would be beneficial to have at least one more member of the play team to support their work. There was no cover for the play specialist if they were on annual leave or off sick. In these instances there was no play specialist to aid the division. This showed a lack of commitment and understanding of the importance of play specialists by the trust.

There were no designated separate bays for adolescents within the children’s wards. Staff told us they would try to separate the children into age groups if possible. This separation would help ensure children would feel more at ease and surrounded by their peer group.

Children needing routine surgery are admitted to the Short Stay Paediatric Assessment Unit (SSPAU) and collected from there by the paediatric surgical team. Parents can accompany children to theatres and with them in the anaesthetic room until the children have fallen asleep and were called to recovery as soon as their children started to wake. The recovery area was separated from the adults and had decoration appropriate for children to make it less clinical.

Meeting people’s individual needs

The service was inclusive and took account of children, young people and their families’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

We saw key staff worked across the service to co-ordinate care and involvement with families.

The service was responsive to ongoing needs of patients.

We saw evidence of specific pathways and assessment tools support children with complex needs to assist in meeting their particular needs to help their admission. A ‘This is me my hospital passport’ and ‘Disability Distress Assessment Tool’ was used. For children and young people with very complex behaviours we were told individual planning meetings were convened to assist in the planning of extra-ordinary reasonably adjusted pathways.

There was currently no learning disability specialist nurse in post as they had recently left the trust, a replacement was advertised at the time of inspection. It was on the divisional risk register that currently there was no learning disability flagging in place, however, the initial risk assessment undertaken by all children admitted addressed this.

The trust had a Chaplaincy and Pastoral Care Service focussed on ensuring that all those in hospital, be they religious or not, have the opportunity to access pastoral, spiritual or religious support when they need. This included visiting patients to provide pastoral, spiritual and religious support to them and close relatives as appropriate. There was an out of hours on-call service ensuring 24 hour 7 days a week access to Chaplaincy for emergency cases. We heard an example where the on-call service was recently accessed by staff on Kipling ward following the death of a Muslim child to support the family with their needs. The trust had policies for the urgent
release of the deceased outside out working hours for those patients whose religion requires internment within 24 hours. All relatives and friends of deceased patients are signposted to the bereavement office and the team can provide information and direct people to services as required.

A ‘Delivering accessible Information’ policy was available outlining support and processes to delivering accessible healthcare. Following a recent national alert that an interpreter had been using their position for re-trafficking vulnerable people the trust had been using increased levels of video interpreting. The trust provided face to face interpreting through a service level agreement. Staff raised a request via an online booking form, email or they can telephone the equalities and diversity team. The equalities and diversity team reviewed the request and supported staff in deciding the best approach to meeting the patient’s needs. Slightly longer or more complex appointments could access video interpreting or face to face interpreters.

Written translations were also available. This included translating material such as patient leaflets and follow-up letters into other languages, large print and braille. Trust wide the fulfilment rate for face to face interpreting 2018 to 2019 was 98%, and for written translation was 100%.

We saw that staff mandatory training included the "taking the 5 steps" of The Accessible Information Standard. The Accessible Information Standard says that people who have a disability or sensory loss should get information in a way they can access and understand. To ensure that people using our services receive information in the way they can access and understand there are five basic recommended steps you should follow: ask, record, alert, share and act.

Sound monitoring was in place on SCBU to ensure a calm environment for babies and parents. There was an established period of quiet time between 1pm and 3pm for parents only. Doctors and nurses were encouraged to not carry out any rounds or treatment at these times, if possible.

Parents could accompany children to theatres and remain with them in the anaesthetic room until their children have fallen asleep. The children could be accompanied by the play specialist if they were working. The recovery area was separated from the adults, although children needed to pass through an area where adults beds were in use. It was curtained off and had decoration appropriate for children to make it less clinical.

There was no routine onsite schooling provided. Staff told us there was a very small number of children who stayed in hospital for any length of time. Figures showed that 80% of children are discharged from the children’s services within 23 hours. Children who were likely to have longer stays were often children with a neurodisability; these children were all seen under a community paediatrician, who fed into the child’s special educational needs (SEN) provision. On occasions where children require longer stays, for example children admitted with mental health issues the flexible learning service is contacted for advice and guidance, until the children can be placed in an appropriate setting or care facility.

Ward rounds took place twice a day and we saw posters advertising this on Kipling ward and the SCBU, so parents could aim to attend if they wanted to. Patients’ needs were discussed at morning handover alongside any additional support. If needed staff would talk to the patients GP or home visitor (if appropriate).

An outreach team had recently been introduced which was run by the SCBU sister and two nursery nurses. This aimed to support parents in their homes on discharge from hospital. Parents staying on SCBU were entitled to meal vouchers during their stay to ensure they were well nourished.
Night staff on the ward handed over any cases where there were concerns about the condition of children and young people in the late evening and any possible admissions. Daily handovers were attended by a wide range of disciplines, but not the play specialist which could mean that play opportunities and support that could be offered was missed.

Generally, palliative care pathways were established by either tertiary hospitals or specialist community teams. We saw evidence these were well communicated and completed with family and key members of staff. On review we found they were comprehensive and ensured all care needs were met as required.

Although there was no lead for transition in children and young people’s services, there was a newly established transition group (chaired by the Director of Nursing), who met regularly and were working to strengthen transition services across the trust.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. Although the division had a higher than national average cancellation rate.

The capacity on Kipling ward was monitored throughout the day and its status made known to the site team and accident and emergency department. This was completed using the use of the Red Amber Green (RAG) rating tool. When all the Paediatric ward inpatient beds were full, children would be placed in the beds in SSPAU provided there was adequate and additional staffing to ensure patient safety. If a child cannot be accommodated within the SSPAU the nearest alternative Paediatric inpatient bed was be identified and the child transferred. There we 19 occasions where Kipling ward had to close to admission from January 2019 to October 2019.

The service had access to advice from a mental health nurse based at Eastbourne or Hastings from Monday to Friday 9am to 5pm. There was a Psychiatrist on call 24 hours seven days a week for advice and guidance. During the 12-month period from 1 July 2018 to 30 June 2019, there were 43 occurrences of patients under the age of 19 being admitted after being referred to mental health services. Of these 22 were for periods of less than 8 hours, mostly to Clinical Decision Unit (CDU) or the paediatric short stay assessment unit. The remaining 21 were admitted for periods of more than 8 hours, four of these to Kipling ward and the rest to CDU, Acute Assessment Unit or Acute Medical Unit.

We saw that there were 89 children not bought to appointments within the outpatient unit in September 2019. We use the term ‘was not brought’ rather than ‘did not attend’ for children and young people. As it is rarely the child’s fault that they miss appointments. Staff told us they would call the relevant consultant for follow up if regular non-attendance was recorded. We spoke to two staff members including a matron who did not know of a formal policy surrounding this. The trust had a policy titled ‘Did Not Attend (DNA) Was Not Brought (WNB) Policy for Children / Young People under 18’ which was updated after our inspection November 2019. Missing appointments for some children may be an indicator that they are at an increased risk of abuse.

Following on from an incident where someone had entered SCBU that was not supposed to be there, swipe access was now being installed to restrict entry. At the time of inspection this was still not in place and we saw there was no signage on the door to discourage visitors from not entering the unit At present visitors are buzzed in by staff members at the entrance to the SCBU and the entrance to the post-natal ward which connects to the SCBU without restrictions.
On our previous inspection we saw there was no quiet room for parents who may be receiving bad news. During this inspection although there was still no access to a quiet room, there had been a room allocated in the ward and work was due to start soon after our inspection.

There were 4,690 transfers from Kipling ward and the SSPAU in the past 12 months, most of these were discharges to the usual place of residence, with 64 transferred to other hospitals for further treatment or care. In most cases this was due to the patients having needs such as mental illness, or disability that could be better met elsewhere. The SCBU provided level one support to obstetric services for babies born prematurely or with underlying medical conditions. Occupancy rates from January 2019 to October 2019 were 44.2%.

Children were held on a separate paediatric surgical list so there was no need to prioritise over any adults as they had a separate pathway. Surgery waiting times were dependent on the urgency of the surgery, for example those in urgent need could be operated on immediately.

There were dedicated transfer bags available for children after surgery, these were specific to age groups, for example up to four years old, five to 12 years and 13 to 18 years. These included items to enable smooth transfer to the wards.

There were good links with local GPs and they could call a consultant (who held a bleep) for telephone advice or could directly contact the consultant in charge. The service has helped to reduce referral to hospital and improved patient experience. We saw evidence that discharge summaries were sent to GP’s and any other relevant healthcare professionals. Each child had an electronic discharge letter written and a copy given to family before the discharge. This was then sent electronically to the GP at the time of completion.

For children where there was a child protection concerns the decision to discharge was made by the consultant paediatrician responsible for the patient. We saw this documented clearly in a patient records we reviewed who had been discharged during our inspection. We saw a documented plan of care and designated professionals responsible for any further care or treatment.

If a child presented with unscheduled care needs, parents and carers were provided with both verbal and written safety information.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Information on how to complain was clearly displayed in all areas we looked at. There were also details of how to complain in patient information leaflets and bedside booklets. This included raising issues with the matron or senior staff member in the first instance and information on how to contact the patient advice and liaison service within the hospital and email address for the complaint’s manager.

All complaints were reviewed by the matron and ward manager. We reviewed five complaints and saw complaints were properly investigated and responses were clear. These detailed any actions that were taken as a result of the investigation. Although some of the wording was formal there was clear signposting to advocacy services.

Complaints were triaged with specific risk assessment prompts to ensure they were dealt within a timely manner. There was a named complaints manager assigned to each separate complaint so
that consistent approach could made.

**Trust level**

From August 2018 to August 2019 the trust received 12 complaints in relation to children’s services at the trust (2.2% of total complaints received by the trust). The trust took an average of 29 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be completed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>7</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

**Conquest Hospital**

From August 2018 to August 2019 there were six complaints about children’s services at Conquest Hospital. The trust took an average of 29 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be completed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>3</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

From August 2018 to July 2019 there were four compliments about children’s services at the trust. A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

The common themes arising from compliments relate to:
- The kindness and professionalism of staff
- The quality of the care and treatment provided
- The quality of the environment and services provided (such as food)
- The kindness extended to the patient’s relatives and family
- The overall care and treatment provided to patients by the trust as a whole
All feedback received via the Friends and Family Test (FFT), thank you cards and letters, verbal compliments, feedback received via the trust website and NHS website reviews page is shared with senior managers for wider dissemination to staff.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Lessons learnt from complaints were fed back to the wider team through huddles, team meetings and newsletters. Trust wide feedback was also disseminated via email to all staff. The Matron said she would prefer to receive feedback directly and try and help patients who were not happy face to face and swiftly.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Although there had recently been a change in the leadership structure, staff understood how this would improve the service moving forward. Many of the recently employed or interim staff were previously within the department and had a good understanding of the division as a whole.

The leadership team consisted of a chief of division, an associate director of operations, an assistant director of midwifery and nursing who was also the head of midwifery, who managed maternity and children and young people’s services. The service had speciality leads for acute and community paediatrics who were consultant trained, they oversaw obstetric, gynaecological and paediatric service managers. The associate director of midwifery and nursing worked closely with the head of nursing and had an oversight of the deputy head of midwifery for acute services. The associate director of operations fed down to the health visiting, community paediatric service manager and the acute paediatric service manager.

The division had a consultant of the week and nurse lead identified on each shift. This gave a clear indication to staff and patients who the leads were on each shift. The Matrons were reported to be visible and approachable and leadership throughout the division was positively reported about by all staff we spoke with.

The paediatric advanced nurse practitioner (PANP) had been recently recruited and split their attendance between the two sites. Monthly one-to-one meetings with managers and monthly supervision days ensured that they were working in line with best practice and up to date evidence. They were given time to network with other advanced nurse practitioners both in the region and nationally. They were in the process of reconfiguring policy and training for non-medical prescribing, the PNAP told us they had developed a standard operating procedure for ward observations and a policy for lumbar puncture. They felt the leadership team had been supported and pro-active in making sustainable changes to the service. The service had two further PANP staff recruited to further aid the delivery of the service.

Although there was no clear nominated surgical lead we were told any surgical issues were discussed with clinical lead and escalated as needed. We could not confirm this on inspection as the clinical lead did not make themselves available for interview.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The division's vision included a mission statement which was ‘The very best start in life’. The focus was to combine community and hospital services in East Sussex to provide safe, compassionate, and high-quality care that improved the health and wellbeing of children, young people and their families.

Services were being transformed to make sure acute, outpatients, nursing outreach and community paediatric services holistically met the needs of children and young people. The leadership team were reviewing the following services:

- Care closer to home, to avoid unnecessary admissions.
- Effective transition into adult services for adolescent children with long term conditions.
- Health, education and social care working in unity.
- Co-design and co-production with young people and their families.

We spoke with several staff who were aware of the vision for the service and could speak of upcoming changes across the service. Leadership were aware of departmental strategy, which was aligned to national recommendations for children and young people’s service provision.

Progress was monitored at board level, and since our last inspection some changes have been made to the provision of transition of young people. Examples included the medicines room being established on Kipling Ward, and the development of a quiet room. Both as a result of feedback from incidents and patients. However, there was still a lack of transition services within the unit for all adolescent children or children with mental health needs.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Despite several changes the staff were mostly positive and spoke of feeling proud to work within the service. Staff demonstrated a focus on improving children’s health outcomes.

There were clear policies and processes in place to monitor and assess staff performance. Appraisals gave managers and staff an opportunity to discuss career development, personal limitations and review of staffs work life balance. The matron had a clear oversight of sickness and special leave rates which were routinely managed in line with the appropriate policies.

Several members of staff we spoke to had been given opportunities to progress their training or career within the division. Recent promotions of two band five nurses up to band six, university fees being paid for to develop staff and several specialist roles within the division are all examples we were given during interviews that demonstrated this.

A freedom to speak up guardian was available for staff cross site to support them with any concerns relating to care. The ward culture encouraged staff to be open and honest, staff told us
that they felt the matron was open and approachable and listened to their concerns. Staff routinely used the online incident reporting system to report concerns over staffing, workload or risk, all staff knew how and when to raise concerns at ward level. Staff reported an improved culture where they had no fear of raising concerns or reporting incidents. This is an improvement from our last inspection where staff reported the culture was not as positive.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear divisional governance structure, system and process of accountability which supported the delivery of sustainable, safe and quality-controlled children and young people’s services.

We saw a clear governance structure which went from floor to board. Several committees fed into the integrated performance meeting (IPM) which was held monthly. The focus of this meeting was to provide assurance to the executive team about the effective delivery of the five areas within the governance framework. These were quality and safety, leadership and culture, clinical strategy, access and operational delivery and financial control and capital development.

Women’s and children’s services, which children’s and young people sit within, also had a designated Non-Executive Director for the service who also had direct access to the board.

The matron routinely held staff meetings, and video links were provided for cross-site team meetings. We were shown evidence of minutes from teams’ meetings, which demonstrated meetings were clearly structured and designed to engage staff with the everyday management of the ward.

The chief of division, associate’s director of operations, assistant director of nursing, head of midwifery and deputy were accountable for practices and to commissioners of services across the catchment area of East Sussex.

The clinical governance lead, with administrative support, was responsible for leading daily risk meetings on the maternity unit and weekly governance meetings in the paediatric areas of the trust. All reported incidents were routinely fed up to the governance leads and there were clear processes in place to define, rate and investigate incidents across the unit.

The governance team was responsible for reporting to external agencies which included, the Perinatal mortality review board, the health service investigation bureau (HSIB) and the clinical commissioner group (CCG). The governance lead had a duty to oversee professional reviews, support staff for evidence provision and produce reports from audited data across all children’s and young people’s services. The division attended monthly Mortality and Morbidity meetings which we saw were minuted.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
We saw that risks, audits, incidents, complaints and patient feedback were escalated from the ward meetings to the monthly risk meeting. From there anything that needed to be further escalated was bought to the Governance, business and assurance meeting which was held monthly and fed directly into the Integrated Performance meeting (IPM).

Minutes of meetings of an acceptable standard and contained appropriate information. We reviewed the last three ward meeting and trust risk minutes. 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.

Other monthly meetings included, Perinatal mortality and morbidity and guideline assessments and implementations.

There was a major incident policy and the matron knew what was expected of her and her team in the event of incidents that impacted on the service. Major incident plans included the redeployment of staff cross site and possible ward reconfigurations.

The inspection team found that there were limitations for children and young people experiencing mental health problems because the system integrates with the children and adolescent mental health services (CAHMS) division of care. The lack of community mental health services for young people impacted on the trust’s bed capacity, this meant that children with mental health conditions were being cared for in an acute setting, where staff had limited skills and knowledge in dealing with complex situations. Staff raised concerns over the impact this had had on staff and patients.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Records were managed securely, and we saw computer screens were shielded from public view behind nurse stations. Any boards we saw did not contain patient identifiable information.

Separate rooms were available in all areas for staff meetings and handovers ensuring patients confidentiality was maintained.

We spoke to staff throughout the division who could explain and demonstrate how to access information through the trust’s comprehensive intranet pages. This was accessible to all staff including agency staff who were given a login as part of their induction. This ensured staff could access up to date policies, guidance and training opportunities. They could also access safeguarding information and contact details for internal and external professionals if needed.

Once patient’s notes were completed and they had been discharged, notes were then scanned and sent for storage offsite. This enabled access online to clinical notes from several departments if needed. We saw that test results and x-rays were also available online for instant review by consultants. This was demonstrated to us during a routine handover where staff could view test result and x-rays displayed on a large screen for maximum input from all staff.

An “Excellence in care” model is being introduced in the division. 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.

Information about ward or clinical unit performance was displayed on whiteboards in each area. The ward dashboards showed the number of non-attendances over time, cleanliness audit results and the planned and actual staffing levels and the incidence of certain infections.

The division held bi-monthly audit meetings for children services and paediatric morbidity and mortality meetings, these were attended by clinical and governance leads, and other clinical staff involved in patient care. Learning from outcomes was shared across the division.

Staff were aware of the need to protect patient information with notes trollies being kept in secure areas and locked cupboards. Whiteboards in the public area of the ward, only had the patients initials, staff understood their responsibilities to store information securely.

Staff had access to a range of information to support them with their roles and were provided with unique log in and protected passwords to ensure safe access to patient information. Management access 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 the ward and clinical areas, staff we spoke with were informed about how they were performing and how this compared to other areas of the division and to other divisions.

**Engagement**

**Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Although staff were aware of some changes within the department, we heard they were not always part of improvement plans. Staff we spoke with said they were not involved in the recent improvement to the play room. We spoke with one key staff member who said they didn’t know it was being developed until two days before the work was due to start.

Staff safety and wellbeing was a priority for the ward matron, who would make reasonable adjustments to shift patterns for staff who had children or vulnerable adults to care for at home. Extra support for staff was provided by the occupational health department and staff had access to six free counselling session’s if they were experiencing emotional issues.

The trust had lesbian, gay, bisexual, transgender, disability and cultural diversity networks in place. Staff told us everyone was treated as equal, and people recognised as having protected characteristics under the Equality Act (2010) were supported by managers.

We saw patient feedback was gained through Friends and Family questionnaires and we said you did boards were seen in around the department. Several boards included feedback from children themselves.

The SCBU had lots of useful information in clearly marked folders for parents to access including wellbeing resources.

The trust held quarterly staff awards which highlighted the good work of particular staff. We also saw staff being recognised for improvement work in monthly newsletters.
Learning, continuous improvement and innovation

Staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust actively sought to participate in national improvement and innovation projects. 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.

The team had been awarded the clean care and sepsis improvement awards. We were told that a serious case review flagged transition of children to adult care as a risk, because the service listened to parents more than young people. With support from the deputy director of nursing, who took ‘up the baton of support’ The service now plans to provide transitional care for all young people attending the neuro disability service by 2021.

The SCBU had recently introduced parentcraft classes three times a week to help parents feel more confident to care for their babies when taking them home.

A diabetic specialist nurse and consultant ran a weekly type 1 diabetic clinic. The diabetic team followed national quality standards which involved in National Paediatric Diabetes Audit (NPDA). for children with type 1 diabetes as a result the clinic had gained funding for a child clinical psychologist.
End of life care

Facts and data about this service

The trust provides end of life care at a number of settings. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services.

End of life care is provided for people and those most important to them who are approaching the end of their life and after death. This service is delivered across a number of settings, including acute and community hospitals and in people’s own homes supported by community teams. Mortuary, bereavement, chaplaincy, and volunteer services provide valuable services and support to patients and their families. Where additional expertise is needed specialist palliative care teams are available in both acute and community settings.

The trust works in close partnership with local hospices to provide seamless care supporting patients to be cared for in their preferred place of death. Recently funding was approved to extend the team to allow provision of the service seven days a week.

End of life care is delivered either indirectly or directly by over 4,000 employees within the organisation. Education for staff is predominately provided by the supportive and palliative care team, local universities and through e-learning modules.

The trust has recently introduced recommended summary plan for emergency care and treatment (ReSPECT), an alternative process for discussing, making, and recording recommendations about future emergency care and treatment, including CPR. This process encourages patients to focus on both the treatments they do want, those they do not want and planning ahead for their care and treatment should they be unable to make decisions due to a future emergency.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The trust had 1,627 deaths from March 2018 to February 2019.

(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 and made sure everyone completed it.
Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training.

The trust set a target of 90% for completion of mandatory training, other than the information governance module where the trust set a target of 95%.

The end of life nursing team for the trust was managed as one team across their multiple sites which includes the Conquest hospital in Hastings. The data provided by the trust was identified as Eastbourne District General Hospital, but this information was for the team that covered all sites. However due to the way the information was submitted the data analyst below is identified as Eastbourne District General Hospital.

The trust did not provide mandatory training data for medical staff within end of life care.

Eastbourne District General Hospital end of life care department

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at Eastbourne District General Hospital for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>5</td>
<td>9</td>
<td>55.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for five of the six mandatory training modules for which qualified nursing staff were eligible. In addition, nursing staff met the 95% trust target for the information governance module. However, care should be taken when interpreting completion rates due to small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust ran its own end of life training programme which was mandatory for all staff. It was provided in three levels. Level one was for all staff who would be involved in end of life care. This was delivered as part of the induction process. Level two of the mandatory training was a three-hour session provided to all members of staff that were patient facing. Staff told us this was delivered twice a week and was alternated across the two acute hospital sites. Level three training was provided to all the ‘specialist’ staff working full time in the end of life care team.

The level 2 training was at 59% at the end of September 2019 which was discussed in governance meeting minutes we reviewed, and this said that they were just above their current target trajectory. This course was started in March 2018 and the trust has set themselves a target of achieving 100% over three years. So, they are just over half way through there target period and have achieved 59% the training they wanted to have staff complete.
Nursing staff we spoke to said they had found the new end of life care training useful. The medical staff we asked said they had completed their training, but it could have been more detailed. The palliative care staff told us they thought the training had helped them receive more referrals as staff were identifying more patients they could support.

**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.

Staff received training specific for their role on how to recognise and report abuse. Non-clinical staff received training in safeguarding level 1 for children and vulnerable adults this was in line with the trust policy. This included staff in the bereavement office and chaplaincy service.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Although, they reported they had not had any concerns to raise yet they would feel confident to raise one if needed.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The three staff we asked to describe what would be a safeguarding concern could describe the different types of abuse and signs of these.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The three staff we asked about how to make a referral showed us how they would refer a concern to the safeguarding team. They also knew they could contact the safeguarding team if they needed advice.

The service had completed the required safety checks before employing their staff. We looked at five staff files which all had completed checks of; enhanced disclosure and barring service, identity, professional registration, and references. This was in line with schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

**Safeguarding training completion rates**

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

The end of life nursing team for the trust was managed as one team across their multiple sites which includes the Conquest hospital in Hastings. The data provided by the trust was identified as Eastbourne District General Hospital, but this information was for the team that covered all sites. However due to the way the information was submitted the data analyst below is identified as Eastbourne District General Hospital.

The trust did not provide safeguarding training data for medical staff within end of life care.

**Eastbourne District General Hospital end of life care department**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at Eastbourne District General hospital for qualified nursing staff in end of life care is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>9</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service-controlled infection risk well. They kept equipment and the premises visibly clean. Staff used infection control measures when visiting patients on wards and transporting patients after death.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. We saw cleaning logs in the mortuary for the past four weeks and these had been completed in line with the trust policy. We noted within the mortuary there was no unpleasant smell and observed all areas were visibly clean.

Staff followed infection control principles including the use of personal protective equipment. We saw personal protective equipment such as gloves and aprons were widely available and supplied in sufficient quantities. We also saw staff in the mortuary using appropriate protective equipment and decontaminating their hands before and after contact with the deceased.

The service had a policy for preventing the spread of infectious diseases that was in line with national guidance. All staff we saw were ‘bare below the elbow’ in line with this policy.

We saw staff from the palliative care nurses carrying out hand hygiene in line with national and trust guidance. There were sufficient handwashing sinks and hand decontamination gel within all areas we visited, and we saw there was soap and paper hand towels available next to the sinks. During our inspection we saw staff including those from the palliative care team washing their hands or using the hand decontamination gel correctly, in line with the World Health Organisation’s ‘five moments of hand hygiene’ and National Institute for Health and Social Care Excellent (NICE) quality standard (QS) 61, statement three. We saw there were posters on display encouraging staff and visitors to clean their hands.

Staff told us about when they would need to use a body bag and they had a form to complete on the ward to alert the porters and mortuary staff to the reasoning for using the body bag. The mortuary staff told us they had a plan for high risk infections. They also had a quick reference guide for common infections and precautions that should be taken by them and porters for each infection. Staff told us if they had any concerns about what precautions to take then they would review the policy on the trust intranet or call microbiology for advice.

The mortuary staff showed us the handover form they used to alert the funeral directors to routes of possible infection. This told them the routes of infection risk but not the name of the infection to protect the confidentiality of the patients.
Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had enough suitable equipment to help them to safely care for patients. Staff spoke with told us they could always access syringe drivers when needed from the equipment library.

The service had suitable facilities to meet the needs of patients’ families. The service had a bereavement office for relatives to attend for support after their relative had passed away. The mortuary had a viewing area for relatives that was decorated with realistic artificial flowers, a bed with blankets and sheets which was used to display the deceased, and sofas with cushions to provide an area for relatives to sit comfortably. The hospital had room for relatives of patients at the last days of life for them to stay overnight or to rest away from the ward.

The design of the environment followed national guidance. The service had considered the Health and Safety at Work Act 1974 and reduced the risk to staff within the mortuary by acquiring an electrically operated hoist for moving bodies. This reduced risk by meaning staff no longer needed to climb on a step ladder to access the highest fridges and removed the need for foot pump assisted raising and lowering of bodies.

Staff carried out daily safety checks of specialist equipment. We looked at logs for the past four weeks of mortuary fridge temperature checks which had been completed without gaps. These showed they were all within the temperature range required.

The mortuary had secured entry and was controlled by intercom from the mortuary staff office. Identity was checked, and we were informed that an appointment had to be made for staff visits. For relatives visiting there was a separate entrance that was also secured and when they were admitted to the department their identity would be carefully checked, also the area relatives were allowed to enter was secured so they cannot access the rest of the department while visiting. There was capacity to store up to 91 patients there and they had never reached maximum capacity.

Staff disposed of clinical waste safely. The three bins we checked in the mortuary had clinical and non-clinical waste segregated in line with national guidance. The two sharps bins we looked at were assembled and were being used in line with trust guidelines. This included having the temporary closure covers slide across to prevent accident needle stick injuries.

The state of repair of the flooring throughout the hospital was not of a consistently good quality. Staff reported they were concerned when transporting patients around the hospital that these uneven surfaces could cause discomfort to patients.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Shift changes and handovers included all necessary key information to keep patients safe. The palliative care team worked day time shifts only but as some of these staff worked part time the team had one case load that was shared. A member of the palliative care team told us this worked well for them.
Comprehensive risk assessments were carried out, and risk management plans were developed in line with national guidance. Risk assessments such as falls, malnutrition and pressure ulcers were recorded in the patient record and included actions to lessen any identified risks. They had also introduced plans that were started with patients in the community to make advanced decisions and provided additional information for ambulance crews and hospital staff. This allowed the risk assessment to be a continual process and involved the patient as much as possible. Staff in the emergency department said they had found these plans very useful and help them to comply with the wishes of the patient. They also told us this has resulted in a reduction of unnecessary hospital admissions against the advanced decisions of the patient and thus a reduction of the associated risks of hospital admission.

Staff knew about and dealt with any specific risks identified. We looked at records that showed doctors had reviewed a patient’s renal impairment and changed their pain relief prescription in line with guidance from the British National Formulary 2019. In the mortuary a three-point identity checking system was carried out to ensure patients were not misidentified.

Staff shared key information to keep patients safe when handing over their care to others. The service used an integrated care pathway for patients in the last days of life. This contained all the necessary information in one place, so all members of the multidisciplinary team had access to information quickly. We were told when a patient was handed over to the hospice, their notes were sent with the patient. Ward staff and mortuary staff described a form they used that could be quickly completed to hand over important information to the mortuary staff. This included any infection risk, any personal request by the deceased or family, also what name the deceased liked to be called so they can carry this on in the mortuary. The mortuary staff described the process they used for handing over the deceased to the undertakers. This included alerting them to infection risks.

When a patient entered the last days or hours of their life, or were placed on a syringe driver, staff would use a different chart to monitor these patients. The standard checks of blood pressure and pulse were replaced with a form to monitor comfort, such as assessments of pain, nausea, vomiting, breathlessness, agitation, mouth dryness and respiratory secretions. This form was completed at least every four hours and each symptom was categorised between zero and three with zero being the absence of the symptom. If the symptom was rated as one, two or three the form had advice on what to do. This included consideration of additional medication to control the symptom or to look for other causes of the symptom. These ratings were also used to advise nursing staff if there were two consecutive rating of two or a single rating of three then a doctor should review the patient. We saw these had been completed in the three records we looked at where the trusts policy would have required this.

The palliative care team also saw patients that were in the last year of life or had a terminal diagnosis but were not in the last days of life. The palliative care team used stickers placed at the start of each entry in the patient’s record to easily identify the last entry by them. Staff told us this was useful as it also contained a phone number to call the team for advice. In the nine patient records we looked at these were used in all of them.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
The service had enough nursing and support staff to keep patients safe. Staff we spoke with told us when they asked for support from the palliative care team there was always a quick response. A ward nurse we asked about how long would be the longest they had to wait for response to a referral said this depended on the urgency of the request but for something that was not urgent they said the longest would be 24 hours. Ward staff told us for urgent support with symptom management the palliative care team were always there quickly.

The supportive and palliative care team was made up of eight specialist nurses and two support workers. This team worked across both of the trust’s main sites which included the Conquest hospital. This team was also support by palliative care link nurses based on each ward in the hospital. The link nurses attended additional training with the palliative care team and also attended regular link nurse meetings. Ward staff told us they found their link nurses very helpful and they were always around to answer questions. We looked at the minutes from three end of life care link nurse meetings and these showed that issues faced by the wards were discussed and solutions proposed.

The service had low vacancy rates. At the time of inspection, the service did not have any vacancies with their nursing or support staff for the palliative care team.

The service had low turnover rates. Staff told us they stayed in their roles for long periods as they enjoyed their jobs. A member of mortuary staff we spoke to told us they had been with the service in that role for 16 years. Another member of staff in the bereavement service told us they had been with the service for three years and found their job very fulfilling.

The service had low sickness rates which were within the trust target as seen below.

The end of life nursing team for the trust was managed as one team across their multiple sites which includes the Conquest hospital in Hastings. The data provided by the trust was identified as Eastbourne District General Hospital, but this information was for the team that covered all sites. However due to the way the information was submitted the data analyst below is identified as Eastbourne District General Hospital.

The service did not use agency staffing for the palliative care team.

**Eastbourne District General Hospital**

The table below shows a summary of the nursing staffing metrics in end of life care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
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<td>Target</td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>9.0</td>
<td>12.8%</td>
<td>0.0%</td>
<td>3.7%</td>
<td>58 (&lt;1%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
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<tr>
<td>Qualified nurses</td>
<td>7.4</td>
<td>6.5%</td>
<td>0.0%</td>
<td>3.7%</td>
<td>58 (&lt;1%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
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</tbody>
</table>

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The table below shows a summary of the nursing staffing metrics in end of life care at trust level compared to the trust’s targets, where applicable:
Nurse staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and, bank use or agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The supportive and palliative care team had five medical staff which was made up of three consultants and two specialty doctors. These medical staff had undertaken specialist training in symptom control and end of life care. This medical team also support the hospice and community end of life care.

The service always had a consultant on call during evenings and weekends. This out of hours cover was provided by the local hospice.

The trust did not provide data for medical staffing within end of life care. So, we did not have rates of sickness, agency usage, turnover rates, or vacancy rates. However, staff reported the service had enough medical staff to supply effective support to patients.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff told us they could always access the patients notes when needed. The trust had a last days of life integrated care pathway record which all members of the multidisciplinary team used to record their interactions with the patient. This contained prompts that included: religious needs, symptom control, and background medical history. We looked at four of these and they were consistently completed. Staff reported this was useful as information was quickly accessible to staff that were not familiar with the patient.

Records were stored securely. On all wards we visited patient records were stored in locked trolleys in areas that were visible to the nurse’s stations. The mortuary records were stored securely within the mortuary and staff in the mortuary checked all visitors’ identities before allowing entry to the department.

The service used paper-based record for end of life care. The mortuary was using a paper-based records system but were trialling a new electronic records system. They were using both systems at the time of the inspection to ensure the new system worked as needed before switching to only using the electronic records system.
**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored safely and securely on all the wards. Access to medicines was limited to authorised staff only. Controlled drugs were stored safely and securely.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. The ward and supportive and palliative care teams reviewed patients’ medicines regularly. Each morning the ward teams would review the symptoms and needs of each patient on end of life care. The pharmacy team were available to provide specific advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. All medicines were stored securely in line with the provider’s policy and national guidance. Access to medicines was limited to authorised staff only. Each ward had access to end of life care observation and prescribing charts as well as ReSPECT forms. ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they were unable to make or express choices.

Staff followed current national practice to check patients had the correct medicines. A full medicines reconciliation was completed on admission to the wards by the pharmacy team. Records of this were passed onto the doctors to ensure continuity of care. The nine medication charts we looked at all had known allergies clearly recorded.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trust operated an incident reporting system on which staff could record incidents and medicines safety concerns. Staff were aware of recent medicines safety alerts and the actions that had been taken around these.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Midazolam was commonly prescribed when needed to help manage agitation and restlessness. It was not used excessively and was prescribed in line with trust and national guidelines.

Staff were trained on the use of syringe drivers (A small battery-powered pump that delivers medication at a constant rate throughout the day). Medicines were prescribed on a separate syringe driver prescription chart that also prompted staff to perform checks on the device every four hours to ensure it was working correctly and we saw consistently completed charts.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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.

Incidents regarding end of life care came from all divisions. The service drew information from the electronic incident reporting system and any elements that related to end of life care were reviewed by the palliative care team. The incidents in turn were fed back to the end of life improvement group to identify any key themes. The incidents and the themes drawn from them formed part of the mandatory training that was provided to all staff across the trust.
Staff knew what incidents to report and how to report them. The four staff we asked could describe how to report an incident via the online reporting tool on the trust’s intranet. In the past twelve month the trust had recorded 32 incidents relating to end of life care. There were 25 rated as near miss or no harm and the remaining seven were rated as minor severity.

Staff raised concerns and reported incidents and near misses in line with trust policy. We looked at five incidents which included two near misses. One of these incidents related to an error in the prescription on a discharge letter. The error was reported but was identified by the trust’s pharmacy team, so no harm was caused to the patient. The incident was also discussed at the service’s weekly patient safety summit, so learning was shared with the wider staff group.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. In the incident reports we showed apologies had been given to patients for incidents that related to patient care.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. In one of the incidents we looked at, the matron that was the investigator had spoken with the patient to gain further understanding of the impact to them.

Staff received feedback from investigation of incidents. The four staff we asked told us they had received feedback from incidents that they reported.

Staff met to discuss the feedback and look at improvements to patient care. There had been an incident where a patient had been sent home without a follow up being arranged for the care of the syringe driver they had running. This was investigated and a gap in knowledge of ward staff was identified. This was then discussed with the staff related to the incident and then the wider staff group to ensure all staff were aware of the handover process to the community when discharging a patient receiving end of life care with a syringe driver.

**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 July 2018 to August 2019, the trust did not report any never events for end of life care.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

From July 2018 to August 2019, the trust did not report any serious incidents for end of life care.

*(Source: Strategic Executive Information System (STEIS))*

**Is the service effective?**
Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service was using personalised care plans for those in the last days of life which was in line with the National Institute of Clinical Excellence (NICE) standard NG31 “care of dying adults in the last days of life”. These had consideration to the six recommendations of this which were; recognition, communication, shared decision-making, hydration, pharmacological interventions, and anticipatory prescribing. The service had recently released version three of this care plan along with new guidance to support staff in the use of these new care plans. These care plans included individual’s preferences regarding the type of care they would wish to receive and where they wanted to be cared for. We saw these priorities of care were also displayed on end of life care notice boards on the wards and departments we visited.

Care, treatment and support was delivered in line with legislation and national evidence-based guidance. Patients had venous thromboembolism risk assessment completed and prophylaxis medication prescribed when needed, which was in line with NICE QS3 Statement 5 “Venous thromboembolism in adults: reducing the risk in hospital”. We looked at nine patient records and all these showed staff had considered and treated risk of venous thromboembolism. A venous thromboembolism is a clot that can form in the body due to low levels of activity, which affects hospital patients as they tend to be less active than in their everyday lives.

The service had audits to monitor the compliance of staff with the national standards. These included audits of the completion of the last days of life personalised care plans. The service also submitted information to the national audit of care at the end of life which they then used to monitor their performance against the national priorities for end of life care. The latest national report issued was for the 2018 data and showed that the uptake and completion of the individualised care plans was lower than the national average. This had been considered by managers of the service and they had designed the new version three care plan to improve completion rates. Ward staff told us they liked the new design and found it easier to use.

Nutrition and hydration

The service supported patients through regular assessments for nutrition and hydration. Staff supported patients to make sure they had enough food and drink to meet their needs. Patients were encouraged to eat and drink normally for as long as possible despite this need reducing as people approached the end of their life.

When reviewing patient notes we saw that patients at the end of their life were receiving the necessary nutrition and hydration. The service also used a symptom monitoring tool for those in the last days of life included dry mouth to prompt staff to either offer a drink or to provide mouth care and consider clinically assisted hydration. We saw in the records of four patients in the last days of life that these had been completed consistently.

Patients were offered a choice of menu options and dietary requirements were considered. A patient we spoke with reported the food was good, and options were available.

We saw patients were encouraged to eat and drink normally for as long as possible despite this need reducing as people approached the end of their life. In the last days of life personalised care plan there was a section that prompted staff to think about nutrition and hydration including what the patient would want after they were unable to eat and drink normally.
The service had completed an audit on patient end of life care plans which included looking at recording of hydration status. The trust had compliance of 53% in April 2019, 68% in March 2019, 58% in February 2019, 50% in January 2019, and 84% in December 2018. The trust’s audit acknowledges that this is below where they would like this to be and they have formed a task and finish group to improve and simply the end of life care planning document. This group has also produced a completed example of an end of life care plan to guide staff that has been placed on the trust’s intranet.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw records showing staff used a non-verbal pain score for patients in the last days of life that could not verbalise their pain level. This included consideration for facial expression, body language, physiological changes, physical changes and vocalizations such as crying. This allowed staff to continue to assess a patient’s pain level if the patient was unable to say how much pain they were in.

Patients received pain relief soon after requesting it and staff prescribed, administered and recorded pain relief accurately. When a person was entering their last days of life the ward would stop vital observations and instead use a ‘symptom observation chart’ to record and manage symptoms and maximise comfort. ‘Just in case’ or ‘Anticipatory’ medicines (medicines prescribed pre-emptively to provide relief from symptoms if needed) were used on the wards. The trust used drug dispensing charts for end of life care which would support prescribers to provide medicines in line with national recommendations for the management of symptoms in the last days of life. This allowed ward staff to give pain relief in immediate response to the symptom. We saw in the five records of patients during the last days of life had been given pain relief in this way.

Syringe drivers were available from the hospital equipment library. These delivered measured doses of drugs over the course of 24 hours which when needed included pain relief. Medicines were prescribed on a separate syringe driver prescription chart that also prompted staff to perform checks on the device every four hours to ensure it was working correctly.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service took part in relevant national clinical audits. Outcomes for patients were not always positive such as national standards. However, managers and staff had used the results to improve patients' outcomes. When we visited the service the latest national audit report was published in April 2019 however the data used in this report was from 2018 and we saw on inspection the service had worked to make improvements to the areas of concern identified. The results of the trusts national audit of care at the end of life for 2018 are below:
Managers used information from the audits to improve care and treatment. To improve communication and support for families of those in the last days of life, the new personalised care plan had included several sections focused on the needs of the family and suggested actions. These included giving them a comfort box and information leaflets of coping with dying. The service had also reworked their personalised care plans to improve them based on feedback from staff. Staff reported the new version of the care plans were easier to use and helped them remember to look at all areas of the patient’s and family’s needs.

Leaders of the service also told us they had recently expanded the workforce in the palliative care team to allow them to provide more support for ward staff. Ward staff reported they always had access to specialist palliative care support when they needed it.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw the service had started using a new personalised care plan and managers had started their audit of the use of this care plan to identify more potential improvement.

Managers shared and made sure staff understood information from the audits. We saw in the end of life care newsletter there was information about recent audits and their effects on practice.

The service provided a fast track discharge process for patients that were approaching the end of their life and had a preferred place of care outside of the hospital. Data from the end of life care dashboard showed that between November 2018 and August 2019, the service referred 270 patients to the community healthcare service for rapid discharge. Of those, 203 were successfully discharged to their preferred place of care. In this period, patients were able to be discharged within two days from the date of referral for all months except for June 2019 (three days) July 2019 (three days) and August 2019 (five days). In the same period, a total of 58 patients died in the hospital before they could be discharged.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Ward staff told us they were confident the palliative care team had the right skills and knowledge to provide the support they and their patients needed. A patient told us they felt the palliative care team were good at their role.
Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke to in the bereavement office and mortuary both told us their induction had been supportive and beneficial to them when they started their roles. Additionally, end of life care training was included in the induction for all hospital staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they felt their appraisals were focused on developing them. A member of mortuary staff told us their manager had supported them to work shifts in different departments to gain a better understanding of patient care throughout the hospital. This had included going to work in the operating theatres and were planning to work in histology to see how the samples they take get analysed.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. A manager in the bereavement service told us they supported their staff to develop their skills by identifying additional training course that could help their staff. They said although it was not mandatory training they encouraged their staff to attend the trusts de-escalation training. This course could be useful to their staff as the relatives they interact with are emotionally distressed and this could lead to them becoming agitated.

**Appraisal rates**

The end of life nursing team for the trust was managed as one team across their multiple sites which includes the Conquest hospital in Hastings. The data provided by the trust was identified as Eastbourne District General Hospital, but this information was for the team that covered all sites. However, due to the way the information was submitted the data analyst below is identified as Eastbourne District General Hospital.

The trust did not provide appraisal data for medical staff within end of life care.

From August 2018 to July 2019, 88.9% of eligible nursing staff in end of life care received an appraisal compared to the trust target of 90%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some staff groups.

**Eastbourne General Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
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<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
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<tr>
<td>Nursing and midwifery registered</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90.0%</td>
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(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was good multidisciplinary team working. Staff had input into the planning, assessing and delivering of patients’ care and treatment. Staff told us they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another.
While we were on inspection the effective multidisciplinary working supported a patient to get discharged to the hospice on the same day the patient was referred.

The service ran a multi-disciplinary ward round which included the palliative care doctors, nurses and the ward nursing staff. The palliative care team also arranged to do combined ward round visits with the patient’s medical team so that they could discuss plans for treatment and symptom control together with the patient.

We looked at nine patient records, talked with 22 members of staff, and two patients, which all confirmed there were effective multidisciplinary working practices. This involved nurses, doctors, physiotherapists, occupational therapists, chaplains, and pharmacists. Staff told us they felt supported by their colleagues and their contribution to overall patient care were valued.

The mortuary staff had been attending ward meetings to run training sessions to share knowledge about the mortuary and to dispel myths. Ward staff told us these training sessions had been very helpful so that they could now share this information with patients and relatives. The mortuary staff also told us they had been organising days for staff from the wards to visit the mortuary to gain a better understanding of how the service worked. The mortuary staff did say that due to new regulations, staff could not observe post-mortem examinations unless there was a clinical or forensic reason for them to be present.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, 24 hours a day, seven days a week. The palliative care team worked 8am until 4:30pm Monday to Friday. Out of these hours the ward staff were supported by telephone advice from the local hospice and staff on wards told us they found this worked well. Managers told us they had a plan to expand the palliative care service to cover out of hours support but this had not been started when we visited.

The mortuary staff worked during the day Monday to Friday. During the night and at weekends the porters would take the deceased to the mortuary, record their details and ensured that the patient was safely placed in the mortuary.

The chaplaincy service was available for patient 24 hours day, seven days a week. The chaplain was present on site during the day Monday to Friday and also held a Sunday service. Out of hours there was an on-call rota so if a patient needed chaplaincy services someone would come into the hospital to see them.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on wards. We saw posters with information on smoking cessation with phone numbers of other agencies to call for advice.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw in patient records risk assessments were completed, and support was offered where needed. The last days of life personalised care plan contained a section prompting staff to offer information leaflets to relatives about coping with dying.

In the end of life care newsletter, we saw an article telling staff about a club in the community for
patients at the end of life can join. This club was set up to educate people of what options they had for their funeral.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and they knew who to contact for advice. Staff we spoke with could describe how to assess patient’s mental capacity and the intention behind decisions made in the best interests of the patient.

Staff clearly recorded consent in the patients’ records. We looked at nine sets of notes and all had consideration for mental capacity and consent clearly recorded.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering patients’ wishes, culture and traditions. During the inspection we saw an example of a recommended summary plan for emergency care and treatment (ReSPECT) document completed and end of life care initiated where the patient did not have capacity to make the decision themselves. Staff had discussed the situation with the family and they had come to the decision together to work in the best interests of the person.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff showed us how they would access the policies on the trust’s intranet and told us they would seek advice from their manager.

Mental Capacity Act and Deprivation of Liberty training completion

The end of life nursing team for the trust was managed as one team across their multiple sites which includes the Conquest hospital in Hastings. The data provided by the trust was identified as Eastbourne District General Hospital, but this information was for the team that covered all sites. However due to the way the information was submitted the data analyst below is identified as Eastbourne District General Hospital.

The trust did not provide training data for medical staff within end of life care.

Eastbourne District General Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Eastbourne District General Hospital level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
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<tr>
<td>Mental Capacity Act (MCA)</td>
<td>7</td>
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Is the service caring?

Compassionate care

Staff providing end of life care truly respected and valued patients as individuals. Staff consistently treated patients with compassion and kindness, respected their privacy and dignity. They thoroughly understood and respected patients’ personal needs and preferences. Staff were dedicated to making sure patients received the best individualised patient-centred care possible, at the end of their life. Feedback from patients and those close to them was overwhelmingly positive.

Staff took time to interact with patients and those close to them in a respectful and considerate way. A patient told us the palliative care team visited them and that they would prefer to be seen when their partner got to the ward, so the palliative care team arranged to come back at that time.

Patients said staff treated them well and with kindness. We saw on a ward round that staff identified a patient was in discomfort. The ward nurse immediately went to get medication to provide the patient with relief. Patients told us staff took the time to listen to them.

Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treated people. The two end of life care patients we spoke with both told us the staff were compassionate and kind. We looked at seven compliment cards and these were overwhelmingly positive. Comments such as, “the care and kindness shown was simply exceptional”, “we will never forget any of the wonderful staff”, and “can’t thank them enough for all they did for us” were seen.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw information about this was recorded as part of individual care records and staff demonstrated an understanding of respecting patients’ wishes in all aspects of their care. We were told about a recent patient that had wanted to keep a music box playing prayers with them until their burial. This was organised by the family and then the ward staff organised with the mortuary for this to be continued while they were with them. The mortuary staff kept this with the patient at all times and changed the batteries when this was needed to ensure the patient’s wishes were followed.

People were always treated with dignity by all those involved in their care, treatment and support. We saw staff-maintained patient’s privacy and dignity, including during physical or intimate care. We saw curtains were used to provided privacy during examinations. End of life care patients were considered at the bed meeting and they tried when possible to get a side room for these patients.

In the inpatient areas, there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. Discreet signs were used to identify patients who were receiving end of life care. In the accident and emergency department they had laminated pictures of doves they clipped to the curtains to alert staff to be discreet.

Staff also told us about weddings they had organised for patients in the last days of life. This included one that was planned and had been completed within two days. This included the hospital chapel being decorated in their favourite colours. The patient was supported to spend the day with his family in the chapel. The following day the patient passed away with his new wife by his side.
The chaplain told us they had also organised for baptisms within the hospital for patients in the last days of life. One that they told us about was a young adult that was on the intensive care unit and wanted to be baptised before they died.

Staff told us about a service to take hand or finger prints of the patients that had passed away as a memory of their loved ones. The mortuary had been designed with a garden at the visitor’s entrance which created a quiet space for families to wait and reflect.

**Emotional support**

Staff provided high quality emotional support to patients, families and carers to minimise their distress. People’s emotional and social needs are highly valued by staff and are embedded in their care and treatment.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The chaplain told us about a patient in the last days of life that told the staff they were a Buddhist but up to this point had not told anyone about this belief including their partner. The chaplain visited and spoke to the patient and found out that what the patient wanted was a woodland burial and the patient thought the only way this was possible was if they said they were a Buddhist. The chaplain and the bereavement team provided advice and support for arranging a woodland burial for the patient for after their death.

Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. Staff confirmed they considered a person’s faith and involved local community leaders where needed. We looked at nine patients records and saw evidence in eight that the patient’s faith had been considered and discussed with a patient. This was in line with National Institute for Health and Care Excellence (NICE), quality standard 13, statement six. The ninth patient’s records showed the patient had died suddenly so there had not been time to discuss this with them.

Staff understood how to break bad news in a sympathetic way and demonstrated empathy when having difficult conversations. A patient we spoke to told us doctors had been sensitive when they broke the news of the patient’s terminal condition.

Staff understood the emotional and social impact a person’s care, treatment or condition had on their wellbeing and on those close to them. The chaplain service provided support for patients and their families for those in the last days of life. The chaplain told us they had recently visited a patient and their family in the cardiac outpatient’s department as the patient had unexpectedly died during the outpatient’s procedure. They told us they went and said some words to comfort the relatives that were grieving.

The emotional requirements of patients were considered as part of the personalised care plan that was used when it had been recognised that a patient was in the last days of life. We saw in patient records we looked at the service was monitoring patients distress and agitation. Staff told us the tool they used to record this monitoring was helpful as a reminder but that they would do this even if they did not have to record the results.

Staff told us about a patient and their family who, due to their beliefs wanted incense burnt during the mourning period where their body would be stored. The mortuary arranged for the family to be able to burn the incense in the garden area outside the relatives’ entrance to the mortuary.

Staff supported patients in the last days of life that became distressed. Staff from the bereavement office told us about how staff had contacted them about a patient that was getting distressed about leaving the arrangement of their funeral to their wife. The bereavement staff came to see the
patient and talk through the process after their death and planned the patient’s funeral with them before his death. Staff told us the patient was very grateful for this and seemed to relax after receiving this support.

After death the body of a person who had died was cared for in a culturally sensitive and dignified manner. Staff honoured the spiritual and cultural wishes of the deceased person, and their family and carers. Any specific requirements were discussed with the patient prior to their death, including how they needed to prepare the body to meet religious obligations, if family members or carers wanted to be present or honouring peoples wishes for organ or tissue donation. This was in line with National Institute for Health and Care Excellence (NICE), quality stand 13, statement 12.

Understanding and involvement of patients and those close to them

Staff always supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Relationships between people who use the service, those close to them and staff are strong, caring and supportive. These relationships are highly valued by staff and promoted by leaders.

Staff made sure patients and those close to them understood their care and treatment. One patient told us they had been given as much time as they needed to ask questions and understand what the doctors and nurse were telling them. We looked at two compliment cards from relatives that said they had felt included and supported. This was in line with National Institute of Health and Care Excellence quality standard 15, statement 2.

Staff supported patients to make advanced decisions about their care. We saw in the nine patient records we looked at that all had a recommended summary plan for emergency care and treatment (ReSPECT) form. These forms were used to create a summary of personalised recommendations for a person’s clinical care in a future emergency in which they were unable to make or express choices; this included a discussion about wishes about the cardio pulmonary resuscitation. These forms also ask professionals to consider the involvement of family or friends of the patient.

People valued their relationships with staff and felt they often go ‘the extra mile’ for them when providing care and support. We were told about a mother that had lost her newly born baby and the mortuary staff work with the ward as she did not want her baby to be alone in the mortuary. So, the mortuary staff member went to the ward to talk with the mother about the process and reassure her they would not leave their baby alone. They then organised for the undertaker to be ready to collect them as soon as possible and organised the mortuary so the mother could sit with her baby in the viewing area. Also, they organised for the formal process that needed to be complete to be ready as soon as the baby arrived in the mortuary. Staff report that through this they managed to limit the time they spent in the mortuary to 30 minutes.

Staff went above and beyond to contact relatives to ensure that the patient was not alone in their last hours of life. In one of the patients records we looked at we saw a junior doctor had tried to contact the patient’s partner as the patient was in the last days or hours of life. They got no response to all the numbers listed in the hospital records. The doctor then phoned the patient’s general practice to ask for any other contact information for the patient’s relatives. They did then succeed in contacting the patient’s partner.

On the relatives’ feedback forms given out by the bereavement office there was an offer for the bereavement staff to call the relatives back to talk about their feedback. The bereavement staff told us normally they liked to organise viewings by appointment as this allowed the mortuary
plenty of time to prepare the viewing area. However, they told us this had been organised at short
notice. They told us about a relative that was struggling to cope after the loss of her husband and
they spent two hours talking with her and arranging support that was available to her. They also
organised a viewing on the day as she had not wanted to visit her husband in the mortuary but
changed her mind while talking with the bereavement office staff. Then the bereavement staff
walked her to the radiology department as she also needed to have a scan that day.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and
the communities served. There was a proactive approach to work with others in the wider
system and local organisations to plan care that met the needs of patients, their families
and the wider community. The services were flexible, provided choice and ensured
continuity of care.

Managers planned and organised services, so they met the changing needs of the local
population. Staff told us they tried to allocate side rooms to patients who were receiving end of life
care, to offer quiet and private surroundings for the patient and their families. However, there was
a demand on the availability of side rooms due to priority given to patients who needed isolation
which meant that end of life care patients was sometimes cared for on open wards. We saw side
room allocation would be discussed three times a day at the hospital bed meeting. The end of life
care team had decided to trial putting patients that were on the open ward area by the window of
bays. Staff told us this was to reduce the noise made by people going past their bed and also to
provide the option of a view.

There were facilities at the hospital for families and relatives. These included a canteen, a shop,
coffee shops, and vending machines. In the main entrance area of the hospital there was a piano
that had a rota of people that volunteered to play music during the day. This entrance area is
where bereaved relatives would wait for the bereavement staff to show them to their office. There
was also overnight accommodation for relatives and friends of those in the last days of life. This
room had a double bed, a towel, sink, shower, and kitchen facilities. We were told about a family
that had used this room recently as they had come from outside of the country and wanted to stay
near the hospital. The service also had recliner chairs for families to use if they wanted to stay
next to the bed side of their relative.

Managers and staff worked to ensure accessibility to the service. There were no visiting time
restrictions for family and friends visiting a patient in the last days or hours of life. This allowed
family and friends unlimited time with the patient. The hospital was accessible by a variety of
methods including 12 bus routes, visitor car parking and blue badge spaces. Friends and relatives
of those in the last days of life were given tickets for free parking. A relative told us the staff on the
ward always checked how they were going to get home.

The emergency department had almost finished a project to create a dedicated viewing room for
patients that died in the department. This room was just waiting for a sink to be installed. Staff in
the emergency department told us they were proud to have got the funding and approval for this
room and felt it would help grieving families have a private quiet space. They also told us as
families could want to spend extended periods with the relative that has passed away the room
would be equipped with a cooling blanket to start the cooling process to preserve evidence of the
cause of death.
The service had comfort boxes for the relatives of those in the last days of life. These boxes included items such as; lip balm, a bag to keep a lock of hair, and forget me not seeds for planting as an act to remember their loved ones. These also contained information leaflets about coping with dying, the chaplaincy service and organ donation.

The critical care team held six monthly memorial services for the friends and family of those that had died in the critical care department. The chaplaincy service also ran six monthly memorial services for the friends and family of anyone that had died at the conquest hospital. The chaplain told us the relatives appeared to value these.

The end of life care team worked closely with service in the community. The palliative care team had a close working relationship with the local hospice as this provided out of hours cover to the trust for end of life care support. We saw records that showed this relationship was working well to also facilitate efficient unexpected discharges to the hospice. The chaplain told us they had a list of faith leaders from other religions that were available to support people of those faiths. Staff told us they can also contact these faith leaders via the switchboard.

We saw the wall outside the mortuary entrance area for collecting the deceased patients was in a state of disrepair. Staff reported they were concerned this could negatively affect the relative’s impression of how their loved ones had been looked after while within the mortuary.

We saw outside the mortuary there was a parking area for funeral directors to collect patients from the mortuary. Staff told us that this did have a “no parking” sign painted on the ground, but this has worn off which has meant people now park there and sometimes cause obstructions. The mortuary staff were concerned about the dignity of the patients being collected if other people were using this area to park.

**Meeting people’s individual needs**

Services were tailored to meet the needs of individual people and were delivered in a way to ensure maximum flexibility and choice. The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people’s needs. The service was inclusive and took account of patients’ preferences. Staff made reasonable adjustments to help patients access services. They reliably and consistently coordinated care with other services and providers.

Patients were supported to meet their needs through a holistic approach that incorporated spiritual, psychological and social needs as well as the physical care needs at the end of life. We looked at nine patient records of which four had completed last days of life care plans. This was in line with National Institute for Health and Care Excellence (NICE) quality standard 13, statement five. Four of the other records we looked at, the patients were not in the last days of life so had not been placed on the care plan. The one remaining record was for someone that had died suddenly in the intensive care unit, so staff had not had time to complete the care plan.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us there was not a high demand for languages other than English, but some leaflets were available on the trust internet in other languages.

Managers made sure staff, patients, loved ones and carers could get help from interpreters when needed. Staff told us when needed they had access to a telephone interpreting service, however none of the staff we spoke to could recall a time when they had needed to use this service.

The service considered the spiritual needs of their patients. The chaplaincy service ran a religious
service on a Sunday and Thursday. The chapel had been designed to accommodate hospital beds so patients that could not move out of bed could still attend the services. Staff told us they had had difficulties to get patients to the Sunday service as there are fewer staff over the weekend, so the chaplain decided to run a service on a Thursday as well. They also recorded the Sunday service which was then played on hospital radio so patients that could not come to the chapel for the service could still be involved.

The chaplaincy service had a chaplain, two assistant chaplains and about 70 volunteers. This team visited the end of life care patients and all wards each day to support people in religious needs but also emotional needs.

Patients at the end of life were supported to make choices about their care. We saw evidence of advance care planning conversations recorded in patient’s notes. This included discussions around cardiopulmonary resuscitation, preferred place of care, ceilings of treatment and care after death. The trust was using the recommended summary plan for emergency care and treatment (ReSPECT), an alternative process for discussing, making, and recording recommendations about future emergency care and treatment, including cardiopulmonary resuscitation. Staff told us they were using the proactive elderly advance care (PEACE) documents in partnership with the local hospice and community end of life care team. These were more detailed plans of what the patient would want to happen given different circumstances, such as if they wanted to die at home then they may consider situations that may result in them being admitted to hospital and make an advanced decision that they do not want to go to hospital.

The service was aware of the cultural needs of deceased patients and their relatives and processes and procedures were in place to support them. For example, rapid release of the deceased was facilitated where possible, so families could meet their faith needs in accordance with the trust’s legal obligations. When we spoke with staff they told us they were aware of cultural differences that arise and how they had to adapt communication styles to make sure the service provided the right support to people. Staff told us about how they had supported a patient with Islamic beliefs and their family. They had organised for the family to be involved in the preparation of the patient after death and for the mortuary and undertaker to be ready to allow for a burial within the time limitations in line with their beliefs.

Guidance literature was available for patients and their relatives. This included a booklet about the end of life care and what they might expect to happen. The service supported family’s choice in collection of the deceased. The bereavement office had information about how to organise this. Staff told us some relatives wanted to organise a funeral without a funeral director and they told us they had supported families that had chosen this option.

If a deceased patient had no known next of kin, the trust had a procedure to follow. Staff we spoke with in the mortuary and the bereavement office were aware of the procedure, this included who to contact, and additional checks needed to try and locate a next of kin.

The mortuary had 91 spaces to accommodate patients. All the fridges they had were larger than the standard size requirements to allow larger patients to be accommodated and for patients these fridges were insufficient for they also had five larger spaces for patients up to 35 stone. For patients above 35 stone they had two much larger fridges for these patients. They had also had five spaces set up for long term storage that were set to a freezing temperature.

**Access and flow**
Patients could access the specialist palliative care service when they needed it and had access to services in a way and at a time that met their needs. There were arrangements that ensured specialist advice was available at all times. It was easy for staff to refer patients to specialist palliative care services and barriers to referral had been removed. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

The supportive and palliative care team were able to take a patient onto their caseload with just one call to their service. The team had two categories of referral to the service. They were priority one and priority two. Priority one would mean they sent one of the team to see the patient on the same day. Priority two patients would be seen within 24 hours. The trust set a target of seeing 95% of priority one patients within those timeframes. Between November 2018 and August 2019 (the most recent month for which data was provided) the service met the target in four of the months. In the six months it did not meet the target the team achieved 90% in January 2019, 94% in March 2019, 94% in May 2019, 94% in June 2019, 94% in July 2019 and 84% in August 2019.

The target for priority two referrals was 90%. In the same period, this was achieved in six of the 10 months. January 2019 the team saw 85% within the target timeframe, in March 2019 it was 82%, May 2019 81% and August 2019, 85%. In this period, the service responded to a total 1,341 referrals across both of the acute hospitals.

Managers and staff worked to make sure patients had rapid access to palliative care when needed. The palliative care team took referrals via telephone that was answered by a dedicated nurse to triage the urgency of response needed. All staff we talked to told us when they needed support from the palliative care team all they had to do was call them. One member of ward staff said at most they would wait 24 hours but said mostly support was much quicker. We saw in the records we looked at the palliative care team would visit patients’ multiple times each day when needed.

The service did not have criteria for palliative care support instead responding to all calls for support and then assessing the level of input needed in collaboration with ward staff. Staff told us when they phoned the palliative care team for advice and support this was always readily given. Palliative care staff told us not having a written set of criteria for referrals was working well for them and they found the work load manageable.

Staff worked to make rapid discharges including those to the hospice happen quickly. The service was able to discharge patients to the hospice within 24 hours; also, staff told us about a patient that had been discharged to the hospice at the weekend. Staff told us the wards would help patients to be rapidly discharged from hospital wards, so they were able to die in a place according to their wishes where possible. The wards worked with district nurses and families to provide end of life support after discharge.

Staff at the trust worked together to get as many patients to their preferred place to spend their last days of life. We looked at the audit of the trusts fast track referrals for August 2019. Fast track referrals are made for patients that are in the last months of life to allow for support to be arranged quickly. In that month the service received 37 referrals and 22 patients were discharged successfully, with six patients dying before discharge was able to be arranged, four patients were discounted from the fast track system, and the remaining four patients the decision was made that care on a hospital ward was more suitable for them.

**Learning from complaints and concerns**
It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service if possible included patients in the investigation of their complaint. Feedback and learning from complaints were always considered, shared with the wider team and used to make improvements.

The trust had a process for handing complaints and concerns. Patients could make a complaint in four ways, face to face, via the telephone, by email or by letter. The trust had a policy for the management of complaints and in line with this policy patients were advised to contact the trust’s patients’ advisor liaison service but also were told they could also contact the chief executive by post.

The end of life care team received a report from the complaints team regarding any complaints that related solely to the provision of end of life care or if they contain an element that links to the care provided at the end of a patient’s life. The senior nurse from the palliative care support team oversaw the investigation of all complaints. The outcomes of all investigation were fed back to the end of life care improvement group to review.

The service clearly displayed information about how to raise a concern in patient areas. Bereavement staff told us they give relatives a survey card that they can complete with any complaints they want to give. We also saw in this office leaflets displayed giving advice on what to do if they were not happy with the care that had been given to their relative.

Staff understood the policy on complaints and knew how to handle them. The two staff we spoke with about complaints could describe the policy and how they would support patients or relatives to make complaints.

Staff could give examples of how they used patient feedback to improve daily practice. Staff in the bereavement office told us they had feedback that their relatives survey was too long and not well laid out. The service made their survey shorter and simpler for relatives to complete. A manager told us they had seen an increase in the completion and return rate after they made this change.

Managers investigated complaints and patients received feedback from managers after the investigation into their complaint. We looked at four complaints and these all had detailed investigations that included the complainant’s views and the patients consent to disclosure of personal information. We also saw the service gave a prompt response within the timeframe of the trusts policy. Within these responses we saw the trust advised what they had done to reduce the risk of reoccurrence and what to do if the complainant is not satisfied with the response. We also saw in one response advice about additional ongoing support for the complainant.

Managers shared feedback from complaints with staff and learning was used to improve the service. In one of the complaints we looked at there was a record saying that the manager investigating had supported the staff involved with additional training and reflection.

Summary of complaints

Trust level

The trust supplied complaints data, however, none of it was applicable for end of life care.  
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Data we looked at after the inspection showed that from August 2018 to July 2019 the trust had eight complaints that related to end of life care across the trust. This included complaints that
related to the Conquest hospital and Eastbourne hospital.

**Number of compliments made to the trust**

The trust supplied compliments data, however, none of it was applicable for end of life care.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

While on inspection we looked at seven compliments so although the trust did not submit this data the service was receiving compliments. Themes included staff being compassionate and providing effective support to relatives.

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**Is the service well-led?**

**Leadership**

Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

A palliative care consultant and a senior palliative care nurse led the end of life care service. Staff we spoke with across all areas of the hospital that were involved with the provision of end of life care told us the leaders of the service were visible and would involve all staff in what was happening in the service. They also spoke of how the service had transformed in the last two to three years since there had been a shift in emphasis towards good end of life care. Staff told us there had been a recent change in the leadership team and this had improved their visibility and accessibility.

Staff told us clinical leaders operated an open-door policy and they could discuss concerns. The palliative care team worked closely with other service providers and had a good understanding of the priorities for the service and the challenges faced. The palliative care team reported to the deputy director of nursing.

Staff across the whole end of life care core service told us they felt supported by their leaders to develop their skills. Staff in the mortuary told us they had been supported to develop their teaching skills by their managers facilitating opportunities for them to do education sessions about the mortuary for the wards. They also did education tours of the mortuary for staff from other departments in the hospital.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. These were aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The supportive and palliative care team’s vision was for end of life care to become everyone’s business. The services strategy statement was “one change to get it right”. Staff we spoke to all
knew this statement and were able to describe how this applied to getting the death of each and every patient right. Staff also acknowledged that what “right” was varied for each patient.

The services current vision and strategy was based on the five national principles set out by the Leadership Alliance for the Care of Dying People. These priorities were:

1. Recognising those people that may die within the next few days or hours.
2. Communicating with those that are dying and those close to them in a clear and sensitive way.
3. Involving the person dying in planning there care as much as the wish to.
4. Supporting the needs of family and others that are important to the person that is dying.
5. Plan and do. Complete a personised care plan and carry this out.

Staff we spoke with were aware of these five principles. We saw in the patient records we looked at that personalised care plans had been created in line with the patients identified needs. These records were recorded on the services last days of life personalised care plan which included covering needs such as; nutrition, hydration, spiritual, social, psychological, symptom management, preferred place of death and support needs of the family. This showed us patients and families had experienced the benefits of these principles.

We saw that on each department and ward we visited there was an end of life care notice board which displayed the services current vision and strategy. The service worked closely with their link nurse from each ward and with the wider community teams and the local hospices.

The trust wide strategy included end of life care. This noted that they aimed to improve definitions of end of life care and adopt these. At the time of the inspection, the end of life care service did not have any performance data displayed on the overall trust performance dashboard. However, the leaders of the service anticipated they would be able to get some measure of their performance incorporated into the trust dashboard at some point in the future.

Culture

There was a strong culture that was centred on the needs of patients at the end of their life. Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values to deliver high quality person-centred care. The service provided opportunities for career development and staff could raise concerns without fear. Staff are proud of the organisation as a place to work and spoke highly of the culture.

Across all areas we visited staff told us they were committed and passionate about providing high quality end of life care to their patients. They reported feeling proud to work for the trust and were positive about the job they did.

There was a culture of collective responsibility between teams and services. Staff told us end of life care was considered a priority for them and the trust. All staff we spoke with told us they felt part of a team and felt they worked well together and supported each other. They also reported the supportive and palliative care team were always willing to give them extra support. Ward staff also told us the palliative care link nurses also supported them.

The leaders of the end of life service told us how they were proud of how cohesive the supportive palliative care team had become and how proud they were of what the ward staff did, through the
work of the link nurses and healthcare assistants. They believed this had led to an improvement to
the care provided at the end of life.

All staff we asked told us they would feel confident in reporting any incidents and told us how they
would report incidents using the trust’s intranet. Staff that had experienced incidents had told us
they had reported these and had been supported with these reports by their managers.

Openness and honesty were encouraged at all levels of the trust and staff felt able to report
incidents and raise concerns. Staff we spoke with had not been involved in incidents that would
have led to responsibilities to implement duty of candour but had an awareness of the policy and
where to find it. Duty of candour requires providers of health and social care services to notify
patients (or other relevant person) of ‘certain notifiable safety incidents’ and provide reasonable
support to that person. Patients and their families were told when they were affected by an event
where something unexpected or unintentional had happened.

**Governance**

Leaders *operated effective governance processes, throughout the service and with
partner organisations. Staff at all levels were clear about their roles and accountabilities
and had regular opportunities to meet, discuss and learn from the performance of the
service.*

The end of life care service was jointly represented on the trust board by the director of nursing
and the medical director. There was a non-executive director on the trust board that had
responsibility for end of life care.

The end of life care governance system had nine workstreams that feed into the end of life care
improvement group. This improvement group then reports to the trust’s clinical outcomes group
which in turn reports to the quality and safety committee. This committee then conveys information
onto the trust’s board.

We looked at the minutes of a supportive and palliative care governance and team meeting which
showed they had discussed there plans to start a seven-day service from the beginning of the year
2020. This also included details on new recruitments and barriers that were still to be overcome.
We then looked at the minutes of the following end of life care improvement group which showed
this information had been passed on to this group to keep them updated. At this meeting there are
trust hospital and from the local community end of life services.

**Management of risk, issues and performance**

Leaders *and teams used systems to manage performance. They identified relevant risks
and issues and identified actions to reduce their impact however did not always keep
records of these updated. However, the service did not have plans to cope with
unexpected events.*

The service had started to conduct an audit of the completion of ReSPECT forms. This was
carried out by a consultant anaesthetist. This had highlighted concerns around the quality of
information being provided at the time of discharge. At the time of the inspection the supportive
palliative care team were about to start a project to work on the quality component and conduct
further audits into the practices that took place at the time of discharge.

The end of life care service had its own risk register that fed into the wider trust risk register and
was reviewed at board level. We saw the risk register showed that the risks were identified, given a risk scoring which fed into a rating. There were five entries on the risk register that we were shown. Four of the risk were rated as high, and one was rated as extreme. These were all related to clinical matters however, when we spoke with the service leads, they also identified that recruitment, staff wellbeing and accommodation were all risks to the end of life care service. However, these were not recorded on the risk register. Staff we spoke with were aware of local risks present in their service and were also aware of the financial position of the trust.

The service had started an audit of their last days of life personalised care plans, but this had only been started three months before the inspection so did not have enough data points to establish trends yet. This new audit had been restarted because the service had implemented a new version of their last days of life personalised care plans. They had taken feedback from previous audits, staff, relatives and patients to make improvements to their care plan document.

The mortuary service had a major incident plan specific to the mortuary area. However, this plan had only recently been produced by a team responsible for emergency preparedness, response and resilience. Staff we spoke with were not aware of the content of this new major incident plan. A review of the trust's major incident plan did not specifically mention the mortuary services.

**Information management**

The service collected a wide range of reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The end of life care team collected data and submitted this to the National Audit of Care at the End of Life. The national audit was used by the service to ensure the service improved patient care in line with national guidance, patterns of incidents and clinical data outcomes.

The trust collected, analysed, managed and used information well to support all its activities. The hospital shared information with the local hospice through an electronic portal. This allowed the hospice to see the hospital’s notes on the patients and the hospice could also see the patient’s hospital notes. The service had secure electronic systems with security safeguards including individual usernames and passwords for each member of staff. The service had a dashboard that they used to track trends and monitor their performance against their targets. This included the monthly totals of patients seen within their target timeframe. This also included information on total numbers of; incidents reported, relatives surveys sent and returned, along with information from the mortuary and the community end of life care service.

Staff were aware of how to use and store confidential information. Patient confidentiality arrangements were in place, for example, on all the wards we inspected we saw medical records were stored in a locked trolley or kept in an area where staff were able to observe who was accessing these records. Staff on all ward we visited checked our identity cards before allowing us access to patient records.

**Engagement**

Leaders and staff use innovative approaches to gather feedback from people who use services and the public, including patients with a diverse range of needs. This was then used to plan and manage services. They collaborated with partner organisations to help
improve services for patients. There were consistently high levels of constructive engagement with staff.

The service leads had been working with local general practitioners to promote the use of the ReSPECT form for those patients with long term conditions that may be approaching the end of their life. The service leads told us this had led to an improvement not just in the numbers that were being completed but also in the quality of the information being provided.

The service produced a staff newsletter to keep staff up to date with projects and changes within the end of life care service. We looked at the September edition that included information about recent audit results, the updated last days of life personalised care plans, recommended learning opportunities, and a local palliative community support group. This newsletter was used to share stories of good practice from across the service. This included a short description of how the staff of Benson Ward helped facilitate a transfer so that the patient could be with his wife for his final hours, his wife also being an inpatient at the time.

The service conducted surveys with bereaved families and friends regarding the care that they and their loved ones received. Between May and October 2019, the service gave bereaved families and friends a questionnaire when they met the bereavement officers to collect the Medical Certificate of Cause of Death, property and all information they needed following the death of the patient.

Two-hundred questionnaires were given to the bereaved and 43 were received back. The response rate for the period was 21.5%. The service was managed as one service across both the trusts sites, so the information was produced at trust level. This means the information below reflects the service at both the Eastbourne District General Hospital and the Conquest Hospital.

Results

Some respondents did not complete all questions, therefore there is a percentage deficit in some of the following results:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you given the opportunity to speak with nursing or medical staff about any concerns you may have had?</td>
<td>84%</td>
<td>8%</td>
</tr>
<tr>
<td>Did a member of staff tell you that your relative/friend was coming to the end of their life?</td>
<td>84%</td>
<td>12%</td>
</tr>
<tr>
<td>If yes, did you feel you had enough privacy when you were told?</td>
<td>80%</td>
<td>12%</td>
</tr>
<tr>
<td>Did staff discuss with you where your relative/friend wished to be cared for in their last days?</td>
<td>60%</td>
<td>32%</td>
</tr>
<tr>
<td>Did you feel the personal wishes of your relative/friend were respected by those caring for them?</td>
<td>88%</td>
<td>0%</td>
</tr>
<tr>
<td>Did you feel that the religious/spiritual beliefs were taken into consideration by those caring for your relative/friend?</td>
<td>96%</td>
<td>4%</td>
</tr>
<tr>
<td>Question</td>
<td>Percentage</td>
<td>12%</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Did you feel that you were involved in the decisions made about the care of your relative/friend?</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Did you feel that the hospital was the right place for your relative/friend to spend their last days?</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Your relative/friend had a personalised care plan focusing on their care. Did you feel that every element of the plan was met?</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>How much support did the ward and medical staff provide for you?</td>
<td>Less than needed</td>
<td>12%</td>
</tr>
<tr>
<td>Were you offered support from the Chaplaincy and Pastoral Care Service?</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Were you given the ‘Guidance Following Bereavement’ booklet by the ward staff following the death of your relative/friend</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>If no, were you given advice about the Bereavement Office?</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>If you accessed the Bereavement Office, how would you rate your experience?</td>
<td>Poor</td>
<td>0%</td>
</tr>
<tr>
<td>Overall, how do you rate the staff on the following points of care:</td>
<td>Communication</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Emotional support</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Respect and dignity</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Learning, continuous improvement and innovation**

The leadership team drove continuous improvement. Staff were committed to continually learning and improving services. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service leads told us how the previous CQC report into the end of life care service had given them the impetus needed to look at the whole service again and rebuild the culture. It brought end of life care to the attention of the trust. They changed the palliative care team to be known as a supportive team rather than a specialist team to make the work they did more open to everyone to get involved with. They explained that they no longer look back on the report now but that it did inform their work plan.

The service was looking to move to a seven-day service from the early part of 2020. The
recruitment process to appoint a second whole time equivalent to the team was well advanced and they expected an appointment in the new year. Once this appointment had been made, the service planned to increase the education provision to all areas, ultimately leading to divisions and wards being more pro-active in the provision of end of life care and auditing their own work in this area.

Staff told us they were supported to try new ideas. Staff told us about an innovation from a nurse in the intensive care unit to introduce comfort boxes. This initiative was supported by the chaplaincy team and together they created the comfort boxes that included a few items to comfort relatives of patients in their last days of life.

Staff from the bereavement team told us they had noticed that not many relatives were completing the feedback survey they gave them. Managers supported them to change the form in response to relatives’ comments about the form being too long. The team had now produced a new survey that is smaller and has multiple choice questions with some spaces for comments. Managers told us they had been auditing the return rate which has increased since they changed the form. Staff were also aware the change had been received well by relatives.
East Sussex Healthcare NHS Trust provides outpatients services at Eastbourne District General Hospital, Conquest Hospital, Bexhill Hospital, Uckfield Hospital, and a wide range of community-based clinics. Outpatient administration is provided through a centralised clinical administration team (CAT) who lead on bookings, health records and clinical correspondence. The trust provides clinical and nursing services through a range of specialties and divisions.

The trust launched an outpatient transformation programme in 2019 to respond to the needs of patients, increasing demands on capacity and digital opportunities, in line with the long-term NHS plan.

Musculoskeletal (MSK) services are provided through two different organisations in the east and west of the county. The trust provides outpatient care for MSK patients in both pathways as well as directly managing outpatient therapy services.

The trust had 417,579 attended first and follow up outpatient appointments from March 2018 to February 2019. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

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 March 2018 to February 2019.
<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne District General Hospital</td>
<td>211,809</td>
</tr>
<tr>
<td>Conquest Hospital</td>
<td>172,169</td>
</tr>
<tr>
<td>East Sussex Healthcare NHS Trust</td>
<td>38,148</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>26,109</td>
</tr>
<tr>
<td>Uckfield Community Hospital</td>
<td>2,675</td>
</tr>
<tr>
<td>This Trust</td>
<td>451,570</td>
</tr>
<tr>
<td>England</td>
<td>109,324,322</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage of outpatient appointments at East Sussex Healthcare NHS Trust by site and type of appointment, from March 2018 to February 2019:

(Source: Hospital Episode Statistics)

Outpatient services at Conquest Hospital are located throughout the site, with the main outpatient department located close to the entrance to the hospital. Other specialist clinics are situated within different areas of the main hospital.

The hospital provides outpatient services covering a range of specialities including but not limited to: medicine, cardiology, respiratory, oncology, rheumatology, diabetes, endocrinology, ophthalmology, ear, nose and throat (ENT) and dental. There is an orthopaedic outpatient and fracture clinic.

The service provides both consultant and nurse led outpatient clinics across a range of specialities. Outpatient clinics are held between 9am and 6pm with some clinics running later up to 8pm during the week and on a Saturday dependent on need and speciality.

During this inspection we visited the main general department, medical outpatients, the diabetic and endocrinology centre, the orthopaedic and fracture clinic and the outpatient phlebotomy service.
We spoke to 14 patients, 10 relatives/carers and 28 staff including nurses; consultants; healthcare assistants; therapists; receptionists; administrative staff and directorate and service managers. We reviewed performance information about the department and the trust.

The service was previously inspected in 2016. That inspection also included diagnostic imaging services. Diagnostic imaging services are now inspected separately and have a separate report and therefore we cannot directly compare ratings. During this inspection, we only looked at services provided within outpatients.

The last inspection rated the service as requires improvement overall. On this inspection we rated the service as good overall.

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 monitored compliance to trust targets. Not all staff had completed the mandatory modules.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training, with the exception of the information governance module where the trust set a target of 95%. The trust did not provide any training data for medical staff as it does not have dedicated medical staff for outpatients.

All medical staff running clinics were assigned to different specialities within the trust and mandatory training compliance was reported within those specialities.

Trust level

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fire safety</td>
<td>54</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>52</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>52</td>
</tr>
<tr>
<td>Information governance</td>
<td>52</td>
</tr>
<tr>
<td>Infection control</td>
<td>51</td>
</tr>
<tr>
<td>Health and safety</td>
<td>50</td>
</tr>
<tr>
<td>Medicines management</td>
<td>16</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
</tr>
</tbody>
</table>
In outpatients the 90% target was met for five of the seven mandatory training modules for which qualified nursing staff were eligible. However, please note that care should be taken when interpreting the rates which may be based on small numbers.

Nursing staff had a completion rate of 94.5% for the information governance module, just lower than the trust target of 95%.

**Conquest Hospital**

Nursing staff and healthcare assistants received and kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified nursing staff in the outpatients department at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fire safety</td>
<td>29</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>29</td>
</tr>
<tr>
<td>Information governance</td>
<td>28</td>
</tr>
<tr>
<td>Basic life support, immediate life support</td>
<td>27</td>
</tr>
<tr>
<td>and resuscitation</td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>27</td>
</tr>
<tr>
<td>Infection control</td>
<td>27</td>
</tr>
<tr>
<td>Medicines management</td>
<td>7</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
</tr>
</tbody>
</table>

At Conquest Hospital outpatients department, the 90% target was met for five of the seven mandatory training modules for which qualified nursing staff were eligible. However, care should be taken when interpreting the rates which may be based on small numbers.

Nursing staff met the 95% trust target for the information governance module.

The mandatory training was comprehensive and met the needs of patients and staff. Training consisted of both eLearning and face-to-face teaching. Staff we spoke to told us they were given time to complete their training whilst at work.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. All departments displayed a timetable of each staff member’s training needs and there was evidence of forward planning to ensure staff completed their 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.

Safeguarding training completion rates

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

**Trust level**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>55</td>
<td>55</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>55</td>
<td>55</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>50</td>
<td>55</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>50</td>
<td>55</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

In outpatients the 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

**Conquest Hospital**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for qualified nursing staff in the outpatients department at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>29</td>
<td>29</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>29</td>
<td>29</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>25</td>
<td>29</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>25</td>
<td>29</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

At Conquest Hospital outpatients department, the 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. However, care should be taken when interpreting the rates which may be based on small numbers.

In services such as phlebotomy, which provided an outpatient service for adults and children over the age of five, we found staff were trained to level three safeguarding in line with national guidance.
Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could identify the lead for safeguarding locally and had access to a trust policy.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff gave an example of referring to the hospital safeguarding team when a patient gave some concerning information about their home arrangements.

Notices were displayed across all areas informing staff how to raise and escalate a safeguarding concern. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

Staff had access to infection control policies on the intranet. The service generally performed well in cleanliness audits. The main outpatient areas and the orthopaedic clinic including orthopaedics and fracture clinic were clean and tidy. However, in the medical outpatient’s waiting area there was a carpeted waiting room. The carpet was visibly stained and presented an infection risk.

All consulting and treatment rooms were in line with Hospital Building Note (HBN 00-09) Infection control in the built environment. The flooring in all clinical areas was seamless, smooth, slip resistant and easily cleaned in line with HBN 00-10 Part A (flooring).

We observed staff following national guidance on infection control. All staff were ‘bare below the elbows’ at all times to enable effective hand hygiene and minimise the risk of contamination.

We observed staff followed National Institute of Health and Care Excellence (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.

Alcohol hand sanitiser was at the entrance and throughout the departments and staff and visitors were observed using it. Posters were displayed informing staff and visitors of the importance of good hand hygiene. The service completed hand hygiene audits and in general outpatients the results were 100%.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was adequate supplies of PPE in all areas.

We observed disposable curtains in treatment areas had been changed in the last six months in line with trust policy. Chairs in the waiting rooms of all areas were made from a material that could be easily cleaned. This meant that the spread of infection would be reduced.

Staff understood precautions to be taken if seeing patients with suspected communicable diseases. For patients undergoing minor procedures cases would be put to the end of the list followed by a thorough cleaning regime. In the fracture clinic staff had a separate single room available if required.

There were cleaning policies for staff to follow. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Records were kept of daily clinic room cleaning and safety checks. All outpatient areas had cleaning audits displayed and consistently scored above the 95% standard. However, in the diabetic and endocrinology centre the last six
months averaged a score of 90% for housekeeping; below the department target of 95%. There were actions in place to address this.

Decontamination of instruments took place on site in the central sterilisation department. When a clinic using scopes was in progress, clean pre-packed scopes were delivered to the department in a designated clean trolley. This was kept separate from a second trolley that stored scopes after they had been used and before they were returned for cleaning. Staff were able to explain the process and were following the Department of Health Technical Memorandum on decontamination. There was a process for identification and monitoring of all instruments used in each patient procedure which was recorded in patient record.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

All outpatient areas were tidy, corridors were kept clear and there were no trip hazards observed on floors or walkways.

However, in the main general department there was no designated area for patients on stretchers to wait. Staff told us they try to see these patients as soon as they arrive in the clinic to ease any congestion. The orthopaedic clinic had designated one room as a waiting area for stretcher patients.

The service had suitable facilities to meet the needs of patients’ families. There were areas within the departments where patients could be taken if a quiet room was required to have a confidential conversation.

Staff told us they had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were available in all areas of the outpatient department and in all outpatient clinics throughout the hospital. The trolleys included tamper resistant seals on each of the drawers for additional security while ensuring that the emergency medicines and equipment were easily accessible to staff.

Emergency equipment and medicines stored on the resuscitation trolleys were subject to regular checks. This included daily checks to ensure that the seals were secure. Weekly checks of the trolleys included expiry dates of medicines and a detailed check of all equipment and single use items that may be required in a medical emergency.

We checked three resuscitation trolleys; one in general outpatients and two in cardiology. In other clinic areas such as ENT, orthopaedics and in the phlebotomy clinic there were grab bags located with adult and paediatric resuscitation equipment. Regular checks of the equipment were recorded.

Medical devices maintenance was carried out by the in-house Electronic and Medical Engineering (EME) team. Medical devices were risk rated and subject to regular safety and maintenance checks that reflected equipment needs and requirement. During the inspection we checked 18 pieces of equipment in the outpatient departments and found that all had evidence of safety checks and identification recorded on them. Outpatient staff described the process for dealing with equipment that needed repair or checking and described the EME team as responsive and efficient.

In the ophthalmology clinic area where there were two lasers there was a security lock on the door to ensure no staff entered when the laser was in use. One member of staff was trained as the laser supervisor. An external laser advisor provided support and audited the service. Local rules were in
place and signed. Personal protective equipment including goggles were available for staff using this equipment.

The dental clinic area had signage above the X-ray room indicating to staff when not to enter the room due to X-rays being taken.

In the ophthalmology clinic we reviewed the Control of Substances Hazardous to Health (COSHH) and noted the utility room where these substances were stored to be secure. Staff checked that security was maintained and these checks were complete.

Waste was seen to be handled appropriately with separate colour coded systems for clinical waste, general waste and sharps bins. Waste bins were not over filled, and sharps bins were correctly labelled and signed.

In the main outpatient department, the health and safety board was up-to-date with names of representatives, latest guidance and a record of first aiders in the department.

Quality walks around the departments took place six monthly and enabled staff to review changes that were needed to the environment to improve the patient experience.

Assessing and responding to patient risk

Staff completed patient risk assessments and removed or minimised risks. Staff responded promptly to any sudden deterioration in a patient’s health.

All outpatient areas had emergency call bells in clinic and treatment rooms and staff knew how to summon emergency help if needed. All staff were trained to recognise patients with deteriorating health. We observed staff monitoring the waiting areas on a regular basis to identify patients who were unwell or needed particular help.

Staff had access to the National Early Warning Scores (NEWS) tool to monitor the patient and to identify patients at risk of unexpected deterioration, in line with National Institute for Health and Care Excellence (NICE) Guidance. The department had sepsis tools and protocols and staff knew how to make urgent referrals if patients became clinically unwell or required hospital admission.

Staff knew about, and dealt with, any specific risk issues and reported them appropriately. We were given examples and staff knew how to get support in the case of any aggressive or violent incident. The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental wellbeing.

The main outpatient department held daily staff meetings, giving staff an opportunity to discuss any incidents and concerns in the department. Staff were encouraged to participate and contribute any safety issues. Notes were made of the meeting, which staff not on duty at the time could refer to.

Staff working in areas where minor procedures were carried out used the World Health Organisation (WHO) five steps to safer surgery checklist. The checklist was designed as a safety measure to ensure patient safety. The checklist was audited monthly and showed 100% compliance by staff.

Certain clinics including ophthalmology had a number of children attending. Other clinics had children accompanying adult patients, staff had access to a registered children’s nurse at all times for advice and support. There were arrangements were to summon emergency support if needed.
Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Trust level

The table below shows a summary of the nursing staffing metrics in outpatients at trust level compared to the trust targets, where applicable:

<table>
<thead>
<tr>
<th>Outpatients annual staffing metrics</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff group</strong></td>
<td><strong>Annual average</strong></td>
</tr>
<tr>
<td></td>
<td>establishment</td>
</tr>
<tr>
<td>Target</td>
<td>8.0%</td>
</tr>
<tr>
<td>All staff</td>
<td>193.5</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>56.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

Vacancy rates
Monthly vacancy rates over the last 12 months for qualified nurses showed a downward trend from August 2018 to December 2018. This could be an early indicator of improvement.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Conquest Hospital

The table below shows a summary of the nursing staffing metrics in outpatients at Conquest Hospital.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>110.5</td>
<td>4.8%</td>
<td>10.2%</td>
<td>6.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>27.4</td>
<td>10.5%</td>
<td>4.2%</td>
<td>4.4%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within outpatients at Conquest Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

Sickness rates

![Sickness rate - qualified nurses graph]
Monthly sickness rates over the last 12 months for qualified nurses showed a downward trend from October 2018 to February 2019. This could be an early indicator of improvement. On inspection this was discussed with managers and had improved further to 4%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

The service had enough nursing and support staff to keep patients safe. There was little use of bank and no use of agency staff in the outpatient department as managers were able to cover any absence or sickness with their own contracted staff. Some nursing staff worked across both Conquest and Bexhill hospital.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants. Rotas were planned a month in advance. The number of nurses and healthcare assistants matched the planned numbers. In all outpatient departments quality and safety board’s were completed with up-to-date information about planned and actual staffing levels which showed no shortfall in staffing numbers. Staff told us they were satisfied with staffing levels.

The service had low and reducing vacancy rates. Clinics managed by the medical directorate were staffed to establishment. The ophthalmology clinic area used some regular bank staff but had no need to use agency.

Medical staffing

There were no dedicated medical staff within outpatients. Medical staffing was provided by the specialties responsible for delivering the clinics. Consultants staffed their own clinics and did not report to the outpatients department.

Allied health professional staffing

Trust level

The table below shows a summary of the allied health professional staffing metrics in outpatients at trust level compared to the trust targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>193.5</td>
<td>8.6%</td>
<td>10.5%</td>
<td>6.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>13.7</td>
<td>-21%</td>
<td>13%</td>
<td>2.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Allied health professionals had an annual vacancy rate of -21%, indicating that the service was overstaffed.

Allied health professional staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

**Sickness rates**

Monthly sickness rates over the last 12 months for allied health professionals showed a shift from February 2019 to July 2019. This could be an indicator of change.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Conquest Hospital**

The table below shows a summary of the allied health professional staffing metrics in outpatients at Conquest Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>110.5</td>
<td>4.8%</td>
<td>10.2%</td>
<td>6.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>4.5</td>
<td>-124%</td>
<td>0.0%</td>
<td>2.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Allied health professional at Conquest Hospital had an annual vacancy rate of -124%, indicating that the service was overstaffed. The trust had an average whole time equivalent (WTE) staff establishment of five from August 2018 to July 2019. However, from January to July 2019 the number of substantive WTE staff increased to an average of 13.

Allied health professional staffing rates within outpatients at Conquest Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and sickness.

Vacancy rates

Monthly vacancy rates over the last 12 months for allied health professionals showed a shift from February 2019 to July 2019. This could be an indicator of change.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The percentage of patients seen in outpatients without their full medical record being available, in the last six months up until October 2019 was 0.19%. The most common reason for this were late additions to clinics with less than 24hrs notice, the hospital mitigated this by the increasing availability of digital records.

In clinics, notes prepared each day for patients were stored securely. In ophthalmology a pack was prepared for medical staff including an outcome sheet for doctors to record their findings. Patient records were written at the time of consultation. These records were legible, dated, signed and easy to navigate.

As notes were prepared for the orthopaedic and fracture clinic we saw these were secured in a keypad locked hub area. In other areas hard copies of patient records were stored securely in locked trolleys.

The trust had an electronic storage and tracking system for patient records. Staff told us the system was easy to use and all clinic notes were scanned onto the system within 48 hours. Electronic patient records were password protected.
We were told that GP letter were typed off site and returned for signing and 75% were sent out within seven days. This was monitored, and there were plans to improve this to 100% sent out within five days.

Patient records included multidisciplinary team plans and referrals.

A register recording minor procedures was completed and kept securely in the minor procedure room. The room was secured with a keypad lock. In the plaster room a similar record of procedures was completed and stored securely.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff provided specific advice to patients and carers about their medicines. One patient told us that they were well informed of the benefits and side effects of a new medication. The patient had been struggling on a particular medication with side effects. After moving to a new medication, the patient felt a positive impact and felt the staff had fully involved them in the decision.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. In all outpatient areas we found staff kept medicines secure. There were records of staff checking expiry dates of medicines and stock levels.

Staff prescribed medicines using FP10 prescription forms. These were stored securely, and staff kept a record of serial numbers of prescriptions issued which indicated the system was secure. Any prescriptions unaccounted for were recorded as an incident and investigated. Staff could only recall this happening once.

In the ENT and ophthalmic clinic areas medicine fridge temperatures were checked daily and there was an electronic and paper record of this. Staff knew what action to take when temperatures were outside the required range.

Minor procedure rooms were secured with a keypad lock. All medicines in these rooms were secure at the time of the inspection and stock levels were kept to a minimum. Emergency medicines were stored securely. The outpatient departments did not keep any controlled medicines.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Staff knew what incidents to report and how to report them using the electronic reporting system. All staff had access to computer terminals and had training on how to report incidents.

The service had systems to ensure staff knew about safety alerts and incidents. All alerts were discussed at governance and quality meetings and if relevant to the department these were discussed at daily huddle meetings.
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 July 2018 to August 2019, the trust reported one never event for outpatients.

The incident, a surgical invasive incident which met serious incident (SI) criteria, took place in October 2018 at Conquest Hospital. A patient was undergoing a removal of a lesion. When stitching up the wound the needle came away from the thread. After an x-ray one week later, the needle was seen.

(Source: Strategic Executive Information System (STEIS))

The root cause analysis investigation into this incident demonstrated an investigation in line with trust policy. A completed action plan showed the learning from this incident and how this was shared with staff across the trust. The duty of candour was completed.

One action following the incident was the development of a procedure WHO safe surgery checklist for minor procedures. This was in use on the day of inspection.

Managers shared learning with their staff about never events that happened elsewhere in the trust.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from July 2018 to August 2019. A breakdown of incidents by incident type is shown in the table below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))
Staff understood the duty of candour, were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers investigated incidents thoroughly. Managers debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service. This was organised by division. The medical division newsletter showed slips, trips and falls to be the most common incident in September 2019 across the division and included learning for all staff.

Staff met to discuss the feedback and look at improvements to patient care. Team meeting minutes showed that staff discussed incidents and learning, and the minutes were kept available in the staff room for all staff to refer to. A trust notice called ‘safety pin’ was also displayed for staff with information on incidents with two headings, what happened and what did we learn from this. Managers used the huddle meeting in the morning to discuss with staff any incidents and actions taken.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis to department teams to monitor their performance in delivering harm free care. Patient safety thermometer data shows new pressure ulcers, falls with harm and new catheter urinary tract infections. There was no patient safety data on display in the outpatient department, but this would be reported under each divisional structure.

The quality and safety boards in the departments did show the planned and actual staffing for the day and any falls and incidents would be reported through the incident reporting system.

**Is the service effective?**

We inspected but did not rate effective as we do not currently collect sufficient evidence to rate this. We found the following.

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies referenced relevant guidance and relevant National Institute for Health and Care Excellence (NICE) guidelines was managed across the trust and the clinical divisions.

Staff in the outpatient department participated in external audits. Audits were developed against the quality standards and clinical guidelines from the relevant guiding body, for example The National Institute for Health and Care Excellence (NICE).

Most audits were the responsibility of the speciality that oversaw that condition, for example the Diabetic and Endocrine centre was overseen by the medicine division, with some of the pathway occurring in outpatients. Research, audit and staff involvement in this was displayed within the department.
There was a board with information about a scheme where children and adults with newly diagnosed TYPE 1 diabetes could enter a register and be forwarded to clinical trials pioneering new treatments. The nurse specialist said that they only referred patients to trials if they are fully consenting to the scheme and outcomes would be audited.

The respiratory service participated in the chronic obstructive pulmonary disease and national pulmonary rehabilitation audit.

Other audits with outpatient contribution included the Getting It Right First Time (GIRFT) Audit which was part of the outpatient transformation plan.

**Nutrition and hydration**

All outpatient areas had access to vending machines which contained drinks and snacks. Water dispensers were available, and, in some areas, there were tea and coffee making facilities. We observed staff directing and assisting patients to use these facilities.

The main outpatient department was located close to a patient café area where patients or relatives could access hot and cold food.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**

Staff told us as part of their assessment process they would check to see if patients attending outpatients department were in any discomfort. Patients undergoing procedures were asked if they were comfortable and any pain would be assessed verbally. Staff had access to pain assessment tools online if required and staff were able to demonstrate how these would be used and would be part of the patient record.

The department held a small stock of oral pain relief medication which was administered if a prescription was signed by the medical staff. This was likely to be a once only dose and a prescription would be given if further pain relief was required.

Departments undertaking surgical procedures such as the removal of minor skin lesions or procedures such as endoscopes held a stock of local anaesthetic drugs which were administered according to a signed prescription.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

**Follow-up to new rate**

From 01 March 2018 to 28 February 2019,

- The follow-up to new rate for Conquest Hospital was similar to the England average.
- The follow-up to new rate for Eastbourne District General Hospital was similar to the England average.
Outpatient services had processes to record patient outcomes after each clinic. Staff completed an outcome form; we saw this being used in the ear, nose and throat (ENT) clinic. Outcomes recorded whether further referral was required, and to which service. Any further appointments were documented and any test such as blood, scans or x-rays were also recorded as an outcome. All outcomes were reported at divisional level and across the trust and were visible on the outpatient clinical dashboard. The dashboard was still to be fully populated as part of the outpatient transformation programme across the trust. Patient outcomes were documented alongside demand, referral, response time, delivery and utilisation and patient feedback enabling local review of the service and enabling managers to monitor trends and service delivery.

The trust participated in a national benchmarking programme in 2019. Results were published in October 2019 and at the time of inspection the trust was reviewing the findings and necessary actions through three main work streams including the outpatient transformation programme, the getting it right first time programme and existing workstreams. Some actions had already been taking including revised booking procedures for follow up appointments to avoid cancellations.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff described being supported by their managers to complete relevant training.

Managers gave all new staff a full induction tailored to their role before they started work. In the phlebotomy service staff were supernumerary for six months to complete induction which comprised of supervised practice and competency based assessment.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From August 2018 to July 2019, 71.1% of staff within the outpatients department at the trust received an appraisal compared to a trust target of 90%. Eastbourne District General Hospital had the lowest overall completion rate of 67.5%. Conquest Hospital had an overall completion rate of 74.4%.
Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff had access to local and national training and this contributed to the process of revalidation. Staff told us they were well supported with time and either full or part funding of external training.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All healthcare assistants working in the outpatient departments completed the care certificate as a basic qualification. Other training and competencies were available and healthcare assistants were being developed to take on a nursing associate role.

Managers made sure staff received any specialist training for their role. In the ophthalmology department, non-medical injector clinics were supported by four trained staff and four who were in training from across the trust.

Staff completed competencies for their own specialist area. In ophthalmology these were accessible on line for orthoptists and technicians. In the phlebotomy area competencies for staff were renewed annually. In the dental clinic two members of staff were supported to complete an external course to develop their skills over a nine month period.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All departments had a list of nurses who had taken on specific responsibilities such as infection prevention and control, learning disabilities and dementia. These staff had received training and acted as a resource for other staff in the department.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were seen just outside the main department assisting and directing patients.
Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff told us that they worked together well and different specialty clinics supported each other when the department was busy. Reception staff were supported by clinical staff. We observed staff engaging with each other in a courteous and supportive way.

In specialist clinics such as respiratory services, weekly meetings were held with the hospital multi-disciplinary team. Fortnightly meetings were held with commissioning groups and with consultants across the trust to monitor the delivery of patient care.

Patients could see all the health professionals involved in their care at one-stop clinics. Staff held regular and effective multidisciplinary clinics to see patients and improve their care. The staff developed a diabetic foot pathway bringing together specialist medical, nursing and allied health professionals in one area of the outpatient department, so patients only needed to attend one appointment.

Many clinics were multidisciplinary including, women’s health specialist consultants working alongside, speech and language therapist and nutritionist to provide a one stop service. Medical and nursing staff worked together to manage a post-operative service.

We observed multidisciplinary working in the oncology service where specialist staff worked with outpatient staff to provide care for patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental health conditions.

Seven-day services

Outpatient clinics did not work a seven-day week but worked Monday to Friday 8am to 6pm, with evening clinics on Wednesday and Thursday. Some clinics took place on Saturday to manage capacity and this was the case with ophthalmology.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Two patients told us they were given advice on healthy living during their appointment.

Staff assessed each patient’s health at every appointment and provided support for any individual needs to live a healthier lifestyle. We observed a medical consultation which included advice on flu vaccination. We saw posters advertising flu vaccinations.

Health promotion information for patients was on display and in some cases was prepared in advance of clinics being run. In the dental clinic there was a fortnightly nurse led clinic supporting patients with good oral care.

Staff spoke about the initiative to Make Every Contact Count (MECC). This evidence-based approach enables health and care workers to engage people in conversations about improving their health by addressing risk factors such as diet, alcohol and mental wellbeing.
A notice board in general outpatients explained MECC and all staff had received training to offer advice and support to patients, whether it was help with smoking cessation, dietary advice, referral to specialist services or help to arrange transport.

All outpatient areas across the hospital had relevant information promoting healthy lifestyles. This included the leaflet Change4life family snack challenge. There was also information on smoking cessation and alcohol misuse. In the cardiac department, there was a helpline advertised to help people stop smoking. In the outpatient’s department there was support information for people who were suffering with gambling addictions.

There was comprehensive patient and carer information about living with cancer and other long term health conditions such as dementia. There was also information about services that specifically supported older people and carers.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff gained consent from patients for their care and treatment in line with legislation and guidance and following trust policy.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and were able to give examples of how patients were supported.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff demonstrated the appropriate consent form that would be used in this circumstance.

Staff made sure patients consented to treatment based on all the information available. Staff demonstrated that they knew which consent form to use and recorded consent in the patients’ records.

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

Staff received and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for qualified nursing staff in outpatients is shown below:
In outpatients the target was not met for MCA/DoLS training modules for which qualified nursing staff were eligible.

**Conquest Hospital**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Conquest Hospital for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>16</td>
<td>29</td>
<td>55.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

In outpatients the target was not met for MCA/DoLS training modules for which qualified nursing staff were eligible.

Information from the trust following the inspection stated that completion was low due to the change in training requirement with all staff grades now being required to complete this training every three years. There were plans to ensure all staff would complete this training requirement by the end of the year.

**Is the service caring?**

**Compassionate care**

There was a strong visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people’s dignity. Feedback from people who used the service and those close to them, was always very positive about the way staff treated people.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff calling patients to the treatment room. Away from other patients the nurse checked the patients date-of-birth to ensure the right person had been called. This meant staff were protecting patient information.

We observed members of staff interacting with patients in waiting areas. Not all areas had a receptionist as patients used self check in, but volunteers and staff were seen to support patients if
they were unsure what to do or where to go. In medical outpatients, we saw administration staff greeting patients in a warm and welcoming manner to the department. One visitor to the department told us that staff were always there to help.

We observed a member of nursing staff greeting a patient in an engaging and supportive way. The member of staff approached a patient in a waiting room to check some details said clearly who they were and reassured them they were next to be seen, making sure they were comfortable.

We also observed a moment where a nurse took the time to stop the task they were doing to check on a patient in the waiting area. The nurse asked the patient how they were feeling and told the patient that they “looked really well today”. After the nurse left, the patient was heard saying how pleased they were to be spoken to in such a positive way.

Patients’ dignity and privacy was protected during appointments. In all areas of outpatients, we observed staff knocking on treatment room doors and waiting to be invited in. All rooms had a facility to say the room was engaged, preventing any interruption. We saw this was always used by staff.

There were easy to read notices informing patients that chaperones were available in all areas of outpatients. One patient told us that staff had informed them that chaperones were available. We observed a consultation where a chaperone was requested, and one was made available immediately. Staff told us that when possible the chaperone would be the same gender as the service user.

Staff understood and respected the individual needs of each patient. In the phlebotomy department there was a range of toys to distract younger patients and afterwards sweets including gluten free were available. One patient told us that staff really cared about them as an individual.

During the inspection we spoke to 14 patients and 10 relatives. The feedback we were given was always positive. Patients told us: “Staff are lovely, kind and caring”, “Staff feel like family”. Patients described staff as wonderful, brilliant, caring and amazing. One patient told us ‘I have a real sense of confidence in the care I receive, staff are really professional’. Staff were able to raise concerns about disrespectful or abusive behaviour. All staff had received safeguarding and conflict management training.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress and recognise and respect the totality of people’s needs. They understood patients' needs and made adjustments to care and support that was highly individualised.

In the trauma and orthopaedic clinic staff told us that on two occasions recently the plaster service was expecting two stretcher patients, one from a hospice and another from a nursing home for treatment. On reviewing the patients’ needs and considering their physical and mental wellbeing it was decided to take the service out to the patients. In both cases this was successfully done and so minimised distress to the patient while delivering care required.

In phlebotomy staff had discussed and agreed the most appropriate and confidential way of ascertaining a patients residency status being sensitive to the patient whilst gaining that information. A certain phrasing of words was agreed as appropriate.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. In the orthopaedic and fracture clinic staff identified that it was important that stretcher patients had a private place to wait to see the medical staff. A clinic room
was adapted to enable the patient, to both be seen and wait there, minimising unnecessary moving. At the end of the appointment while waiting for transport, staff stayed with the patient which could mean staying beyond their shift time.

We observed a patient becoming concerned and looking worried while waiting in the clinic. A member of staff immediately approached them and spoke to them in a quiet and supportive way. On hearing that they were waiting for results the staff member found out how long the wait would be, answered their question and the patient was reassured.

A quiet room was made available if a patient needed a space or received bad news. Staff gave examples of how to manage patients that have received distressing news and ensured a member of the clinical team stayed with the patient and family. Appropriate patient information would be given and was readily available in the department.

Staff told us that they had access to the Macmillan team and other specialist nurses if they felt they needed support.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We observed a member of staff speaking to the relative of a frail patient to discuss how a referral to a service in London could be managed.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. All patients we spoke with felt well informed on the care and treatment they were receiving in outpatients.

Patients attending outpatients had access to an information sheet which they received or could access on the hospital website encouraging them to consider what questions they may want to ask. There were prompts reminding the patient to ask questions such as, what are my treatment options? There was space to write their own questions.

Staff told us they would support the patient to ask any questions and time would be given for this during the appointment. We observed two consultations, and, on both occasions, medical staff asked the patient if they had any questions.

In the fracture clinic, patients were given the department contact details and a list of staff who were on call. If staff were unable to resolve the patients concerns they would refer onto medical staff.

Two nurses were observed interacting with a patient’s relative who was raising a concern. The relative was unable to find a wheelchair for the patient to use. Both nurses apologised in a sincere way. The patients relative was upset and concerned for the patient. The nurses interacted in a kind, compassionate way, and told the relative and patient not to worry, they would resolve the issue immediately. The nurses did so and checked to see if there was anything else they could do.

In medical outpatients a relative had brought their baby to the patient’s appointment and asked for baby changing facilities. A member of staff accompanied that person to a suitable facility and made sure they had everything they needed.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. In general outpatients there was a hearing loop for the hard
of hearing, and some information was available in large print. In the ophthalmology clinic a magazine with large print called smart read was available for patients.

Staff supported patients to make informed decisions about their care. A healthcare assistant or nurse was often present with patients during their appointments. Staff checked that the patient understood what was being said. Staff we spoke with told us they always checked patient’s understanding at the end of the appointment before they left the department. Staff understood that patients might need extra support or time.

Feedback from patients’ friends and families spoken with during the inspection was positive. One family member told us that they felt well informed and involved in the patients care. The patient told us that made them happy.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. In all areas of outpatients, we saw posters advertising the friends and family feedback process. There were comment cards and collection boxes available to make it easy for patients and visitors to leave feedback on the service.

There was information that the friends and family survey was available to all patients and available in alternative formats, including inclusivity, such as easy read and large font. In many areas alongside feedback forms there were examples given of service change in response to patient feedback.

Patients gave positive feedback about the service. Copy of feedback received was sent to relevant members of the team so they could include this in their own personal records and could be used to support reflective practice and revalidation.

The NHS England website shows the trust had only a 5% return rate for Friends and Family test (FFT) related to outpatient services. However, the results showed 99% of patients would recommend the service and no patients would not recommend it.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Facilities and premises were appropriate for the services being delivered. The main outpatient department was located on level three, close to the main entrance to the hospital. Two self check-in points were located external to outpatients and this enabled staff within the department to see who had arrived for their appointment. There was a live screen which informed patients of the location of their clinic within the main department and the doctor running that clinic.

Outpatient clinics ran from 9am to 6pm as a minimum on weekdays, with some later finishes and some weekend working.

The main department was divided into three areas A, B and C. Each area ran different specialty clinics.

The orthopaedic outpatients and fracture clinic was located on the same level but separate to the main department. A manned reception desk was located at the front and a live screen showed clinics and waiting times.
The medical outpatients running cardiology, chest and respiratory and oncology clinics was located on level two. A receptionist was available to support patients with self check-in. The diabetic and endocrinology centre located on level two also ran a small number of clinics out of three consultant clinic rooms.

The outpatient phlebotomy service was located in the pathology department on level four.

Signage around the hospital and outpatient department was clear enough to be understood by people unfamiliar with the environment. Volunteers were available in all areas to support patients with self check-in and to direct them to their clinic.

There was enough seating in the waiting areas for the volumes of patients observed during our inspection. However, there were no seating seen for patients with specific needs. Chairs were all the same height, there were no chairs that were higher for people who had difficulties sitting. There was a separate area for children in an adult clinic. Patients had access to toilets and refreshments.

The department had developed the role of clinic support, a member of staff who supported patients and facilitated smooth running of the clinic by carrying out tasks required such as taking bloods, ordering transport and any admin work required.

Carparking was provided on site, although patients commented that it was sometimes difficult to find a space to park. The hospital has direct access to a bus service and the hospital website had clear directions to the train station. There was information how it may be possible to reclaim travel costs. The website enabled patients to download a map of the hospital giving directions to all departments.

Information was provided to patients before their appointment, with appointment time, consultants name and any tests, samples or fasting required. The hospital website contained information about how to prepare for the appointment, what to bring and contact numbers.

Managers planned and organised services, so they met the changing needs of the local population and relieved pressure on other departments by developing clinics that could treat patients in a day. This minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests in one visit. One stop clinics were run for number of specialties including breast, vascular services and gastroenterology.

Part of the trust wide outpatient transformation programme involved working with GPs, clinical commissioning groups (CCG) and service users to prevent patients attending hospitals unless absolutely necessary. Specialist respiratory provided training to GPs and other medical staff to prevent inappropriate referral into the service.

More virtual clinics were being developed in ophthalmology and other specialties. Video clinics were being trialled and the epilepsy service had developed a patient initiated follow up pathway. Patient information explained why the patient would be on this plan, which empowered the patient to manage their own appointment requirement and how they would do this.

The service had systems to help care for patients in need of additional support or specialist intervention. The diabetic service ran sessions for patients using insulin pumps or new diabetic monitoring systems. On the day of inspection, we saw this session was well attended.

Staff could access emergency mental health support during department opening hours for patients with mental health problems, learning disabilities and dementia.
Did not attend rate
From March 2018 to February 2019,

- The did not attend rate for Conquest Hospital was similar to the England average.

(Source: Hospital Episode Statistics)

Managers monitored and took action to minimise missed appointments, patients who did not attend appointments were contacted. There were arrangements made so patients could attend on an alternative day.

The service had appointed a failsafe officer who had been in post a year to ensure all ophthalmic patients had a follow up appointment.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The trust provided details of how to access outpatient services for patients with mobility issues. The hospital website highlighted the blue badge parking areas.

There were toilets for patients living with a disability in all areas.

If patients met eligibility criteria, hospital transport could be arranged 14 days in advance of the appointment. If there was a long wait for transport following an appointment, patients were able to use the discharge lounge.

Staff carried out essential care rounds every hour. These nurse-led rounds included speaking to patients to check how they were, checking appointment times and visually ensuring the area was safe.

Provision for bariatric patients was not consistent across all areas. In trauma and orthopaedics provision was made for bariatric patients with appropriate seating. In other areas the seating was not specific for bariatric patients and in main outpatients some changes to doorways were to be made to accommodate wheelchairs for these patients.

Staff made sure patients living with dementia, received the necessary care to meet all their needs. All staff were trained to meet the needs of patients living with dementia.

Dementia champions were identified in all areas as a resource to other staff, and up-to-date information leaflets were available for patients and carers. In the information received prior to the appointment, patients and carers were encouraged to let the clinic staff know if they had any special needs.

The hospital produced information for patients with complex needs such as dementia and learning disabilities and informed patients and carers how they could contact the specialist nurses if necessary. There were also leaflets on dementia related topics, the care passport and how to contact the care team at Sussex County Council.

There was a range of specialist nurses available in all areas and staff were aware how to contact specialist support if needed. In the medical outpatients there were nurse led clinics for oncology, cardiology and respiratory services. There were specialist nurses supporting patients with other chronic conditions including Parkinson’s and epilepsy, acting as a resource for patients and staff.
Junior and adult special needs clinics were running in the ophthalmology area with very good feedback from relatives and carers, plans were in place to extend this service.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was patient information on how to access information in different formats by contacting the equality and human rights department.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The trust appointment letter informed patients that if they needed an interpreter, the appointment centre could arrange this. We spoke to three staff members. All three were able to describe how to access interpretation services for patients who would prefer to communicate in other languages.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us that if a patient required leaflets in other languages this could be printed and provided to a patient. However, in the general outpatient’s department, there were no posters indicating information was available in other languages. Staff had printed a poster and displayed this on the reception desk before we left the department. The poster had a statement written in a number of languages to inform patients that information was available in other languages upon request.

Staff had access to communication aids to help patients become partners in their care and treatment. In the outpatient’s department reception desk there was an induction loop which had a sign to indicate this service was available. However, in the medical outpatients and endocrinology departments there was no induction loop or signs for people who use hearing aids.

Access and flow

People could access the service when they needed it and received the right care promptly.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways was, in most months, worse than the England overall performance. From January to March 2019 trust performance was similar to the England average. The latest figures for June 2019, showed 84.8% of patients awaiting treatment had been waiting less than 18 weeks versus the England average of 86.7%.
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

Seven specialties were above the England average for non-admitted pathways 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>100.0%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>97.1%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>96.6%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>96.5%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Other</td>
<td>92.2%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Urology</td>
<td>88.6%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>83.3%</td>
<td>79.9%</td>
</tr>
</tbody>
</table>

Nine specialties were below the England average for non-admitted pathways RTT (percentage 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>91.5%</td>
<td>94.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>85.3%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>85.2%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>82.0%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>81.0%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Ear, Nose and Throat (ENT)</td>
<td>78.9%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>77.7%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>73.5%</td>
<td>80.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>68.8%</td>
<td>77.0%</td>
</tr>
</tbody>
</table>
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2018 to June 2019 the trust's referral to treatment time (RTT) for incomplete pathways was consistently better than the England overall performance. The latest figures for June 2019, showed 91.2% of patients awaiting treatment had been waiting less than 18 weeks versus the England average of 85.8%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, East Sussex Healthcare NHS Trust.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>99.1%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.4%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.4%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>97.1%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Other</td>
<td>96.5%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>96.0%</td>
<td>90.8%</td>
</tr>
<tr>
<td>General surgery</td>
<td>93.5%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>91.8%</td>
<td>84.6%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>91.6%</td>
<td>87.7%</td>
</tr>
</tbody>
</table>
Two specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>85.4%</td>
<td>86.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>80.7%</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust performed mostly better than the 93% operational standard and England average for people being seen within two weeks of an urgent GP referral. 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), East Sussex Healthcare NHS Trust

(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 worse than the 96% operational standard in Q2 2018/19 and Q3 2018/19 for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The trust performance was similar to the operational standard and England average in Q4 2018/19 and Q1 2019/20. 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), East Sussex Healthcare NHS Trust

![Graph showing percentage of people waiting less than 31 days from diagnosis to first definitive treatment](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 consistently worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. In Q2 2018/19 and Q3 2018/19 the trust performance was worse than the England average. Trust performance improved in Q4 2018/19 and Q1 2019/20 when it was similar to the England average. The performance over time is shown in the graph below.

![Graph showing percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, East Sussex Healthcare NHS Trust](Source: NHS England – Cancer Waits)

Managers monitored waiting times and worked towards patients accessing services when needed and receiving treatment within agreed timeframes and national targets.

The clinics at Conquest were part of the trust wide transformation programme for outpatients. This programme aimed to address service issues and improve efficiency and delivery of outpatient services to the patient. This programme had been running for over a year.
Managers told us that actions had been taken to improve access and flow, for example, improved digital services to enable patients to access services more easily and improved engagement with patients to understand their needs. Service redesign included more virtual, video and one stop clinics to reduce waiting times and better utilisation of clinic time using a standardised approach which ensured clinics were not left empty.

The trust put improvements in place which reduced clinic cancellation from 30% in 2017 to 23% in October 2019. Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

The trust had staff who monitored the pathway for cancer patients and these staff worked with the specialist area to manage cancer appointments. Work to improve cancer wait times was part of the transformation work and the two weeks wait had improved and there was a plan to improve this further.

Staff told us that that the transformation programme had made a positive difference to clinic wait times. There was much better use of clinic slots. Changes to the telephone system had improved patient handling. Staff felt they were part of the process.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns. Information about how to do this was available in all departments. Laminated notices directed patients to contact the patient advisory liaison service (PALS). During the inspection two patients told us that they were aware of how to make a complaint but had never felt the need to do so.

The hospital website gave information about how to raise a complaint and how the trust dealt with complaints. There was information if patients wish to have guidance or support in making complaint with details on how to contact an advocacy service.

Staff understood the policy on complaints and knew how to handle them. Staff told us they felt able to deal with any verbal complaints and knew when complaints should be escalated.

Trust level

From August 2018 to July 2019 the trust received 173 complaints in relation to outpatients (34.0% of total complaints received by the trust). Of all core services, outpatients received the highest number of complaints.

The trust took an average of 30 days to investigate and close a complaint. This was in line with their complaints policy, which states complaints should be investigated and closed within 30 days. A breakdown of complaints by type is shown below:
<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>85</td>
<td>45.5%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>50</td>
<td>26.7%</td>
</tr>
<tr>
<td>Communications</td>
<td>32</td>
<td>17.1%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>17</td>
<td>9.1%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>3</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>187</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Out of all complaints received for outpatients, 48.6% were partially upheld, 27.7% were fully upheld and 18.5% were not upheld.

**Conquest Hospital**

From August 2018 to July 2019 there were 82 complaints about outpatients at Conquest Hospital. The trust took an average of 28 days to investigate and close a complaint. This was in line with their complaints policy, which states complaints should be investigated and closed within 30 days. A breakdown of complaints by type is below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>34</td>
<td>41.5%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>23</td>
<td>28.0%</td>
</tr>
<tr>
<td>Communications</td>
<td>14</td>
<td>17.1%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>8</td>
<td>9.8%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>3</td>
<td>3.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>82</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From August 2018 to July 2019 there were 49 compliments about outpatients at the trust. A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne District General Hospital</td>
<td>26</td>
<td>53.1%</td>
</tr>
<tr>
<td>Conquest Hospital</td>
<td>13</td>
<td>26.5%</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>4</td>
<td>8.2%</td>
</tr>
<tr>
<td>Cross Site</td>
<td>3</td>
<td>6.1%</td>
</tr>
<tr>
<td>Avenue House</td>
<td>1</td>
<td>2.0%</td>
</tr>
<tr>
<td>Firwood House</td>
<td>1</td>
<td>2.0%</td>
</tr>
<tr>
<td>Lewes Victoria Hospital</td>
<td>1</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Common themes from compliments received were:

- The kindness and professionalism of staff
- The quality of care and treatment provided
- The quality of the environment and services provided
- The kindness extended to the patient’s relatives and family

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Managers investigated complaints and identified themes. Complaints was a standing agenda item on all governance and departmental meetings. The most recent minutes from the general outpatients showed no current complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. When diabetic patients complained that they had to attend a number of appointments at different times related to their diagnosis. Staff reviewed the service and created a multi-disciplinary clinic, so patients could see different specialists at one appointment.

Staff could give examples of how they used patient feedback to improve daily practice. All area had notice boards that highlighted patient comments about the service and what actions had been put in place. Patients had commented that they were not always informed of waiting times at clinic and staff now made sure patients were being kept in formed if clinic were running late.

### Is the service well-led?

#### Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The outpatient service was managed by matrons reporting through to designated directorates. In the main outpatient department four matrons worked together, with one providing cross cover to Bexhill hospital. Clinic areas outside the main department had matrons in charge, except for the phlebotomy service which was led by a manager.

The matrons we spoke to had completed a line management course and felt supported in their leadership role. Administrative assistants worked alongside the matrons and departmental sisters freeing up some of their time for more clinical activity. Deputy heads of nursing were also visible in the department.

The matrons welcomed the plan in the future for there to be a head of nursing for outpatients and anticipated this to be in place within the next six months. The new role was seen as a positive step to coordinate all services across all sites and to standardise care.

Matrons spoke about the sustainability of the service and the need to succession plan which included supporting more junior staff with developmental opportunities. Departmental senior staff had completed first line management courses.
Outpatient staff knew who they reported to and spoke of the matrons as being visible, approachable and proactive in managing their departments. Staff told us they felt listened to and that leadership in the department was good.

Staff referred to the trust leadership as supportive. The new chief executive was seen to have made a difference to staff morale and improvement of services and staff said he was visible around the hospital. Quality walks by the senior leadership team of the trust were completed six-monthly and were welcomed by staff.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision 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 supported by five strategic objectives including planning for sustainability of the service.

Staff were able to identify the four trust values; working together; improvement and development; respect and compassion and engagement and involvement. The values were displayed across all departments informing patients and visitors.

The general outpatient department had developed a detailed mission statement describing the need to ensure patients receive the highest standard of care, taking into account privacy and dignity. The statement was dated 2016 but staff agreed that they felt the statement was still relevant but should be reviewed in line with changes in the department.

The trust had developed ESHT 2020, an overarching organisational strategy setting out the direction for clinical services. One part of this was the implementation of quality improvement plans.

We saw evidence of quality improvement across outpatient services with the implementation of the outpatient transformation plan. Senior leaders engaged with commissioners and service users to make this plan relevant for the wider health and social economy. A clinical dashboard demonstrated the changes and resulting impact on services and efficiency.

Senior managers in the service spoke positively about the programme driving change, more efficient working practices and a better patient experience. Not all staff were aware of the transformation programme but those that were, spoke positively about changes that made the department work in a better way.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff described the culture as being open and supportive to all staff including those that had disabilities that might not be visible to others. The open culture meant that any incident within the
department was shared and learned from. Staff had training on duty of candour and during the inspection we observed staff apologising to patients if they were kept waiting.

Staff felt valued, were proud of their service and enjoyed working in the department. They described working together well as a team in a good working environment with approachable managers. There were a number of long serving staff members. Staff described good integrated working and some good cross site communication.

Staff were confident that any issues or concerns they had could be resolved at department level as staff felt able to approach managers. Staff were aware of the freedom to speak up guardian and how to raise concerns.

Staff were passionate about delivering the best care to their patients and supported each other to do this. We saw staff from different clinics and specialties supporting each other, if help was needed. Matrons worked together and knew each other’s services which gave the impression of a cohesive service that had the patient needs at the centre of its service delivery.

Matrons in outpatients felt involved in the transformation plan for the department with two of the four, involved in this modernisation programme. Staff told us they feel empowered to make suggestions and make changes about the service.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Staff we spoke to knew the reporting structure in the department. Governance meetings were monthly in each division, for example general outpatients were included in the governance structure of the medicine division, ophthalmology and orthopaedics reported through to the surgical directorate.

These meetings had a standing agenda including but not exclusive to, incidents, complaints, risk, infection control, safeguarding and equality. This meeting reported through to the integrated performance meeting providing assurance to the executive team.

A clear documented structure showed each specialty reporting up to the divisional meeting and down to local department meetings. Monthly team meeting minutes in general outpatients showed a similar agenda to divisional meetings with incidents, complaints, infection prevention and control and health and safety as standing agenda items, giving assurance that communication happened at all levels of the organisation.

A weekly patient safety summit happened at board level with a review of incidents. Outcomes from this meeting was shared with staff by email.

The transformation plan for outpatients included a workstream to improve governance across the service. This included the proposed change of structure with a clinical and managerial lead for the service to give better oversight and coordination of the service.

The director of nursing was the executive lead for infection prevention and control and presented an annual plan to the board with actions from the previous year giving assurance of the service.

Management of risk, issues and performance
Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Each specialty within outpatients was part of the relevant divisional clinical audit programme. Clinical audit meetings took place two monthly and reported through to the divisional quality clinical governance meeting. We saw evidence of clinical audit in all outpatient departments including hand hygiene.

There were effective systems for identifying risks using the high level and divisional risk registers. Risks were rated red, amber or green (RAG) depending on the severity of the risk and the potential for harm. Risk registers included potential risks with actions taken to prevent the risk occurring.

The division newsletter informed all staff of the top four risks in the division. One example on the medical risk register referred to the diabetic endocrinology service and the poor compliance to the diabetic foot pathway for both inpatients and outpatients. It was clear there was regular review, what actions had been taken to improve the service and who had oversight.

The surgical risk register showed a risk to ophthalmology services across the trust due to a backlog of assessment and follow ups. One particular group of patients was at greater risk and actions included the training of non-medical staff to carry out injections. Speaking to staff in the ophthalmology service at Conquest hospital they knew of this risk and had trained four staff and had another four in training.

Staff identified some additional local risks such as facilities for bariatric patients but acknowledged that some changes to the service were already being made to improve access to the department.

Staff also identified the need to redesign some of the clinic locations. For example, the location of the women’s health service, directly next to urology and in the centre of general outpatients. Staff were concerned about dignity of patients and felt empowered to redesign the service keeping managers informed.

In the trauma and orthopaedics clinic the manager involved staff in making risk assessments and there was a current dashboard of health and safety risk assessment.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The continued development of the clinical dashboard gave executive and management oversight of the service which included improved collection of performance data including feedback from service users. Managers described the dashboard as a source of rich information about key performance indicators across the service.

This highlighted areas for improvement and had led to the work being done on better utilisation of clinic times which stood at 91% and the development of tools, policies and procedures to reduce waiting times from 26 weeks to 10 weeks.

The trust used secure electronic systems with appropriate safeguards. All staff had access to computers and had email accounts.
The electronic patient system enabled staff to search for clinics, clinical results and letters. The system was easy to navigate. It was possible to flag on the system any patients with a history of violence and aggression.

Consultation notes were recorded by hand and then scanned onto the system within forty-eight hours. Staff could access an electronic system to make referrals to other departments and to third parties, for example, patients who needed social care. There was an online room diary.

The transformation programme included digital developments including a patient portal through which appointments could be made, letters sent, and results viewed.

At department level information was used to track staffing, appraisal completion and safety information. We saw this being used to populate quality and safety boards and being discussed at the morning huddle and at team meetings to drive improvement.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust engagement and communication plan updated in February 2019 included a plan for public, staff and stakeholder engagement. A supporting strategy document set out how this was to be achieved including an invite to the general public to be a member of the trust or to become a volunteer.

The trust held two-monthly board meetings in public. Information about these meetings including timing and directions were published on the website. There was access to a contact us page, encouraging public to feedback any concerns, compliments or ideas for the service. There was general information about the trust development and news stories. The trust could be followed on social media.

As part of the transformation plan the trust held a public forum to gauge response to the new digital tools. Staff told us that this helped them shaped the functionality of the patient portal. Public feedback about text message reminders for appointments has resulted in patients aged over 75 years receiving a phone call reminder as that was preferred.

The trust had a divisional staff survey action plan highlight report following the 2019 survey which set out actions with time scales and named responsible persons. Many of the actions related to improved communication, a focus on health and wellbeing, and how that could be achieved. The surgical division identified the importance of protecting staff from discrimination. This plan was updated and rated reflecting the level of urgency.

A hospital newsletter informed staff that the next staff survey was currently in progress and instructions on how this could be completed.

Engagement with staff included various networks including black and ethnic minority staff, disabled staff, and lesbian, gay, bisexual and transgender (LGBT) staff. There were also other informal networks such as Filipino staff supporting each other.

In general outpatients the managers identified that a number of the staff in the department were carers for relatives and needed support and were mindful of this when putting together staff rotas. A confidential counselling service was in place that all staff could access.
In all areas there was information about staff awards and who had been successful. In the general department a board of celebration showed what staff had achieved and how that was rewarded. During the inspection we met a staff member who had received an annual achievement award and they described the positive benefits of recognition and how motivated they were to continue their work.

The trust had launched a new ambassadors programme for nominated staff to act as role models for others. A distinctive lanyard identified these members of staff.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust was committed to developing and improving services and the outpatient transformation plan was developing changes to systems and processes in order to improve patient access and flow as well as patient experience throughout the outpatient department. Information continued to be added to the clinical dashboard enabling a good overview of the service. Staff in the departments were involved in this quality improvement plan and felt able to put forward ideas and discuss changes within their areas.

Administrative staff were positive about the impact of the work on productivity and the improvement in clinic wait times with much better use of clinic slots. They also commented that the telephone system had greatly improved the patient experience.

Staff were positive about the development of the digital services improving referral and clinic planning. For patients accessibility to the service had improved.

Clinical staff felt able to make changes to their services. Staff in the trauma and orthopaedic outpatients were enthusiastic about developing their service by adding a complex wound clinic and a more specialised clinic within the plaster room area.

The diabetic and endocrinology suite displayed training and research posters in a room used for patient education. The staff felt supported in developing their service, participating in research and continuing patient education. An insulin safety week had just been promoted for staff and patients and was reported in the hospital newsletter.

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**Community health services**

**Community health services for adults**
Facts and data about this service

District nurses work in partnership with general practitioners, hospices, hospitals, health visitors, specialist nurses and social services. The service delivers skilled patient-focused nursing care and support to individuals who are housebound in a variety of non-hospital settings including patients' homes and residential homes.

The service is made up of the following teams:

- An Integrated Night Service (INS) provided jointly with East Sussex County Council (ESCC), provides night nursing and social care between the hours of 10pm and 8am.
- The dietetics team provides care to outpatients and inpatients.
- The bladder and bowel advisory service see patients in clinics and nursing homes.
- Speech and language therapy services provide a specialist assessment, diagnosis, treatment, and management service for clients aged over 16 who have communication and / or swallowing problems.
- The Joint Community Rehabilitation Team (JCR) is an integrated community service with adult social care and offers a seven-day service providing rehabilitation and reablement.
- The podiatry team specialises in nail surgery, tissue viability and wound care. The service offers advice on conditions such as rheumatoid arthritis, neurological conditions, diabetes, and musculoskeletal conditions.
- The community stroke rehabilitation team provides ongoing rehabilitation for patients on a stroke pathway including early supported discharge for appropriate patients.
- The crisis response team provides an admission avoidance service.
- The frailty team aims to improve the quality of life for older people living with frailty and support them to live well outside of hospital.
- The fracture liaison team work to break the fragility fracture cycle by responding to the first fracture and aims to prevent subsequent fractures.

Information about the sites and teams, which offer community services for adults at this trust, is shown below:

<table>
<thead>
<tr>
<th>Location/site name</th>
<th>Team, ward, satellite name and services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest</td>
<td>Crisis response</td>
</tr>
<tr>
<td>Conquest</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Polegate unit - podiatry</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Frailty practitioner service</td>
</tr>
<tr>
<td>Eastbourne District General Hospital</td>
<td>Crisis response</td>
</tr>
<tr>
<td>Arthur Blackman Clinic St Leonards</td>
<td>Diabetic eye screening</td>
</tr>
<tr>
<td>Avenue House Eastbourne</td>
<td>Community dietetics</td>
</tr>
<tr>
<td>Avenue House Eastbourne</td>
<td>Speech and language therapy</td>
</tr>
<tr>
<td>Avenue House Eastbourne</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Crowborough War Memorial hospital</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Eastbourne Park Primary Care Centre</td>
<td>Audiology</td>
</tr>
<tr>
<td>Hailsham Health Centre</td>
<td>Community bladder and bowel advisory team</td>
</tr>
<tr>
<td>Hailsham Health Centre</td>
<td>Diabetic eye screening</td>
</tr>
<tr>
<td>Facility</td>
<td>Service</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Hailsham Health Centre</td>
<td>Safeguarding team</td>
</tr>
<tr>
<td>Ian Gow Memorial Health Centre,</td>
<td>Speech and language therapy</td>
</tr>
<tr>
<td>Eastbourne</td>
<td></td>
</tr>
<tr>
<td>Seaford Health Centre</td>
<td>Community dental service</td>
</tr>
<tr>
<td>Seaford Health Centre</td>
<td>Dietetics</td>
</tr>
<tr>
<td>Seaford Health Centre</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Seaford Health Centre</td>
<td>Diabetic eye screening</td>
</tr>
<tr>
<td>Seaford Health Centre</td>
<td>Speech and language therapy</td>
</tr>
<tr>
<td>Station Plaza Health Centre</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Hastings</td>
<td></td>
</tr>
<tr>
<td>Station Plaza Health Centre</td>
<td>Musculoskeletal - physiotherapy</td>
</tr>
<tr>
<td>Hastings</td>
<td>Day surgery unit</td>
</tr>
<tr>
<td>Uckfield Hospital</td>
<td>Irvine unit (stroke rehabilitation)</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Frailty practitioner service</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Community bladder and bowel advisory team</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Dowling unit</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Out patients</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Radiology</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Diabetic eye screening</td>
</tr>
<tr>
<td>Bexhill Hospital</td>
<td>Community dietetics</td>
</tr>
<tr>
<td>Bexhill Hospital (Health centre)</td>
<td>Speech and language therapy</td>
</tr>
<tr>
<td>Rye, Winchelsea, and District Memorial Hospital</td>
<td>Diabetic eye screening</td>
</tr>
<tr>
<td>St Anne's house</td>
<td>Community musculoskeletal services - registered location for community physiotherapy services in patients’ homes and other community locations</td>
</tr>
<tr>
<td>St Anne's house</td>
<td>Community podiatry services - registered location for community physiotherapy services in patients’ homes and other community locations</td>
</tr>
<tr>
<td>St Anne's house</td>
<td>Health visiting services - registered location for health visiting services</td>
</tr>
<tr>
<td>St Anne's house</td>
<td>District nursing - registered location for district nursing services</td>
</tr>
<tr>
<td>St Anne's house</td>
<td>Community stroke rehabilitation</td>
</tr>
<tr>
<td>St Anne's house</td>
<td>Joint community rehabilitation (JCR) - registered location for JCR team</td>
</tr>
</tbody>
</table>

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

**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 although not everyone completed it.
The trust set a target of 90% for completion of mandatory training, with the exception of the information governance module where the trust set a target of 95%.

Note: Data received from the trust indicated that there were no dedicated medical staff for community adult services.

**Trust level**

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for qualified nursing staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>245</td>
<td>282</td>
</tr>
<tr>
<td>Infection control</td>
<td>244</td>
<td>282</td>
</tr>
<tr>
<td>Health and safety</td>
<td>243</td>
<td>282</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>242</td>
<td>282</td>
</tr>
<tr>
<td>Fire safety</td>
<td>241</td>
<td>282</td>
</tr>
<tr>
<td>Information governance</td>
<td>193</td>
<td>282</td>
</tr>
<tr>
<td>Mental health act</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Medicines management</td>
<td>123</td>
<td>282</td>
</tr>
</tbody>
</table>

In community services for adults the 90% target was not met for any of the mandatory training modules for which qualified nursing staff were eligible. In addition, nursing staff did not meet the 95% trust target for the information governance module.

**Conquest Hospital community services for adults**

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified nursing staff in community services for adults at Conquest Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>40</td>
<td>46</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>39</td>
<td>46</td>
</tr>
<tr>
<td>Infection control</td>
<td>39</td>
<td>46</td>
</tr>
<tr>
<td>Health and safety</td>
<td>38</td>
<td>46</td>
</tr>
<tr>
<td>Fire safety</td>
<td>36</td>
<td>46</td>
</tr>
<tr>
<td>Information governance</td>
<td>20</td>
<td>46</td>
</tr>
<tr>
<td>Medicines management</td>
<td>19</td>
<td>46</td>
</tr>
</tbody>
</table>

The 90% target was not met for any of the mandatory training modules for which qualified nursing staff were eligible in community services for adults at Conquest Hospital. In addition, nursing staff...
did not meet the 95% trust target for the information governance module.

**Eastbourne District General Hospital community services for adults**

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified nursing staff in community services for adults at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>19</td>
<td>22</td>
<td>86.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>13</td>
<td>22</td>
<td>59.1%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>11</td>
<td>22</td>
<td>50.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met for four of the six mandatory training modules for which qualified nursing staff were eligible in community services for adults at Eastbourne District General Hospital. In addition, nursing staff did not meet the 95% trust target for the information governance module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff across the area told us that mandatory training was of a good quality and equipped them to do their jobs properly.

**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 service had a clear safeguarding policy, available on the intranet, which staff were aware of. Staff we spoke with were aware of different types of abuse and how to spot them. They understood the process and knew who to inform. The trust had a self-neglect policy that staff were aware of and used to guide their work.

Teams across the community adults services worked well with local authority safeguarding teams. In St Mary’s House, the adult social care team were co-located in the same office as the district nurses which allowed for effective joint-working. In Bexhill hospital where district nursing, stroke rehabilitation and podiatry teams were located, social workers had offices where they based themselves, and were available to offer advice or discuss particular cases.

The trust had a safeguarding lead and team. Staff knew who the lead was and how to contact the team and told us they were supportive and responsive. The safeguarding lead attended team meetings from time to time to support teams in their practice. In addition, staff had access to regular group supervision from the trust safeguarding team, where staff were updated on any changes in policy and review case studies.
Safeguarding was a standing agenda item in team meetings for the teams we visited when staff discussed referrals, progress and outcomes and shared learning. Staff in the district nursing, frailty and crisis response teams also had daily safety huddles, where any concerns or updates could be shared and discussed in a timely manner. Learning as a result of safeguardings was also shared across teams during team leader and manager’s meetings.

**Safeguarding training completion rates**

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

Note: Data received from the trust indicated that there were no dedicated medical staff for community adult services.

**Trust level**

A breakdown of compliance for safeguarding training courses August 2018 to July 2019 at trust level for qualified nursing staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults’ level 1</td>
<td>282</td>
<td>282</td>
<td>100%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>282</td>
<td>282</td>
<td>100%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>39</td>
<td>40</td>
<td>98%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>237</td>
<td>282</td>
<td>84%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>237</td>
<td>282</td>
<td>84%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for adults the 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible.

**Conquest Hospital community services for adults**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for qualified nursing staff in community services for adults at Conquest Hospital shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>46</td>
<td>46</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>46</td>
<td>46</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>35</td>
<td>46</td>
<td>76.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>33</td>
<td>46</td>
<td>71.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible in community services for adults at Conquest Hospital.
Eastbourne District General Hospital community services for adults

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for qualified nursing staff in community services for adults at Eastbourne District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>22</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>22</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>21</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>21</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>18</td>
</tr>
</tbody>
</table>

The 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible in community services for adults at Eastbourne District General Hospital.

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional, to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and organisational.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community services for adults made 368 safeguarding referrals between August 2018 and July 2019, of which 150 concerned adults and 218 children.

<table>
<thead>
<tr>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>150 (40.8%)</td>
</tr>
</tbody>
</table>

Looking at adult referrals across the 12-month period, overall there was an increase in referrals during the months of May (18), June (21) and July 2019 (19). However, the increase in referrals from May to July 2019 was due to an improved data collection process implemented by the safeguarding team.

(Source: Universal Routine Provider Information Request (RPIR) – Safeguarding tab)
Cleanliness, infection control and hygiene

The service managed infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

All staff we spoke with were knowledgeable about infection control and adhered to the principles. While out on visits with district nurses, and when observing podiatry appointments, we saw examples of good infection control practice. All staff visiting patients in the community carried good stocks of appropriate equipment.

All locations we visited were clean and well maintained. All patient areas had antibacterial hand gel available, and appropriate waste management arrangements. Clinics we saw were clean, well maintained and well equipped.

The trust had an infection control policy available to staff on the intranet. Staff received training in infection control, although community adults staff were not quite at the trust’s target for this training they told us some of this was accounted for by long term sickness. Where possible, staff were booked onto the required refreshers.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment and managed clinical waste well. When providing care in patients’ homes staff took measures to protect themselves and patients.

Staff from frailty teams carried a medical kit which included a bladder scanner and electrocardiogram (ECG) machine in order to carry out screening tests in people’s homes. Some crisis response staff carried clinical equipment such as a stethoscope, blood pressure monitor, pulse oximeter, adrenaline and dressings. All equipment we saw had in-date checks or calibration, and admin staff oversaw and audited this.

The crisis response team in Hastings was located in a mobile office, where everyone was based, and teams met for daily huddles. The office did not have any private space for meetings nor any quiet areas to work or make telephone calls confidentially. Team leaders tried to divide the space and designate an area for quiet working, but this was difficult and wasn’t working particularly well.

The podiatry teams in Bexhill and Eastbourne had very small clinic areas with minimal waiting space for patients. Bexhill had no reception area, or anyone greeting or checking in patients as they arrived. Clinic rooms were noisy and conversations from within clinic rooms could be overheard from the waiting area. Signs were on display advising patients that if they wished to have a confidential discussion they should let staff know and this would be facilitated.

The district nursing team, which was located with the integrated team in St Mary’s House in Eastbourne, was in a very busy office. Staff told us this sometimes meant it was difficult to hear patients on the phone, or have confidential conversations. Staff also told us that, due to the location of the office, staff could not always attend the safety huddles because of parking issues.

Assessing and responding to patient risk
Staff completed and regularly updated holistic risk assessments for each patient, which removed or minimised risks wherever possible. Staff used information from the referral, the patient’s medical history and any tests or blood results as background before speaking with patients and their representatives.

Frailty teams completed a ‘comprehensive geriatric assessment’, which was created by the consultant for the services. This assessment was extremely comprehensive, holistic and personalised. Patients used this document across the services they needed. Staff across all teams we visited used recognised risk assessment tools to monitor risks such as falls, pressure areas and nutrition.

All patient records were stored on an electronic records system, to which all staff had access. All teams added their assessments, care notes and any other patient information to one patient record. This meant staff across all teams could access the full range of patient information, and see any risks.

The system also allowed for risk flagging, which enabled staff to prioritise according to specific markers. An example of this was that district nursing teams were able to see at a glance any patients who needed their medicine at a specific time or were diabetic. These patients were allocated visits first to minimise the risk to them not receiving their treatment in a safe, timely way. As a back-up, admin staff monitored the system for incomplete visits and alerted team leaders.

Staff identified and quickly acted upon patients at risk of deterioration. All teams held regular multi-disciplinary team meetings to discuss changes to patient’s risks. Most teams also had a daily and/or weekly safety huddle meeting to discuss patient risk.

Some teams, such as frailty and district nursing teams, had waiting lists, however these were due to demand in excess of what was commissioned. Teams were looking at ways to improve these lists and the issue featured on risk registers. Staff had robust processes to triage patients on the list and prioritise based on risk factors. Where appropriate, staff signposted patients to other services to reduce waiting time or referred on to other services, such as the hospice. The district nursing team only accepted referrals for patients who were house-bound in order to manage demand.

Podiatry services had recently increased appointment times to 30 minutes, which staff told us was more realistic and meant they didn’t feel rushed. For an initial appointment, or if a complex treatment was planned, staff could block out two appointments to allow enough time.

Teams across the community adults services worked very effectively together to manage patient risk. Each morning team managers dialled into a brief call to discuss workload, capacity and risks for the day to ensure services were safe. If necessary, staff were shared or one team accepted extra referrals if another was stretched. A weekly call on Fridays reviewed the week’s service delivery and started to plan for the following week. Staff we spoke with were all committed to ensuring patients received safe care.

Where assessments highlighted potential risks to staff, these were considered, and mitigation put in place, such as visits being made with two staff members.

**Staffing**
Generally, the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Staffing budgets were set by the trust but were under constant review. Team leaders and managers told us that senior leaders were always willing to listen if staffing needs changed, and that budgets were flexible.

Across the services there were staffing vacancies. Staffing levels was an item on all services risk registers, apart from podiatry and stroke rehabilitation. In the crisis response team, there was a shortage of occupational therapists and the trust had been unable to recruit into those roles. The team were using bank staff to cover the vacancies, and there was a provision in place for band six occupational therapists to rotate across different teams in the directorate. Most teams were linking with the local universities to recruit nursing and therapy staff by offering student placements.

In the district nursing teams, staffing was an issue. In St Mary’s House, the manager had recently recruited a number of nurses. Of 10 band five vacancies, five had been filled. District nursing teams had trained health care assistants to undertake more clinical tasks, to utilise staffing as best they could. Managers in the district nursing services recognised that the service was limited in terms of career progression for staff. They were in the process of restructuring the service to create more posts and better opportunities to encourage nurses to view district nursing as a career. The crisis response team had recently taken on seeing patients who required urgent catheter support, creating extra capacity for the district nurses.

**Annual staffing metrics**

From August 2018 to July 2019, the comparison of staff groups in post (WTE) in adult community health services is shown in the chart below.

![Chart: Establishment WTE - comparing staff groups](chart.png)

**Nursing staff**

**Trust level**
The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.

Nurse staffing rates within community adult services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency and bank use.

**Vacancy rates**

![Vacancy rate chart](image)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives were not stable and may be subject to ongoing change.

**Sickness rate**
Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019. This could be an indicator of change.

**Allied health professionals**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual “unfilled” hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8.0%</td>
<td>10.1%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>836.1</td>
<td>9.2%</td>
<td>10.0%</td>
<td>5.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>204.5</td>
<td>11.7%</td>
<td>10.0%</td>
<td>3.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Allied health professionals within community adult services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover.

**Vacancy rates**

Monthly vacancy rates over the last 12 months for allied health professionals are not stable and may be subject to ongoing change.
Sickness rates

Monthly sickness rates over the last 12 months for allied health professionals showed a downward trend from November 2018 to March 2019. This could be an early indicator of improvement.

(Source: Universal Routine Provider Information Request (RPIR) Staffing data P16 – P21)

Suspensions and supervisions

During the reporting period from August 2018 to July 2019, community services for adults did not report any cases where staff have been either suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Quality of records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient records were held on an electronic system to which all staff had access. All information relating to a patient was stored on one record, so was easily available to all staff providing care. Records were clear, up to date, and holistic. The level of personalisation varied, with records in the frailty and stroke rehabilitation teams being highly personalised. Records across the district nursing teams were varied and podiatry care plans were generally lacking in personalisation but were appropriate to the input provided. Crisis response records were personalised proportionate to the type of service provided, given they provided urgent response.

The electronic records system was easy to understand and navigate. Staff could flag risks or pertinent information, so it was immediately obvious if someone had risk markers. This meant patients moving through the care pathways were protected from delays in transferring records, or information being lost.

During visits with the district nursing teams, we noted that not all records in patient’s homes were fully up to date or reflected the care and treatment being provided. This meant that other visiting professionals who did not have access to the NHS records system would not have accurate knowledge of what care the patients were receiving.

Medicines
The service used systems and processes to safely prescribe, administer, record and store medicines.

The trust had policies relating to medicines which referenced appropriate National Institute for Health and Care Excellence guidance. These policies were available to staff on the trust intranet.

There were a number of non-medical prescribers across community adults services, which meant access to medicines and supplies was not delayed. Where medicines were stored, this was done in line with national Institute for Health and Care Excellence guidelines.

The frailty teams had dedicated pharmacist time, which was used to review people’s medicines and provide specialist advice. The pharmacist provided advice and support to other teams if needed.

During visits and appointments, we saw staff employing safe practices in managing medicines, and staff appeared to have good knowledge. However, managing medicines was a mandatory training module, and staff across community adults services were well below the trust’s target for completion of refresher training.

### Safety performance

**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.

**Community Settings**

The trust did not report data to the safety thermometer.

### Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The trust had a clear incident management policy which all staff were aware of, and a process including reporting, investigation, outcomes and learning. Incidents were reported via an electronic system, which triggered the necessary steps. Staff in various teams told us what would constitute a reportable incident, and gave us examples of recent incidents, their outcomes and what learning was taken from them. Professional leads within the trust supported incident investigations as needed.

Learning from incidents was cascaded to staff via team meetings or huddles, and managers shared learning across services via managers meetings. The trust also used ‘embedded learning events’, where managers recorded a video outlining an incident and describe what was learned.
The video was uploaded to the trust’s YouTube page and a link posted on the landing page of the staff intranet. Managers were informed when a new embedded learning event was uploaded.

**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 August 2018 to August 2019, the trust did not report any never events for community services for adults.

*(Source: Strategic Executive Information System (STEIS))*

**Serious Incidents**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in community services for adults which met the reporting criteria set by NHS England, from August 2018 to August 2019. Both incidents were classed as slip, trip, or fall incident meeting SI criteria.

*(Source: Strategic Executive Information System (STEIS))*

**Serious Incidents (SIRI) – Trust data**

From August 2018 to July 2019, trust staff within community services for adults reported one serious incident. The incident did not involve the unexpected death of a patient. The incident was classed as a slip, trip or fall incident meeting SI criteria.

The number of the most severe incidents recorded by the trust incident reporting system is not comparable with that reported to Strategic Executive Information System (STEIS). This gives us less confidence in the validity of the data.

*(Source: Universal Routine Provider Information Request (RPIR) – Serious Incidents tab)*

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice.

The trust had an intranet on which staff could find a range of information and best practice guidance to support them in their work. Trust policies referenced National Institute for Health and Care Excellence guidance. The trust provided a range of lead roles to support staff in key areas such as safeguarding, mental capacity and governance. Embedded learning event videos shared learning and good practice across the services.
All teams we visited undertook thorough risk assessments, appropriate to their service. Frailty teams undertook very in-depth and personalised assessments called the ‘comprehensive geriatric assessment’, which covered areas such as pain relief, nutrition and hydration, capacity and consent, and social history, and in addition assessors looked at all pertinent test results. Added to that assessment was an anxiety assessment, memory testing, a pharmacy review and full patient involvement, all undertaken using a range of recognised tools, including SOCRATES which is a tool to measure pain levels.

In addition to a personalised care plan, patients started to develop their PEACE plan. This was an advanced end of life care plan involving discussions with patients, relatives and carers to ensure end of life care is delivered in line with a patient's wishes and preferences. Patients also developed a ReSPECT plan, which outlined the patient’s preferences in the event of a medical emergency, such as whether they would wish to be resuscitated, and under what circumstances. In order to triage and assess patients, the frailty team used the Rockwood scale, a best practice national assessment tool to measure frailty.

The community stroke rehabilitation team were in the process of creating a rehabilitation passport. This single document contained all information relating to a patient’s history, presentation, rehabilitation goals and progress. It also contained a diary where patients could record appointments and other pertinent dates. The passport was designed to follow a patient throughout their rehabilitation process.

District nursing and crisis response teams used an array of best practice tools in their service delivery, such as MUST (malnutrition universal screening tool) for nutrition, NEWS (national early warning score) which determines the degree of illness of a patient and prompts critical care intervention, and Purpose T, a pressure ulcer assessment tool. In addition, we saw staff using a range of other tools including falls assessments, mental capacity assessments and medicines support assessments. Staff in the frailty teams used a FACE tool, a nationally recognised tool to guide professionals through the process of making a single-issue mental capacity decision.

**Nutrition and hydration**

**Staff supported patients to have enough food and drink to meet their needs and improve their health.**

Nutrition and hydration needs were an element of all patient risk assessments. Community adults services had dieticians, dietetics and speech and language therapy colleagues either in their teams or that they referred to.

Where patients had specific dietary needs, these were flagged on the electronic system, so it was immediately obvious to staff, and they could prioritise where necessary. For example, in the district nursing teams, patients with diabetes were flagged and allocated visits first.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

Community adults services used a range of internal and national outcome measures. Staff were also looking at ways to measure other outcomes, such as the effectiveness of pharmacy input into the frailty service, which was not yet being captured due to the involvement being fairly recent.
The trust’s electronic system had a facility for measuring and reporting on certain patient outcomes. This was available to staff via their team’s dashboard and their monthly performance report. This information was regularly discussed and reviewed with staff at all levels, and all staff were encouraged to have input.

Teams used a range of recognised outcome measure tools, for example crisis response teams used the Derby Outcomes Measure to measure the effectiveness of a patient’s therapeutic interventions, and the stroke rehabilitation team used the Rehabilitation Complexity Measure. The stroke rehabilitation team also participated in the sentinel stroke national audit programme, which measures the quality and organisation of stroke care in the NHS.

In the 12 months following the introduction of PEACE plans for care home residents, the trust saw a dramatic reduction in hospital admissions and bed usage days for these people, with an 83% reduction in admissions and 94% reduction in bed days. This was an exceptionally effective outcome for patients and for the trust.

**Audits – changes to working practices**

The trust has participated in one clinical audit in relation to community adult services as part of their clinical audit programme.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Area covered</th>
<th>Key Successes</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture Liaison Service Database (FLSDB) 2017/18</td>
<td>Out of hospital care</td>
<td>Above the national average for 'Falls assessment done or referred'.</td>
<td>1. Review the treatment plan for inpatient neck of femur fractures and look into IV treatments as inpatients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Implement the best staffing solutions to achieve the best outcome for the fracture liaison service patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Review letters and communications.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Identify consultant lead and resolve staffing issues.</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Audits tab)

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

The trust had a supervision policy which staff were aware of. Staff in most teams told us they had regular supervision and appraisals, with meaningful discussions about training and professional development. The regularity of this varied depending on the team and the staff member’s support needs.

The community stroke rehabilitation team were particularly strong around staff support, with weekly catch up calls, monthly one to one meetings, bi-annual professional development reviews (using a dedicated tool) and annual appraisals. Staff in the crisis response teams told us their
supervisions had not always been completed regularly although informal supervision and support was available.

Services record their supervisions on local trackers within their service to ensure these are held regularly and are recorded. Local trackers are reviewed and monitored by team leads. Live supervisions are led by professional leads, service managers, team leads and practice educators.

During quality monitoring visits supervision compliance is reviewed. Relevant data is recorded by service managers within their service exception reports and on the dashboard. This information is presented at the divisional integrated performance reviews for assurance purposes which are attended by executive directors and chaired by the CEO. Supervision compliance is recorded in the main monthly Integrated Performance Report (IPR) to the trust board.

Supervisions take different forms, these include:

- Team meetings
- Safety huddles
- Staff forums
- Revalidation
- Peer supervisions
- Reflective practice
- Coaching
- Mentoring
- One to one meeting
- Appraisals

(Source: CHS Routine Provider Information Request (RPIR) – Clin Supervision tab)

All staff we spoke with told us that managers, and the trust as a whole, were very supportive of staff development, training and continual professional development. Staff attended additional training by applying for funding from the trust and attending internal or external courses. Some staff members had been supported to achieve academic qualifications relevant to their role, such as master’s degrees, and others had received training in quality improvement or professional development.

In the frailty team, staff completed additional training such as dementia awareness, electrocardiogram training, and nutritional training. In the crisis response team, staff completed additional training relevant to their role for example occupational therapists completed hoist and sling use training, and nursing and support workers had completed end of life training.

In all teams, nursing staff were completing advanced physical health assessment training and prescribing training. However, there were limited spaces on these courses, and staff told us that nurses from the frailty and crisis teams were given priority over the district nursing team to attend these courses.

Appraisal rates
From August 2018 to July 2019, 75.6% of eligible staff in community services for adults received an appraisal compared to the trust target of 90%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some staff groups.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Community services for adults</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional professional scientific and technicians</td>
<td>2</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>4</td>
</tr>
<tr>
<td>Students</td>
<td>1</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>91</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>154</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>163</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>231</td>
</tr>
<tr>
<td>Total</td>
<td>646</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Appraisals tab)

Multidisciplinary working and coordinated care pathways

The trust was an integrated community and acute trust which had a strong emphasis on reducing unnecessary hospital admissions, and we consistently saw exceptional evidence of teams working towards this goal. Used of one electronic record system reduced the risk of information being lost, and meant patients did not have unnecessary waits for their notes to transfer between services.

Most referrals for all teams were made via an integrated health and social care connect team. This team had a range of professionals including social workers, occupational therapists and nurses to ensure all incoming referrals were appropriately triaged, and a multidisciplinary decision was made about the best onward referral for the patient. All teams we spoke with told us this was an effective system and had addressed historic issues with referrals being lost or inappropriate.

The stroke rehabilitation team worked very effectively with adult social care rehabilitation staff in the Joint Community Rehabilitation (JCR) service, and shared office space in Bexhill hospital. JCR staff told us they considered themselves to be one team with NHS staff, working in the best interests of patients. Trust staff had read-only access to the adult social care records system, which meant they didn’t have to wait for information to be given to them. A social worker was based at Bexhill hospital and worked closely with the stroke and frailty services.

Crisis response teams worked very closely and proactively with discharge coordinators from the wards, adult social care brokerage team, JCR and the hospices. Crisis response staff also had access to the adult social care records system, and work was underway to give adult social care staff appropriate access to the NHS system. Team leaders within crisis response teams had
accessed adult social care end of life training for staff. Staff from crisis response teams attended regular multidisciplinary meetings held by GPs to discuss the patients who were most at risk.

District nursing teams had links with a range of other services and professionals, working closely with GPs, the hospices, allied health professionals and colleagues in other community adults teams. District nurses provided training to care home staff to support patients to change their dressings if required.

Podiatrists were very proactive in checking patients’ broader health and wellbeing during appointments, making suggestions or referrals as necessary. Podiatrists also told us they check a patient’s full health input prior to appointments to ensure they have a holistic view of a patient’s situation. Podiatry staff within the joint community rehabilitation team undertook an assessment of the most urgent referrals, and took whatever steps were necessary to stabilise a patient’s situation before handing over to the community team. Staff in both teams spoke positively about this process. Podiatry teams had strong links with vascular and diabetes teams and held joint clinics with nurses from each discipline.

All services had multidisciplinary team meetings or virtual ward rounds, and safety huddles, ensuring that all staff within an individual team will be aware of any pertinent information, risks or progress relevant to each patient. Teams use white boards as a visual prompt to show patients most current status, and any onward referrals made. Staff across teams told us the internal referrals pathways were very effective, and they rarely had to chase a referral once it had been made.

Administration staff across all community adults services were very effective in maintaining records and keeping teams organised. In district nursing teams, administrator staff had recently had their practices aligned so that they provided a consistent service across all teams and could provide cover in other locations when needed. They managed a vast range of tasks including monitoring equipment for safety checks and prompting nursing staff when this was required, undertaking all practical tasks for new staff including ensuring they had their equipment, uniforms and inductions booked, monitoring staff supervisions and appraisals, checking staffing against budgets so the manager could be alerted of any issues, producing staff rotas, taking minutes and providing personal assistant services to managers, including a monthly report of all outcomes.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

Across services we visited we saw lots of evidence of health promotion activity. District nurses had training called ‘making every contact count’, which was a coaching approach to health promotion, to help staff support patients to make healthier lifestyle choices, such as eating well and smoking cessation. During podiatry appointments and district nursing visits we saw staff asking health related questions and signposting to other services. The stroke rehabilitation team had a twitter page, which it used to promote healthy lifestyles and signpost patients to support services. All patient areas had notice boards with a range of health promotion information.

A pharmacist undertook an optimisation review of patients’ medicines where appropriate. This is a person-centred approach to safe and effective medicines use, to ensure patients obtain the best possible outcomes from their medicines, and to remove any unnecessary medicines from a patient’s regime. It also looked at how prescribed medicines interacted to ensure a patient’s health and well-being was not being adversely affected by side effects of their medicines.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 90% for completion of Mental Capacity Act / deprivation of liberty safeguards training.

From August 2018 to July 2019 the trust reported that Mental Capacity Act (MCA) training had been completed by 71.0% of staff within community health services for adults.

A breakdown of compliance for MCA/DoLS courses from August 2018 to July 2019 for nursing and midwifery staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>186</td>
<td>282</td>
<td>66.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff within community services for adults did not meet the target for Mental Capacity Act training courses.

A breakdown of compliance for MCA/DoLS courses from August 2018 to July 2019 for allied health professionals in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>154</td>
<td>195</td>
<td>79.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Allied health care professional staff within community services for adults did not meet the target for Mental Capacity Act training courses.

(Source: Universal Routine Provider Information Request - Training tab)

Deprivation of Liberty Safeguards

Records we viewed across the teams we visited showed consent was sought and gained. During clinic appointments and on visits with district nurses, we saw staff explaining treatments and gaining consent.

Staff we spoke with were aware of the Mental Capacity Act, how it impacted on their role and what they would do if they had reason to think someone might lack capacity. Staff in the frailty teams told us they use a FACE toolkit, a nationally recognised tool to guide professionals through the
process of making a mental capacity decision. Staff were also aware of Gillick competence and their role and responsibility when treating young people under 16.

The trust had a mental capacity lead to provide support and advice should it be needed.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We spoke with patients receiving services across community adults teams, and their relatives, and they all told us staff were caring and kind, and genuinely had their best interests at heart. We were told staff always go the extra mile where they could, one example of this was when a staff member in the frailty team arranged to have the patient’s favourite meal cooked by their favourite restaurant and delivered to the nursing home.

Feedback from patients confirmed that staff treated them with kindness and respect. We saw a significant number of cards and letters from patients and relatives expressing their thanks and gratitude. Teams had notice boards or designated walls for displaying patient feedback, cards and letters. Staff told us this was very motivating, and that patients receiving the treatment they deserved and needed was what it was all about.

During all our visits we heard staff talking respectfully and appropriately about patients at all times, and all staff interaction with patients we saw was always extremely kind, compassionate and caring. All records demonstrated respect and protected patients’ dignity.

Staff we spoke with understood equality and diversity, and were able to give us examples of where they had been able to meet diverse needs. Specific information could be recorded on the electronic system for all staff to see, and flagged if it was urgent. All staff we spoke with said they would not hesitate to raise concerns if they witnessed discriminatory, disrespectful or abusive behaviour, and were very clear about how to do so.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff were clear on the importance of emotional support needed when delivering care. It was clear that staff considered patients’ emotional needs and made adjustments as necessary. Patient feedback highlighted that staff provided emotional support to patients in a kind and caring manner. One patient told us that they valued time with their grandchildren and did not wish to have that time interrupted by a district nursing visit. The nurses ensured they knew when that would be, so they could plan visits around it. Similarly, a patient receiving treatment from the podiatry service told us that they preferred morning appointments as they visited family in the afternoons, and that this was always accommodated.

Staff in the crisis response teams had undergone end of life training provided by the hospice, which equipped them to provide emotional support patients and their families at the end of their lives. Staff told us they were encouraged by managers to spend extra time supporting patient’s families when they needed it. The crisis response service had also continued to provide care to
people in their homes beyond their usual time period to ensure they were able to end their lives at home, as per their wishes.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients and their families were appropriately involved in making decisions about care options and the support needed. Our observations of interactions between staff and patients confirmed that staff communicated with patients in a manner that helped them to understand their care and treatment. Feedback from patients indicated that they were fully involved in the treatment decisions.

Relatives and carers of patients we spoke with told us they were very happy with services provided, and that staff were very caring, kind and kept them fully involved where the patient wished for them to be. During visits and appointments, we consistently saw staff showing care and understanding towards relatives and carers. Where patients were longstanding, we could see the relationship that had built between staff, patients and relatives. We were told of examples of people being involved even when they could not physically be there, with staff setting up email links or maintaining telephone contact.

In patient and waiting areas, there were information leaflets about treatment choices, support services, safety advice and advocacy. Staff told us about measures they took to ensure patients were enabled to be involved in their care, including patients who had communication needs, sensory support needs or different types of advocacy. Where information sharing with partner agencies was necessary, patients were consulted and consent requested.

Feedback from patients was routinely sought via feedback forms on discharge and surveys, and Friends and Family Test feedback cards were in all public areas. Most teams had patient representatives who attended meetings, sat on interview panels or are otherwise involved in services.

In district nursing teams, volunteers regularly undertook spot checks of patient satisfaction by phone. They were given the full current caseload and a private space to contact patients. Volunteers then recorded all feedback anonymously and give it to the administration lead for collation.

Is the service responsive?

Planning and delivering services which meet people’s needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The trust was working towards an integrated care model. Across community adults services we consistently saw evidence that this was well embedded into practice. The trust had developed exceptional pathways of care for patients, who received holistic, joined up services and moved seamlessly through the delivery pathways. The trust also aimed to reduce hospital admissions and reduce length of stay. Community adults services provided a solid foundation to facilitate this, with
teams working effectively and creatively, independently and together, to continually find ways to support people in their homes.

Teams had tailored services in recognition of the local demographic, with services developed to meet the needs of a largely older population. Home visits were carried out by all services we visited where needed, although in the district nursing and podiatry teams, home visits were reserved for patients who could not access clinics. Managers we spoke with were aware of constantly changing needs of the local population, and changes in demand. They held regular discussions with senior managers and commissioners to ensure the effectiveness of the services offered was constantly reviewed.

There were adequate seating facilities in the waiting areas at all clinics, although podiatry waiting areas were small and also used for storage.

Translation services were available for patients who did not have English as a first language. Information leaflets were available in a range of languages, and could be translated if the required language was not available. Staff in frailty teams used conversation cards to help them communicate with patients.

Staff were aware of diversity and equality issues and were creative in supporting patients to address them. One staff member in the frailty team told us of an example of where a patient needed to stand up to be able to pray, but had a significant falls risk. The frailty staff member advised and worked with the patient to devise a safe way for the patient to be able to stand for long enough to meet their religious needs.

**Meeting the needs of people in vulnerable circumstances**

**The service was inclusive and took account of patients’ individual needs and preferences.**

Patients receiving care from adults’ community services had a thorough risk assessment carried out, where specific needs were highlighted.

Where there were waiting lists, these were carefully triaged to ensure patients who were most vulnerable were prioritised, and the lists were regularly reviewed to ensure patients’ risks had not changed. For patients who were not prioritised and would have to wait for services, staff used a range of methods to try to offer immediate help, including phone contact to offer advice and signposting or referrals to other services. Patients identified as requiring end of life care were prioritised or referred on to the hospice teams.

Crisis response teams had recently taken over visiting patients with urgent catheter problems, to free up capacity for district nursing teams, who had already had to restrict their visits to house-bound patients only due to demand.

Services had daily team calls to identify risks in staffing and caseloads, and look at ways to manage this, including sharing staff across teams, to ensure the most vulnerable patients received their care. Most teams had daily safety huddles to ensure that patients’ most up to date risk information was shared with the whole team.

The frailty teams undertook PEACE and ReSPECT planning with patients and their relatives (care plans which specified patient’s wishes in specific circumstances), so that when patients were in the midst of a medical emergency or requiring end of life care, their wishes were already known, saving them and their families the trauma of making those decisions at the most difficult time.
Access to the right care at the right time

People could generally access the service when they needed it and received the right care in a timely way.

Of the services we visited, all except the crisis response teams had waiting lists, although in most cases this was due to demand in excess of what they were commissioned to provide. Services monitored these lists and had processes to triage patients to ensure those most urgent referrals were processed quickly. Lists were constantly reviewed to capture any changes to patient’s risks.

Where possible and appropriate, patients were signposted to other services who could assist more quickly, or staff referred patients on to other services such as the hospice. The district nursing team had changed its criteria to accept patients who were house bound only to ensure those most in need received services.

Patients receiving services from the podiatry teams were very positive about the appointment system and told us staff gave them appointments at a time of day to suit them. Where mistakes happened, patients were able to phone in to request a new appointment, which was issued immediately. One patient told us about a time they were worried about their foot and called to request an urgent appointment. Staff were able to arrange a same day appointment for that patient.

Crisis response teams did not have waiting lists, but had defined capacity, so any referrals they were unable to accept were diverted to another provider. Crisis response staff were very proactive in ensuring patient flow, and worked effectively with other teams to ensure patients were moved on appropriately. Examples of other teams they worked with were the joint rehabilitation teams, hospices and adult social care brokerage teams.

Staff from the stroke rehabilitation teams located themselves at acute gateways, such as the accident and emergency department and other acute assessment units, to be on hand to assess patients coming into the hospital to see if they could be supported at home rather than be admitted to hospital.

Similarly, staff from the frailty team located themselves in acute gateways to capture patients coming in from care homes and provided frailty support and advice to care home staff, enabling them to look after the patient in the home rather than admit them to hospital. After the patient had been back in the care home for 48 hours, a frailty practitioner visited them to signpost or refer to necessary services and help put a frailty plan together for the care home staff to follow. This was so successful in terms of impact on admissions and best outcomes for patients that the trust was planning to develop a separate acute hospitals frailty team.

For most teams, referrals came via the health and social care connect service, which was a single integrated point of access for health and social care services. This service had a multidisciplinary team of staff assessing incoming referrals so that they were forwarded to the most appropriate team. All staff we spoke with said this worked well and had vastly reduced historic issues with referrals, therefore speeding up the referrals process.

Accessibility

The trust has provided the four most common languages spoken among ethnic minority groups, rather than the four largest ethnic minority groups. The most common ethnic minority language spoken within the trust catchment area is Arabic.
<table>
<thead>
<tr>
<th>Ethnic minority group</th>
</tr>
</thead>
<tbody>
<tr>
<td>First most commonly spoken</td>
</tr>
<tr>
<td>Second most commonly spoken</td>
</tr>
<tr>
<td>Third most commonly spoken</td>
</tr>
<tr>
<td>Fourth most commonly spoken</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request – Accessibility tab)

The trust met the referral to initial assessment target for 54 of the 76 targets listed and did not meet the target for 22.

The trust met the assessment to treatment target for all 76 targets listed.

(Source: CHS Routine Provider Information Request – Referrals tab)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The trust had a clear complaints policy. However, in all services, staff reported receiving low numbers of complaints and typically resolved concerns before they reached a formal stage.

Learning from complaints was cascaded to staff via team meetings or huddles, and managers shared learning across services via managers meetings.

From August 2018 to July 2019 the trust did not report any complaints about community services for adults.

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

Compliments

From August 2018 to July 2019 the trust did not report any compliments for community services for adults.

(Source: Universal Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders in all teams we visited had the skills, knowledge and integrity to run the service. Leaders at all levels encouraged staff motivation and development and spoke with genuine enthusiasm and respect about the teams they managed.

All staff we spoke with were very positive about managers at all levels, most knew one or more board members personally, and had interacted with someone from the board. All staff were very positive about the trust’s CEO, who they told us had transformed the trust with his visibility, positivity and genuine interest in their work. Staff felt that their feedback and ideas were listened to and many were able to give us examples of this. Staff told us that senior managers and board members were approachable, welcomed direct contact, and responded in a timely manner.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The trust had a clear vision and strategy, which staff knew and understood. Some teams had their own vision and strategy which aligned with the overall trust's, and all staff we spoke with were able to tell us how they felt their role contributed. The trusts values were embedded into the staff appraisal process and all staff spoken with felt the values matched their work and ethos.

The trust’s emphasis on reducing hospital admissions and minimising length of stay was fully embedded across the community adults teams working practices. Staff were committed to this and consistently told us about measures they were taking to ensure it happened. Teams worked exceptionally well together to create effective pathways, ensuring patients received the care and treatment they needed while avoiding hospital admissions.

The service was moving towards an integrated delivery model and teams were in varying stages of this process. The district nursing team at St Mary’s House was already co-located with adult social care. In the stroke rehabilitation and crisis response teams, integrated working was well embedded. Staff told us it created seamless pathways through services for patients, and that the teams across health and social care worked together effectively.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.

Staff we spoke with were very positive about the culture within the trust, which they said has improved dramatically in the last three years. Staff at all levels felt respected, valued and included, and told us they felt proud and lucky to work for the trust.

One staff member told us about a conflict with a colleague, which had been resolved quickly and effectively. Another told us about a conflict which had taken a little longer to resolve, but was now working well.

There was a strong focus on staff wellbeing, although some staff members we spoke to said high workloads could sometimes impact on this. Teams had completed stress risk assessments and had produced action plans to improve staff wellbeing. In podiatry, staff had a “hug in a box”, where they could leave compliments for each other. The stroke rehabilitation team had a notice board in the staff room with a wide range of well-being information.

Staff told us the culture was one of learning, positivity, transparency and no-blame. Staff knew the whistle blowing policy and told us they would not hesitate to use it should they need to.

Board members had introduced several initiatives aimed at boosting staff morale. One such initiative was ‘stay interviews’, which was one-to-one sessions for all staff members with a senior manager where the staff member outlined their feelings about working for the trust, what made them stay and whether they had considered leaving. Another was ‘quality walks’, where a board member walked around wards or team areas to see what was going on that day and check how everyone was. A third was ‘walking in your shoes’, where a board member took a different role for a day to experience the job first hand. All of these initiatives were very successful and staff were
very positive about them. We saw evidence that managers were collating the outcomes of these initiatives where possible and analysing any themes, and produced ‘you said we did’ responses.

Governance

Leaders operated effective governance processes, throughout the service. There was a clear governance structure which staff were familiar with.

Staff told us the structure was effective, and that feedback came back quickly from any issues highlighted or ideas raised.

Teams had weekly or monthly meetings, then team leaders and managers met monthly, with senior managers relaying information to the board. Specific leads, such as safeguarding and mental capacity, also had governance meetings and reported to the board.

Each team had their own targets and KPIs to meet, and had their performance relayed to them in monthly performance reports, which they analysed during team meetings and devised action plans. These were then escalated to the board who fed back quickly. Live performance indicators could be viewed by each team on their own dedicated dashboard, which allowed managers access to real time information. Each element of the service was rated red, amber or green as a visual prompt of the risk and performance level.

Staff consistently told us that they felt managers at the very highest level knew what was going on in their teams, and genuinely cared about improving services.

Management of risk, issues and performance

Leaders and teams used systems to manage risk effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Each service had its own divisional risk register and there was an overall trust risk register, all of which were regularly reviewed and updated.

Managers we spoke with very clear about what the risks were specific to their service, which reflected those staff had told us about, and what action was being taken to address them.

Lone working was highlighted as a particular risk, with all teams using different processes, including mobile phone chat groups, none of which had a robust escalation plan except the stroke rehabilitation team. Managers were aware of this and a focus group was looking at safer processes, with an app under consideration.

The trust planned in advance for winter pressures and had policies to manage other continuity issues such as IT failure or inclement weather.

Information management

The information systems were integrated and secure

All patient information was on one electronic system, to which staff has protected access.

The trust had processes in place to ensure staff who were leaving had their access terminated. There was also a policy to address loss or theft of IT equipment. One staff member told us of an
instance when a staff member had their laptop stolen, so the process was triggered, and the laptop wiped of all NHS systems within an hour.

Information governance was a mandatory training module for all community adults’ staff, although completion rates were very low and well below the trusts KPI for this training.

**Engagement**

**Leaders and staff actively and openly engaged with patients and staff.**

The stroke rehabilitation team had a twitter page, which it used to share information and news about the service and promote healthy lifestyles. This elevated the service’s profile and gained national attention. The service recently held an Olympic style event, involving staff and patients, and also the local community. The stroke rehabilitation team also had a patient representative on the interview panel when recruiting.

The crisis response teams circulated a quarterly newsletter to staff, the Grapevine. This included, among other things, information about the service performance, any news updates, a ‘you said we did’ section and patient feedback.

The community nursing teams also held a recent engagement event with staff to get their views on the future of the service as a whole. This event will feed into the future restructuring of the service.

Staff from frailty teams were engaging with other stakeholders in the community to raise awareness of PEACE plans, and to ensure that anyone who may be involved with an older person will know to look for one and how to use it. These included the carer forum, the fire and rescue service, the ambulance services, GPs and pharmacists.

**Learning, continuous improvement and innovation**

Community adults services displayed a real culture of learning and continuous improvement. Managers genuinely encouraged innovation, and staff at all levels and across teams gave us examples of where their ideas were trialled. Staff told us this made them feel valued and included.

Community services recently introduced an initiative called ‘leading community together’, which brought together service leads, team leaders, nurses, a coach and a psychologist to review the whole service. This identified several areas for improvement, and created workstreams and focus groups to look at the issues. These included triage systems and lone working.

Learning from incidents, safeguarding incidents and complaints was undertaken within and across teams. Embedded learning events are undertaken regularly and involves a multidisciplinary review of a specific incident, with learning identified and shared via a video posted on the trust’s intranet page. The governance lead advised staff when a new video was uploaded.

Quality improvement training was being rolled out to staff, with everyone having the basic session, then others undertaking more in-depth courses. Staff told us this was very effective, and the stroke rehabilitation service was using the training for a number of initiatives.

The trust was developing a decision tree, which was a tool used to input a patient’s symptoms, medical history and other pertinent information, which used the information to guide staff to the most appropriate service or services for that patient.
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 trust did not take part in any accreditation schemes relevant to community adult services.

(Source: Universal Routine Provider Information Request (RPIR) – Accreditations tab)
**Community end of life care**

**Facts and data about this service**

The trust provides specialist palliative care within community services by working closely with GP colleagues, St Michael’s, and St Wilfrid’s hospices to support individuals important to the patient, during their last days of life.

The district nurses undertook holistic assessments for patients in their last year and last days of life, working with hospices and GPs to ensure there was appropriate anticipatory prescribing. The service was piloting a revised process offering structured bereavement support and feedback six weeks post bereavement via a telephone call, or pre-arranged visit.

The crisis response service supported the rapid discharge end of life care pathway, enabling patients to be discharged home quickly if this was their preferred place of care. They also supported with a night sitter if appropriate to enable a patient to remain at home. End of life care delivery was supported by responding to rapid referrals for symptom management and ensuring stat doses (single doses of medication immediately required) were administered in a timely manner.

The integrated night service supported end of life care delivery between 10pm and 8am.

Intermediate care units did not offer specialist palliative care, but worked closely with GPs, hospices, and secondary care colleagues to ensure patients received high quality end of life care.

Frailty practitioners supported residents in care homes in their last year of life, developing Proactive Elderly Advance Care (PEACE) plans, which supported care home staff with appropriate escalation plans and avoiding unnecessary hospital admissions.

A list of all hospices, end of life care networks and partners is shown below:

- St Wilfrid’s hospice, Eastbourne
- St Michael’s hospice, Hastings
- East Sussex end of life care clinical reference group
- NHSI KAHOOTZ end of life care practitioners’ network
- Continuing healthcare care team
- Local chaplaincy
- Local care homes
- Adult social care
- South east coast ambulance trust
- Volunteers
- Healthwatch
- Patient representative on end of live care improvement group
- Local CCGS
- Health education Kent, Surrey and Sussex end of life care network
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 relevant staff and made sure they completed this.

**Mandatory training completion rates**

Data provided by the trust indicated that no nursing staff were employed within community services for end of life care. The end of life service did not have a dedicated staff group. Instead, all end of life care was provided by community nursing, frailty and crisis response team staff. As such, mandatory training statistics for staff engaged in end of life care could not be separated into statistics for the end of life community service.

The trust set a target of 90% for completion of mandatory training and a target of 95% for the module information governance. Medical staff were all allocated to Eastbourne District General Hospital.
A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for medical staff in community services for end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support, immediate life support and resuscitation</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0</td>
<td>7</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for end of life care the 90% target was met for four of the six mandatory training modules for which medical staff were eligible. In addition, the 95% trust target for the information governance module was not met.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff in the community nursing, frailty and crisis response teams (out of hospitals teams) who provided end of life care attended a range of mandatory training related to end of life care. This included a half day, three-yearly training course provided by the acute specialist palliative care team, including recognition of the dying patient, advance care planning and essential conversations amongst other topics. Registered staff also attended an afternoon mandatory session covering symptom management. Staff attendance was recorded on a performance dashboard. At the time of the inspection, this dashboard indicated that 72% of eligible staff within the teams had completed this training. The end of life care community service lead monitored this dashboard and produced a regular report to the compliance group.

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.

All staff with regular contact with patients were expected to attend safeguarding training. The training consisted of a three-hour face-to-face, level two awareness training for adults and children. Band 6 staff and above attended level three safeguarding adults training.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training. Medical staff were all allocated to Eastbourne District General Hospital.
Eastbourne District General Hospital

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at Eastbourne District General Hospital for medical staff in community services for end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for end of life care the 90% target was met for two of the four safeguarding training modules for which medical staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community health services for end of life care did not make any safeguarding referrals between August 2018 and July 2019.

(Source: Universal Routine Provider Information Request (RPIR) – Safeguarding tab)

Although staff had not made any recent safeguarding referrals, they were able to demonstrate an understanding and awareness of their safeguarding responsibilities. Staff contacted the trust safeguarding team or the local authority for advice as needed. The crisis response team at Eastbourne District General Hospital and the community nursing team based at St Mary’s House in Eastbourne were located in the same area as local authority social work colleagues and staff could seek informal support and advice from them as needed.

The community end of life service lead held a weekly capacity and demand call, which included discussing and reviewing any end of life related safeguarding concerns. Any safeguarding alerts raised were logged and categorised as end of life to enable the service lead to monitor these.
Cleanliness, infection control and hygiene

The service controlled infection risk well. They used control measures to prevent the spread of infection before and after the patient died.

The service had an infection control policy, and guidelines for care after death which included infection control. All community staff had mandatory hand hygiene training and were supplied with personal protective equipment including hand gel, hygiene wipes, gloves and aprons, to take on home visits. We saw appropriate infection control procedures on community visits during the inspection.

Environment and equipment

The design, maintenance and use of facilities and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes, staff took precautions and actions to protect themselves and patients.

Staff visited patients in the community in their own homes rather than at the team bases, including visits to care homes by the frailty teams. Some patients were given end of life care in the intermediate care unit in Rye community hospital, but this was not a specific end of life care unit.

Community nurses had a selection of syringe drivers and other equipment for use in the community. If they did not have enough stock availability they could borrow from other sites or from the local hospices.

We found two out of date stock items at the St Mary's Eastbourne community nursing team. We raised this straight away and staff removed the items immediately. These were non-essential sticking plaster items so there was no apparent risk of harm resulting from this oversight.

The crisis response team were able to access same day occupational therapy equipment, such as hoists and specialist slide sheets for patients when needed.

Assessing and responding to patient risk

Staff completed and updated comprehensive risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff completed risk assessments on their electronic system. These were backed up by paper copies in people's homes due to partner agencies such as local hospices, GPs and adult social care teams not having access to the same electronic system. Community nursing staff took laptops out on visits to ensure that as well as updating paper copies of risk assessments, they were able to update the electronic records in real time.

Staff had access to training to help them identify and respond to deteriorating patients, including sepsis training. The service had a flowchart to guide staff in identifying and responding to the deteriorating patient and used the national early warning score (NEWS) to help identify deterioration. Staff also used general observations charts and physical health assessment templates to support this monitoring.

Staff could also access patients' summary care record (including previous hospital or GP input) to update them on the patient's previous medical history to assist with risk assessments.
To ensure that the needs of end of life patients were met, teams used a red amber green (RAG) rating system to highlight priority visits when they experienced difficulty in meeting demand (due to overload of work or staff absence for example). Staff highlighted end of life patients as red to ensure their visits were prioritised and could not be missed, for example when visiting to assist with symptom control. However, early stage end of life patients who did not need intervention would not be prioritised in the same way, to ensure those who were most in need of support received this. The end of life service was included in a working group at the time of the inspection to look at how best to ensure increasing demands on the community service continued to be met.

The crisis response team identified a daily shift co-ordinator to monitor caseload and ensure staff were allocated and completed all urgent and priority visits. The team also held a daily handover and safety huddle to discuss any patient deterioration or increased risks.

The out of hospital service which included community nurses, the frailty and crisis response teams, had an admission, transfer and discharge policy, which supported acute hospital colleagues in arranging timely discharges for patients. The teams aimed to respond straightaway where possible. The crisis response team had a role in helping with discharges, as well as preventing hospital admission, providing a same day response. Most referrals came from the community as opposed to rapid hospital discharges.

The out of hospital teams worked together and with the local hospice to identify the most appropriate teams to deliver the care. The teams held capacity calls every morning, lunchtime and evening to discuss and ensure work was allocated to the appropriate team.

**Staffing**

The service had access to enough staff within the out of hospital teams with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. While the teams were having issues meeting the demands of the services, end of life care was prioritised to ensure needs were met.

Data provided by the trust indicated that no nursing staff were employed within community services for end of life care.

**Annual staffing metrics**

From August 2018 to July 2019, the comparison of staff groups in post whole time equivalent (WTE) in core service is shown in the chart below.
The following information and charts highlight specific staffing areas where there was noteworthy evidence that may prompt further investigation on site.

Please refer to the Data Glossary for further details on what data has been reviewed and how.

The trust set a target of 8% for the overall vacancy rate. From August 2018 to July 2019, the trust reported a vacancy rate of 4% in community end of life care. This met the trust’s target.

The trust set a target of 10% for the overall turnover rate. From August 2018 to July 2019, the trust reported a turnover rate of 0% in community end of life care. This met the trust’s target.

Medical staffing rates within community health services for end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and agency and bank use.

Monthly vacancy rates over the last 12 months for medical staff were not stable and may be subject to ongoing change.

(Source: Universal Routine Provider Information Request (RPIR) Staffing data P16 – P21)
Suspensions and supervisions

During the reporting period from August 2018 to July 2019 community health services for end of life care did not report any cases where staff have been either suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – Suspensions or Supervised tab)

While the end of life community service did not employ nursing and support staff as part of the service, end of life care was embedded throughout the work of all staff employed within the out of hospital teams.

Staff viewed end of life care as everybody’s business and an integral and vital part of their work. Teams had end of life link nurses who attended link nurse meetings and fed back any updates within team meetings.

At the time of the inspection, there was a service workstream looking at how best to meet the demand resulting from an increasing number of referrals to the community nursing teams. A restructuring to the service was being considered to identify how the service needs could continue to be met. The community nursing teams were having to RAG rate tasks to ensure the most urgent ones were prioritised and completed.

Staff received end of life specific training to support them in this aspect of their roles.

Quality of records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Staff generally had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. Integrated support workers in the crisis response team did not have access to the electronic records system, although the team were taking action to resolve this by the beginning of next year and in the interim staff could access paper records.

We looked at 15 sets of patient care records, five proactive elderly persons’ advisory care plan (PEACE) documents, four do not attempt cardiopulmonary resuscitation (DNACPR) documents, one preferred priorities of care (advance care planning) document and two recommended summary plans for emergency care and treatment (ReSPECT) documents on site. We found the recording on these documents to be of good quality, comprehensive, holistic and person centred.

PEACE documents were used for patients in care homes. The preferred priorities of care document was used for patients in their own homes. The service was in the process of introducing ReSPECT documents in place of DNACPRs.

Staff used a mixture of electronic and paper records. Staff took laptops to patients’ homes and updated records in real time to ensure these were current. However, integrated support workers in the crisis response team did not have access to the electronic system and were reliant on the completion of paper records. This was on the crisis response team risk register and it was expected that all staff would be able to access the system by the beginning of 2020. Paper records were completed and left in patients' homes to ensure visiting staff had access to these. Patient drug administration charts were stored in patient homes and added onto the electronic system.
Staff used specific end of life care plans. These included the use of a symptom observation chart which was used for patients in the last few days of their lives. However, the chart did not include a check for breathlessness. We raised this straight away and the end of life lead agreed to follow this up. There was a space on the chart for other symptoms to be recorded, and breathlessness could be added to that space, although there was no clear prompt for this as for other symptoms.

The end of life lead audited 18 care records each month (three from each of the six community nursing teams), to ensure staff completed care plans appropriately. They raised any concerns with the teams to ensure any issues were resolved.

All staff working with patients with DNACPR (do not attempt cardiopulmonary resuscitation) orders in place were made aware of this and it was highlighted on the summary section of the patients’ care records. We looked at four DNACPR documents and found them all to be fully and correctly completed.

All DNACPR forms were completed by the GP or on discharge from the hospital and were signed by an appropriate clinician. The trust resuscitation team audited ReSPECT and DNACPR forms from the acute hospital. If the community service identified any poor quality forms from GPs they liaised with the clinical lead who followed this up with the GPs. The clinical lead had arranged a series of reflection sessions to critique ReSPECT documents and support the improvement and quality of these forms.

We looked at two RESPECT and one preferred priorities of care documents and found these to contain a high level of detail, with a clear communication of the person’s wishes.

The PEACE document, used by the frailty teams for patients in nursing and residential homes, was brought in to try to prevent unnecessary hospital admission. The document was a shared decision-making tool aimed at capturing the patient’s wishes as a proactive advance care plan, helping to reduce unwanted admission to hospital. A copy of the PEACE plan was shared with the patient, family, care homes, the GP and was also made available to the ambulance service. We reviewed five PEACE documents on site and found them to be clear, holistic and comprehensive.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

The service had access to guidelines for anticipatory medicines as part of the controlled drugs policy. Anticipatory medication was prescribed through a range of medication to cover all symptoms. Community nursing teams did not take medicines to patients. If they identified the need for anticipatory prescribing, staff contacted the GP, or on occasion, the specialist palliative care nurses from the local hospices. Medication could then be arranged for the patient’s home just in case this was needed. While nurses did not carry controlled drugs, in an emergency an urgent prescription could be requested and they could collect these from the local chemist and deliver to the patient. The medicines management policy supported the safe transport of drugs from a pharmacy to the patient’s home.

During visits with the community nursing team in Bexhill we noted on one occasion a prescription for anticipatory medicines was prescribed over a year ago, and one was prescribed over ten months ago. It would be good practice for this prescription to be reviewed and re-written every six months. The community nursing team recognised this, agreed that the prescription was out of date.
and should be reviewed at each visit. On these occasions this had been missed. The staff member agreed to take the prescription back to the GP to be re-written.

GPs completed drug instruction charts, which were stored on the electronic system, as well as keeping a copy in the patient’s home. This information told the nurse what medicines they could administer to the patient in case this were needed for symptom control. Community nurses completed a record of controlled drugs within the patient’s home. This showed a clear record of what drugs had been added and used. On a community visit we saw that entries were recorded clearly, and the balance recorded matched the stock available. All stock was in date.

While community nurses did not prescribe medicines, the team at Conquest Hospital had two non-medical prescribers and the team at Bexhill had three non-medical prescribers with two more undertaking their training. Nurses within the crisis response service were also completing this training. Staff in the frailty team were either trained non-medical prescribers or were expected to be working towards this.

The crisis response team was waiting for a medicines cupboard to be fitted and had agreed what basic medication would be stored in the cupboard in preparation for the staff to qualify as non-medical prescribers.

Community nursing teams had a stock of syringe drivers, stored in locked perspex boxes. This allowed for inspection of the pump but prevented damage or tampering. Staff took responsibility for the delivery and return of these through completion of a register. Reciprocal arrangements were in place with the local hospices and other teams in case additional syringe drivers were needed. 72% of community staff were trained in the use of syringe drivers.

The service had a working group reviewing drug charts to ensure these were appropriately updated, as well as an anticipatory prescribing multidisciplinary working group.

**Safety performance**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

Staff from the out of hospital teams collected data through their reporting systems to enable the service to understand the burden of harms (such as pressure ulcers, or falls for example), measure improvement over time and connect frontline teams to the issues of harm, enabling immediate improvements to patient care.

The teams completed audits of care and reviewed incident forms to identify any ongoing trends or concerns. Any end of life specific concerns were fed back to the end of life lead, who fed this information into a report sent to the end of life improvement group.

**Incident reporting, learning and improvement**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.
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 July 2018 to August 2019, the trust did not report any never events for community services for end of life care.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trust level

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in community services for end of life care, which met the reporting criteria set by NHS, from July 2018 to August 2019.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From August 2018 to July 2019, trust staff within community services for end of life care did not report any serious incidents.

(Source: Universal Routine Provider Information Request (RPIR) – Serious Incidents tab)

Prevention of Future Death Reports

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths. These reports each contain a summary of Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

The trust stated that in the last 12 months, no prevention of future death reports or inquests requiring significant actions were sent to the trust.

(Source: Universal Routine Provider Information Request (RPIR) – Prevention of future death reports tab)

Staff understood their responsibility to raise concerns, and report and record incidents, concerns and near misses. Reported incidents for end of life patients were often related to pressure ulcers or falls.

We were shown an example of an incident that led to an investigation. Learning from this investigation was shared as part of a shared learning in practice bulletin. The learning was shared with teams through the bulletin and was discussed in team meetings and team safety huddles.

We were also given an example of an amber rated incident where a patient ran out of their controlled drugs stock due to having taken more doses than anticipated. Staff were unable to collect more medication due to the chemist being closed. As a result, the staff member had to collect another prescription and visit another chemist, delaying access to medication. Following an
investigation action was taken to ensure staff were aware of opening times and availability of local chemists to prevent future issues.

The crisis response team was involved in an incident where an integrated support worker resuscitated an unresponsive patient on arrival at their home. This resulted in an investigation into appropriate support for staff, leading to a change in practice to ensure all staff received a debrief from a dedicated staff member following an incident. A flowchart had been devised to ensure all staff received support following an incident.

Managers reviewed serious incidents within an integrated performance review meeting. The service lead was also involved in a weekly patient safety summit, which reviewed and reported back on any high severity incidents.

Staff carried out duty of candour verbally and in writing if a serious incident took place. Patients or carers were offered a copy of investigation reports, and the governance lead for the Trust tracked this to ensure the duty had been followed.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

National guidance was incorporated into systems, processes and policies. For example, the end of life care strategy and training, assessment and care planning templates used were based on the ambitions for palliative and end of life care and the priorities of care for the dying person national framework. The service had nine workstreams related to end of life care, all of which were related to the implementation of this framework. All audits of the service were matched to these expectations.

The national audit for care at the end of life had been completed in relation to the acute service only, and as such the action plan resulting from this did not sit with the community end of life service, but did influence the workstreams in which the community service was involved. The community end of life service was also part of the wider improvement group for end of life care across the trust.

Staff referred to National Institute for Health and Care Excellence to guide their practice. We spoke to various members of staff who were all aware of national guidance.

Patients were offered information on how to access emotional, psychological or bereavement support. The service had information leaflets covering topics such as planning for end of life care, when someone was dying and local grief and bereavement contacts.

**Nutrition and hydration**

Staff monitored if patients were eating and drinking enough.

The trust hydration and nutrition policy included a section referring directly to support with end of life patients.
Community nursing and frailty team staff completed the malnutrition universal screening (MUST) tool with patients to monitor their food intake where there were concerns about this. Staff also assessed nutrition and hydration needs as part of the assessment and care planning process. Where there were concerns, staff gave advice and support, or referred to the GP or dietician as needed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We observed nurses routinely talking about pain management and symptom control with patients. Patients we spoke with were happy with the way their pain was controlled. We found anticipatory ‘just in case’ medicines were appropriately in place for patients. Staff used the Abbey pain scale tool to assess the level of pain in patients who were unable to describe this. Pain assessments were documented on the electronic recording system and could be accessed and completed with the patient in their own home.

Community nurses told us that if there were ever a delay in accessing a syringe driver, they would offer immediate symptom control by offering bolus doses (a single dose of a drug given over a short period of time, usually through injection).

We observed one community nurse contacting a patient before their visit to let them know when they were visiting, to enable them to take pain relief at the right time to ensure this was most effective in advance of a potentially painful procedure being carried out during the visit.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

A quality dashboard was used to record quality outcome measures for the service, including number of patients on a syringe driver, response time for referrals, and how many patients achieved their preferred place of death. The service did not record details of prevention of hospital admission. However, the frailty team presented data on site that indicated that hospital admissions had been reduced by 83% and the number of bed days was reduced by 94% compared to people who did not have PEACE plans in place.

Audits – changes to working practices

The trust did not participate in any clinical audits in relation to this core service as part of their clinical audit programme.

(Source: Universal Routine Provider Information Request (RPIR) – Audits tab)

The end of life service lead audited three sets of notes from each of the six community nursing teams monthly. This audit considered outcome measures including recognition that the patient was in the end of life phase, considering and achieving the preferred place of death, symptom management, individual care plans, nutrition and hydration and spiritual, religious and cultural
needs. We saw evidence that in the year before the inspection, preferred place of death was considered for all patients audited and was achieved by over 80% of patients audited during that year. All but three of the 36 patients audited in the two months before the inspection had individualised end of life care plans. There was evidence of anticipatory prescribing in all but one of the records audited. Staff reassessed and acted upon symptoms in 100% of the records. However, spiritual, religious and cultural needs were only assessed and recorded in 18% of the records audited. Having recognised this as an issue, the end of life lead identified the need to carry out a more in-depth audit of a number of records, to determine if patients’ spiritual, cultural and religious needs were being considered across the multidisciplinary team (rather than just from the community nursing team), or whether these needs were being considered but not recorded. This piece of work was part of an end of life service action plan but had not yet been completed. The teams also monitored patient outcomes through feedback, and more specifically through friends and family survey results.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff members’ work performance and held supervision meetings with them to provide support and development.

Staff within the out of hospital teams had supervision four to six weekly, and annual appraisals. Staff told us they had access to regular formal clinical supervision sessions. They also undertook case reviews or debriefing sessions after difficult or complex situations.

Clinical Supervision

The trust provided the following information about their clinical supervision process:

The teams adhere to the clinical supervision policy. Services record their supervisions on local trackers within their service to ensure these are held regularly and recorded. Local trackers are reviewed and monitored by team leads. Live supervisions are led by professional leads, service managers, team leads and practice educators.

During quality monitoring visits supervision compliance is reviewed. Relevant data is recorded by service managers within their service exception reports and on the dashboard. This information is presented at the divisional integrated performance reviews for assurance purposes which are attended by executive directors and chaired by the CEO. Supervision compliance is recorded in the main monthly Integrated Performance Report (IPR) to the trust board.

Supervisions take different forms. These include:

- Team meetings
- Safety huddles
- Staff forums
- Revalidation
- Peer supervisions
- Reflective practice
- Coaching
- Mentoring
Appraisal rates

Data provided by the trust indicated that no nursing staff were employed within community services for end of life care.

From August 2018 to July 2019, 100% of eligible staff in community services for end of life care received an appraisal compared to the trust target of 90%. Medical staff were all allocated to Eastbourne District General Hospital.

Staff providing end of life care had access to a range of specialist end of life care training. Staff were expected to attend a half day mandatory training session on end of life care, with an additional half day session for registered staff that included training related to symptom control. The morning session included communication and difficult conversations. Staff could also access a “let’s talk about death” study day and one of the local hospices also delivered an “I don’t know what to say” training session.

Registered staff had access to in-house verification of death training. All community nurses in the Bexhill team were qualified in verification of death. Registered staff also attended ReSPECT advance care plan training, and syringe driver training. The ReSPECT plans also formed part of the mandatory resuscitation training. Staff who wished to undertake additional end of life training through the University of Brighton were supported by the Trust to do so.

Community nursing staff were required to pass a competency test in the use of syringe drivers. Following an initial competency test, staff were required to update and be reassessed every three years, or sooner if needed.

The trust had access to a range of end of life care specific electronic learning modules for staff, including symptom management training. They could also access bespoke training if needed from local hospices or the acute specialist palliative care team, on topics such as titration of medicines and verification of death. The end of life lead was also due to deliver some training to the teams on the new trust policy for non-concordance.

The trust produced an end of life newsletter for staff, which included information about the end of life strategy, training and current developments or projects.

Managers in the crisis response team had identified the challenge of ensuring that all staff were debriefed after serious incidents. As part of the annual stress assessment carried out within the team, managers worked with staff to identify the issues and develop a more effective way forward for managing this.

Following this work with staff, the team developed a debrief protocol, including a flowchart to ensure staff received the appropriate support. The team were implementing a daily debrief link worker, an allocated person to offer any unexpected debriefs as needed, and to ensure that staff were appropriately supported.
Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The out of hospital teams worked together and with the local hospice to identify the most appropriate teams to deliver the care. The service held capacity calls every morning, lunchtime and evening to discuss and ensure work was allocated appropriately.

Teams worked closely with GPs and local hospices to ensure patient needs were met. Medical cover was provided through GP surgeries or through hospice specialist palliative care doctors. Community nursing staff attended local GP surgery multidisciplinary team meetings. The community nursing team at St Mary’s in Eastbourne was based in a shared open plan office. We saw clear evidence of integration between the health and social care teams based there.

Staff told us that communication and joint working between the community nursing and hospice teams was very effective. Hospice staff supported with specialist expert advice around symptom control, and this was available 24 hours a day, seven days a week. GPs were also responsive to any requests for advice or support.

Health promotion

Staff gave patients practical support and advice to help them live well until they died.

Dependent on the patient’s stage in their end of life journey, staff would offer advice and support with diet (including a referral to the dietician if appropriate), sleep hygiene, bowel and bladder issues and self-care (including getting appropriate amounts of rest). We saw staff giving this advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions. However, not all staff were confident with recording of mental capacity assessments and were not routinely doing this.

Many of the staff we spoke with were confident about their understanding of and responsibilities under the Mental Capacity Act. Staff attended mandatory face to face training and had access to Mental Capacity Act assessment templates on the electronic system to support them with completion of assessments. Staff were able to give us an example of how they would respond if there were concerns around a patient’s mental capacity, including seeking advice from another member of the team to help determine if a mental capacity assessment were needed. They were also able to tell us how they would support a patient to make their own decisions where possible.

Staff in the frailty team told us that they regularly completed mental capacity assessments and felt confident with this. Some staff in other teams told us these were not regularly completed and that not all staff were confident with completing mental capacity assessments. The community nursing service had identified this as an issue and were supporting staff to increase their confidence and prevent them from routinely pushing any mental capacity assessments or best interest decisions back to the GP. Managers told us this was an improving picture and that staff could access support
and advice with any Mental Capacity Act queries from the trust safeguarding team to support them.

We saw limited evidence of recording of mental capacity assessments in the patient records we looked at during the inspection. We saw that consent to treatment was considered by staff and recorded in patient records, although we did see a small number of records where this had not been recorded. This was sometimes completed by the GP.

Advance care planning was considered in case of a person lacking capacity to make their own decisions in the future. This was considered as part of the ReSPECT and PEACE plans. The service aimed to ensure the ReSPECT plan was a robust document that clearly demonstrated people’s wishes in advance.

When patients did not have the mental capacity to make decisions about their care and did not have a relative or someone to advocate for them, staff in the frailty team referred patients to an independent mental capacity advocate (IMCA) to support them during the assessment. Staff in the frailty team also demonstrated a good knowledge of deprivation of liberty safeguards (DoLS).

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

Data provided by the trust indicated that no nursing staff were employed within community services for end of life care.

Note: The trust did not provide data for DoLS training.

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

The trust set a target of 90% for completion of Mental Capacity Act / Deprivation of Liberty Safeguards training (DoLS).

From August 2018 to July 2019 the trust reported that MCA/DoLS training had been completed by 57.1% of medical staff within community services for end of life care.

A breakdown of compliance for MCA/DoLS courses from August 2018 to July 2019 for medical staff in community services for end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>4</td>
<td>7</td>
<td>57.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the 90% target for MCA/DoLS courses relevant for medical staff.

(Source: Universal Routine Provider Information Request - Training tab)

**Deprivation of Liberty Safeguards**

This information was not completed within the universal provider information request.

(Source: Universal Routine Provider Information Request (RPIR) – DoLS tab)
Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed a number of care interactions during the inspection, and found staff to be caring, compassionate and kind.

We were given examples on site of staff going “above and beyond” to ensure patients’ needs were met. This was largely demonstrated in staff staying (at times for several hours) beyond the end of their shift to ensure that patients’ needs (including delivery and assessment of safe use of equipment) were being met. Staff had also bought shopping and delivered this for carers who did not feel able to leave their loved ones, and supported families with practical tasks such as contacting funeral directors on their behalf when they did not feel able to do so themselves.

Staff had access to information around spiritual and cultural requirements in care after death to support them. While patient record audits completed by the service lead did not show that personal, cultural, social and religious needs were consistently being met, it appeared that this was more of a recording issue, than a practice issue. We were given examples of staff showing considerable respect and consideration of patient’s holistic needs. This included staff consulting family members including asking if their relative’s eyes should be closed after death, to ensure this was not contrary to any spiritual guidance.

Patient care records and interactions observed between staff, patients and carers, showed staff were considerate, friendly, professional and respectful. Patients told us that staff were “excellent”, passionate, friendly, reliable and responsive. Patients told us that the support they were getting was helping them to stay at home and out of hospital, as was their wish. Carers told us that staff provided great comfort to them, were “lovely” and reliable. Some carers felt that the staff had almost become like part of the family.

The service had a working group which looked at care after death. This was due to issues with certification of death in the community following a patient’s discharge from an acute hospital, having died before seeing their GP in the community. Under these circumstances the acute doctor would be responsible for certifying death, meaning that on rare occasions a patient would have to be brought back into hospital for verification of death. While this was a national problem, and only happened rarely, the working group was set up to look into alternative solutions that would be less distressing and disruptive.

A corridor in Bexhill Hospital included a display of photographs of patients in an environment that they related to and showed something about their personality and interests. This was part of a project aimed at showing patients as individual people outside of their illnesses.

The crisis response team in Eastbourne were looking into the provision of comfort boxes for patients but had not yet put this into practice.

Emotional support
Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

The community end of life service were carrying out a project into bereavement support as one of their workstreams, to look at what support was needed, and how best to provide this. If a patient were known to the local hospice, staff would refer families to their bereavement services.

Teams used ReSPECT plans as a means of supporting patients and families with difficult decisions and conversations, and to gather information about their holistic needs.

Staff told us they were very aware that they were visitors in a patient’s home, and as such it was important that they respected this and aimed to fit in around the family as much as possible.

Staff gave us examples of supporting families, including community nursing staff cleaning patients, to enable family to spend time with them immediately after death without additional unnecessary distress. This was outside of their remit, but staff felt it was important to offer this additional support to family, as well as protecting the person’s privacy and dignity.

The crisis response service provided a personal care element to end of life patients and would sometimes be involved in situations where patients had died just before their arrival, or on arrival at the home. Under these circumstances staff provided comfort to the family and carers, and would on occasion support with care after death, including cleaning the person and changing their clothes, although this was not routinely done. Staff had been notified that they were not to wash a patient until after death had been verified. Where appropriate staff attended funerals or sent a bereavement card to offer support and show respect.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff used the completion of the ReSPECT plan with patients and families as a means of involving them and ensuring that their wishes and needs were known and documented. The plan supported difficult conversations and gathering information to ensure this was known and recorded as and when needed. This also gave the opportunity for sharing information and enabling patients and family to ask questions and be given information to support their decision making.

We observed examples of community nursing staff carrying out holistic assessments of patient needs, offering emotional support, finding out the patient’s wishes, and giving them choices about how best to meet their care needs.

Following input from the crisis response or frailty teams, friends and family received a bereavement questionnaire to gather feedback on the support received with a view to ensuring needs were met and improving the service. Community nursing teams did not send out individual questionnaires as they did not want people who had experienced a recent bereavement to be overloaded with questionnaires. A community nursing student had carried out a work-based learning project to consider how the teams could most effectively receive feedback without overloading people, as well as looking at what support and information people needed. A pilot questionnaire had been compiled and was to be taken forward as part of a quality improvement project to look at how best to gather information from and support patients and carers.
The community nursing service had recently introduced a formal bereavement visit or phone call as an additional form of support to relatives and carers.

We looked at 36 friends and family feedback forms. These were largely positive, and the only feedback given in terms of improvements that could be made related to the length of wait for support, which was referred to within five of the forms.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. Key services were available seven days a week to support timely patient care.

The community nursing service had six teams based across the county to cover East Sussex. The service prioritised end of life care needs due to increasing demands for the service, to ensure patient needs could be met. The service were aware of increasing demands and were looking at more efficient ways of ensuring needs could be met while not compromising patient care at the end of life. The end of life care improvement group had nine workstreams all working on improving the service and feeding into the overall end of life care strategy.

Community nursing services were provided seven days per week, from 8am to 10pm, with an integrated night service taking over from 10pm. Patients or families who were known to the local hospices often contacted them because they were available 24 hours a day, seven days a week.

Referrals were received via a central referral hub and triaged by the community nursing team. If a patient were due to be discharged from the acute hospital, the ward or the specialist palliative care team contacted the community nursing, frailty or crisis response team to discuss the patient, their needs, and identify what capacity the teams had to support. This conversation took place as part of a shared decision-making process. A formal referral then came through the central referral hub and was passed onto the relevant team to action. The nursing team encouraged early referrals to enable them to introduce their service and start building a therapeutic and trusting relationship at an early stage.

The intermediate care unit in Rye community hospital was sometimes used for patients at the end of life. The unit did not have a dedicated family room, or multi faith room. However, there were rooms that could be used for this purpose when the unit was not full.

Crisis response services provided personal care for patients who were awaiting a care package, to prevent hospital admission or on occasion to facilitate hospital discharge. They were also able to access specialist equipment for patients, and to assess the safe use of this through the occupational therapists within the team.

The out of hospital service worked closely within the community nursing, frailty and crisis response teams to ensure patient needs were met by the most appropriate team, while linking in with external partners such as GPs and the local hospices. We saw evidence of effective collaborative working to ensure the patient’s needs were met. This included joint visits between teams and with the local hospice team.

When working with patients with mental health needs or learning disabilities for example, the service assessed the person’s individual needs. The service sought additional support from the learning disability lead nurse within the acute hospital or the dementia lead or link nurses if
needed. The service could also access support from the mental health teams within Sussex Partnership NHS Foundation Trust. Staff told us that for patients with additional needs, family were also a good source of additional information and support.

Staff could access a religious and spiritual needs guide from the acute bereavement service if needed and could access further advice and support from the trust chaplaincy service.

Staff assisted as needed to ensure that patients who died at home were taken to the funeral director of their choice.

Meet the needs of people in vulnerable circumstances

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff provided services in patients’ homes. They aimed to be flexible around appointment times to fit in with the person’s needs and preferences where possible. We saw an example of a carer who requested a later visit than originally planned to enable them to take a break from their caring role but still ensure their relative’s needs were met. To support this request and prevent this impacting on the limited capacity of the twilight shift, the staff member offered to carry this visit out on their way home following the end of their shift, having recognised the importance of meeting the family member’s request.

Staff recorded conversations asking patients about their preferred place of dying within patient records, and both the recording and the achievement of this was part of the service lead monthly audits.

Staff discussed patients’ individual wishes and needs as part of the ReSPECT care planning process. Staff gave patients information about their choices and decisions and supported them to make these as part of this process.

Staff told us that they treated everybody the same when working with patients from disadvantaged groups and would link in with the appropriate groups for support or signpost people as needed. The community nursing team in St Leonards were able to tell us about their work with patients with drug and alcohol problems, and the additional support put in place to ensure they were able to access their medication when this was needed in a safe way. The frailty team also confirmed that (although they did not need to access this regularly), when needed the teams could access a translation service. Staff were able to give examples of when they had utilised this service.

Community nursing teams had a wide range of information leaflets for patients and carers on a wide range of end of life topics. The information was current, relevant and accessible.

Access to the right care at the right time

Patients could access community end of life support when they needed it. Waiting times from referral to achievement of preferred place of care and death were generally in line with good practice. However, the frailty team did have a lengthy waiting list. The service was taking action to address this.
The out of hospital service, which included community nurses, the frailty and crisis response teams, had an admission, transfer and discharge policy, which supported acute hospital colleagues in arranging timely discharges for patients and for supporting people in the community. The teams aimed to respond straightaway where possible. Community nurses could respond within 24 hours for the most urgent of referrals. The crisis response team had a role in helping discharges, as well as preventing hospital admission. They offered a same day response, including access to same day equipment. However, most referrals came from the community rather than rapid discharges, which were more likely to be picked up by the NHS continuing healthcare (CHC) team for people who were eligible for this funding due to rapid deterioration.

Expected response times were variable dependent on the urgency of the referral. Crisis response teams had an expected two-hour response time. However, they were unable to always meet these targets. We were told the two-hour timeframe began from the time the referral was received. Referrals from the hospital were sometimes made the night before, or a few hours before a patient was discharged, so by the time they were in the community the service had already breached the response time. Some patients also did not wish to be seen within that timeframe. Under these circumstances staff contacted the person to carry out a telephone welfare check. At other times staff visited the patient within two hours but did not record this until their return to the office (particularly with integrated support workers who did not have access to the live electronic system). On these occasions, the notes were not recorded until after two hours and would flag up as a breach.

The frailty team had waiting lists of approximately four months. However, plans were in place to remove the frailty team from front of house services in the acute hospital, and it was anticipated that this would make a considerable difference to the waiting times. Patients were discharged from the service 30 days after the first point of contact, although the team were considering reducing this to 20 days to reduce the length of waiting lists and increase patient throughput.

The out of hospital teams worked together and with the local hospice to identify the most appropriate teams to deliver the care. The teams held capacity calls every morning, lunchtime and evening to discuss and ensure work was allocated to the appropriate team. Daily safety huddles were also held to ensure that any issues were discussed amongst the team.

Community nurses were available from 8am to 5pm, with a twilight shift from 5pm to 10pm, and the integrated night service from 10pm until 8am. The twilight and night service could offer visits as needed, although because this was a small team covering a large geographical area there were sometimes delays in attending to callouts. Where possible staff carried out visits during the day shifts to limit the pressure on the twilight shift. The crisis response service was available until 10pm. The out of hospital service was available 24 hours a day, 365 days of the year for all patients over the age of 18. Patients could also access advice from the local hospice night service if they were known to the hospice.

**Accessibility**

The trust has provided the four most common languages spoken among ethnic minority groups, rather than the four largest ethnic minority groups. The most common ethnic minority language spoken within the trust catchment area is Arabic.
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<th>Ethnic minority group</th>
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(Source: Universal Routine Provider Information Request – Accessibility tab)

**Learning from complaints and concerns**

People were supported to give feedback and raise concerns about care received. Although the service received limited complaints, they had a system in place to treat concerns and complaints seriously, investigate them and share lessons learned with all staff. The service included patients in the investigation of their complaint.

**Complaints**

From August 2017 to July 2019 the trust did not report any complaints about community services for end of life care.

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

The service had received one complaint between July 2019 and the beginning of November 2019. However, this was not relevant to service delivery. It was related to an external funding arrangement that was outside of the control of the service.

Staff were familiar with the complaints process. This was shared with patients and carers in several ways, including a letter given to new patients of the community nursing service with complaints information, leaflets, and verbal information.

The service lead produced a monthly service report which included information about end of life related complaints.

**Compliments**

From August 2018 to July 2019 the trust did not report any compliments for community end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – Compliments tab)

The end of life service received a large number of compliments, or plaudits as the service called them. We saw a number of examples of these on site.
Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Many of the staff in the out of hospital service knew the end of life service lead, who had been in post since April 2018. Staff did not all know what the lead’s role was and did not feel they fully understood the leadership structures but did feel able to approach them for advice or support. We also spoke with a leader in the service who had responsibility for a large number of staff but did not feel they had been given sufficient senior management support or training to support them in this role.

Leaders were confident that patients received good end of life care. They were aware of the issues the service faced and were working on these through the number of service related workstreams. Because of these workstreams, improvements had been made to the electronic recording system that meant that staff had access to consistent, up to date information to support them with patient care and to enable greater oversight over the patient journey between care teams.

The clinical reference group acted as a service-wide steering group for end of life care. The community end of life lead had responsibility for overall oversight of the service and reported back into this group on a monthly basis.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The end of life service strategy (2019-2022) set out a three-year workstream plan. The strategy was developed with acute services and partner agencies, and covered community and acute end of life care. The strategy was available to all staff on the intranet. Staff knew where to find this and how to refer to it as needed, and reference was made to the strategy within end of life care training and publicised within the end of life specific newsletter. However, some staff we spoke with were not aware that there was an end of life strategy in place.

The strategy aims included improving the quality of end of life care, coordinating and integrating pathways and services, and improving access to individualised care by improving identification of people in their last year. The strategy highlighted the importance of effective communication and recording, and improving the skills, confidence and capability of staff. The strategy drew on the National End of Life Care Strategy for Adults 2008 and included reference to the national care standards for end of life care (NICE QS13, QS144, NG31) and National Ambitions for Palliative and End of Life Care.

The strategy was delivered through the nine different workstreams developed to improve the service. These workstreams reported back into the end of life care improvement group and clinical reference groups who monitored and oversaw the implementation of the strategy.
also identified risks to the implementation of the strategy, as well as control measures for these risks.

Culture

Staff generally felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and the majority of staff felt they could raise concerns without fear.

Staff we spoke with generally felt supported and valued. The Eastbourne crisis response team were planning a team away day to continue building team relationships and team morale. However, some staff felt that despite recent improvements in culture, there were still some issues in terms of staff members feeling that some staff within teams received better treatment than others.

Staff were encouraged to reflect on the service culture and trust values as part of the annual appraisal process. The crisis response service were holding a values month in November. Each week the staff were invited to reflect on one of the trust values, to consider what they meant in a practical sense for them.

Staff told us that there had been positive changes to the trust, meaning that the service had a much more open and honest approach, and staff felt much more able to raise concerns. The trust had a speak up guardian, although staff were asked to speak with their line manager initially with any concerns if they felt comfortable to do so. However, not all staff felt confident in speaking up, and were concerned about potential repercussions if they were to do so.

The trust had a lone worker working group prioritising staff safety. Staff in the crisis response teams were encouraged to phone in to the office at any time if any support was needed or if they had any concerns.

Staff had access to an external counselling phone line and were signposted to this as needed.

The crisis response service in Eastbourne had recently carried out a stress assessment for the team and had done a piece of work on how best to support the staff through debriefs after traumatic or stressful incidents.

Good practice was recognised and rewarded across the trust. We were given an example of a member of staff in the crisis response team who had resuscitated a patient who was unresponsive on arrival at the home. The staff member received a Trust and division award, presented by a member of the board, and their contribution was acknowledged in the service newsletter.

End of life care was prioritised by staff within the out of hospital teams. While confidence in their ability to deliver good end of life care was variable amongst staff, all saw it as a vitally important part of their job and were committed to and passionate about getting the care right for patients and families.

Governance
Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had clear systems and processes in place to ensure the care provided was of a good standard, safe, and met standards of hygiene and infection control, that staff had access to end of life specific training, patients were assessed and treated well and incidents were reported and learnt from.

The end of life service lead monitored end of life care provision through a service dashboard, audits of care, feedback, incidents and complaints. The end of life care lead was working towards a strategic plan to continue to improve the service and was able to demonstrate changes and improvements from the last inspection, to address issues identified within that inspection. The service improvement group and clinical reference group had oversight of the service and any related issues.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The end of life risk register was held with the end of life improvement group and was discussed at the beginning of each group. We were unable to see this on site and requested a copy following the inspection. The trust confirmed that there were no community end of life risks on the register at the time of the inspection. The only risk identified to the service was that of lack of capacity in the local hospices. This was not added to the risk register as this was an external capacity issue and the trust advised they were unable to mitigate against this. The waiting list for the frailty service was not considered to be a risk to end of life provision as the frailty service prioritised end of life patients.

Information related to end of life provision was collected on the performance dashboard and incident learning reports. Any themes were reported into incident performance review meetings.

The service lead was able to show learning from audits on the service, and action taken following this to improve the service. This included identifying the need for a whole service approach to reviewing spiritual and cultural needs to ensure that all care providers were considering this.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service lead collected and analysed data from the performance dashboard. This data was reported to the quality improvement meetings.
All information related to end of life care was stored on the electronic system. This was accessible to the out of hospital teams, excluding the integrated support workers in the crisis response team, who would be on the system at the beginning of next year. Staff used laptops in the community and had access to the information as and when they needed it, updating this in real time to ensure those providing care had the information they needed.

The crisis response team also could not complete end of life care plans due to an issue with the electronic recording system that meant that community nurses (who were the leading care planning team within the service), would be unable to update these if the crisis response team started them. In response to this issue, the crisis response team completed paper templates of the care plans for community nurses to complete on the electronic system.

Any service specific information (such as audit results and service specific complaints or incidents) was collated, monitored and actioned as needed by the end of life service lead.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The end of life workstreams were open to all staff levels to contribute, and any developments were fed back to staff. End of life link nurses within teams were encouraged to attend quarterly link nurse meetings and contribute to the development of the service, as well as feeding back to their teams.

The service had an active workstream looking at the most effective ways of seeking feedback from patients and carers without overloading them with requests for feedback at a difficult and sensitive time. The crisis response and frailty teams sent feedback forms to family members and the community nurses followed up with a post bereavement visit or phone call.

Lead nurses from the community nursing teams had recently attended a “leading community together” coaching course, to give them confidence in expressing their views and opinions, and having their voices heard within the service. The community nursing teams also held a recent engagement event with staff to get their views on the future of the service and restructuring plans.

The out of hospital teams had good working relationships internally within the different teams and with external partners.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services.**

**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.

Within community health services for end of life care no accreditations were awarded.
The service was involved in a range of projects to improve the end of life provision but were not involved in any accreditation or research at the time of the inspection.

The community nursing team at St Leonards had been involved in a recent project looking at improving mouthcare for patients. The project had considered different equipment and ways of improving and supporting mouthcare. As part of an improving mouthcare pilot the community nursing services were trialling an assessment chart with patients and giving additional mouthcare advice, as well as trying different mouthcare equipment. The service was planning to audit the mouthcare assessments once these are in regular use to evaluate the effectiveness of the pilot.

The crisis response team at Eastbourne had recently completed a stress assessment for the team and brought in a new debriefing process and flowchart to ensure that a member of staff was allocated on a daily basis to provide any ad hoc debriefing sessions to ensure staff were appropriately supported following difficult or traumatic events.

The frailty team had won a trust award for innovation.