We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Eastbourne District General Hospital

Kings Drive, Eastbourne, BN21 2UD
Tel: 01323417400

Date of Inspection: 25 June 2013
Date of Publication: August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

- Care and welfare of people who use services: Met this standard
- Safeguarding people who use services from abuse: Met this standard
- Requirements relating to workers: Met this standard
- Staffing: Met this standard
- Assessing and monitoring the quality of service provision: Met this standard
## Details about this location

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<td>Eastbourne District General Hospital is an acute hospital operated by East Sussex Healthcare NHS Trust. It provides a range of inpatient and outpatient services to the local population, including an accident &amp; emergency unit, a midwifery led maternity unit and short stay Paediatric assessment unit. We only reviewed the Maternity and Paediatric departments.</td>
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| Type of services | Acute services with overnight beds  
Community healthcare service  
Dental service |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Family planning  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 June 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by other authorities. We were accompanied by a specialist advisor.

What people told us and what we found

On the 7 May 2013 the East Sussex Healthcare NHS Trust (ESHT) completed the temporary reconfiguration of maternity and paediatric services. This had been undertaken as a result of an escalation in concerns regarding the overall safety of maternity provision within the acute hospitals.

The Care Quality Commission made plans to review the newly configured service, and allowed a month for the new service arrangements to embed. Prior to our planned visit we received information from a team of consultant paediatricians working at Eastbourne District General Hospital. They expressed concerns that the new arrangements for paediatrics across the Trust were now less safe than before. We met with the consultants on 18 June supported by a paediatric specialist. We listened to their concerns and said that we would give these due consideration in our planned inspection of these services.

When we visited the service at Eastbourne we were supported by a paediatric specialist, and a maternity specialist. We spoke with staff at all levels of the Trust to gain their views about the safety of the service. We looked at systems, and reviewed documentation. We spoke with parents, mothers and relatives of people using these services. From the feedback we received and records viewed we were satisfied that the Trust was providing a safe, effective, responsive, caring and well led maternity and paediatric service.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.
There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

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<td>Care and welfare of people who use services</td>
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<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
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Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

MATERNITY
The reconfiguration of maternity services across East Sussex Healthcare NHS Trust (ESHT), had provided a midwifery led unit (MLU) on the Eastbourne district general hospital site. This was in addition to the midwifery led birthing centre already established on the Crowborough Hospital site. The new MLU at Eastbourne Hospital consisted of two birthing rooms and five bedrooms. The MLU was open 24 hours a day for mothers who had been assessed as having a low risk pregnancy.

There was a day unit which mothers could attend for a number of tests and treatments. These included fetal monitoring and anti-D treatment. This is a medicine used in preventing antibody formation in rhesus negative women. There was a triage service which operated from the day unit between 8.30am and 7pm Monday to Friday. After 7pm all calls were triaged at the Conquest Hospital.

We looked at a completed triage form. This contained details of the woman, the reason for her call and any risk factors, the advice given and action to be taken was documented on the form. The overall risk was then given a Red, Amber or Green (RAG) rating. Women were advised to attend Conquest Hospital labour ward, the day unit at Conquest Hospital or the day unit at Eastbourne. If this was not appropriate and assessed risk was small women were advised to see their GP or community midwife. The provider may find it useful to note that staff told us this had reduced admissions but we did not see any evidence of this. Triage forms were not audited although we were told they had been before the reconfiguration.

We visited the early pregnancy unit (EPU) which provided care and treatment for women in the early stages of pregnancy, between five and fourteen weeks. Referral to this unit was often by other health professionals for example the GP or community midwife. Women who were seen on the EPU whose pregnancy was not seen to be viable would either remain on the ward for treatment, or surgery if required or appropriate. However, if the need was more urgent, for example an ectopic pregnancy, the woman would be...
transferred to Conquest Hospital.

During our inspection we spoke with one woman on the day unit. We were unable to speak to any women or their partners on the MLU. The person we spoke with told us she was happy with the treatment she had received and had no complaints.

Women who used the service held their own records during the antenatal period. Therefore, there were no notes available for us to view on the MLU. Staff told us that antenatal assessments were undertaken by the community midwife. Risk assessments were undertaken to determine whether the woman was able to deliver her baby at the MLU if she wished. The risk assessment was repeated at 37 weeks of pregnancy and risk factors were reassessed.

Women who were low risk and had chosen to have their babies at the Conquest Hospital were able to attend the MLU for assessment if they chose. This included ensuring they were in established labour, and this was not a false alarm, prior to travelling. Staff were able to assess the stage of labour the woman was at, whether there were any risks and whether transfer to Conquest Hospital at that time was appropriate.

Women assessed as high risk and not suitable for delivery at the MLU did not generally attend the unit. Staff were able to tell us of actions that had been taken when high risk mothers had attended the unit. This included delivery of the baby and transfer to Conquest Hospital following delivery.

Paediatric consultants had expressed concern that babies, who had inhaled meconium during the birth process, would be at risk at the MLU out of hours, because staff at the unit might not have the skills to clear airways and provide appropriate resuscitation support to the baby. We saw that there were clear guidelines in place for staff to follow in the event of observing meconium stained liquor.

Where necessary if women and their baby required transfer to Conquest Hospital whilst in labour or following delivery there were systems in place to ensure this was undertaken safely. There was guidance in place for staff. Guidance stated, and the midwife we spoke with told us, the midwife’s clinical judgement was paramount in making the decision.

Midwives were required to have at least two years’ experience prior to working on MLU. One midwife we spoke with had prior experience of working at another MLU. This midwife had chosen to gain this experience prior to the opening of the MLU.

Midwives spoken with were clear about the escalation process for emergencies and did not consider contacting out of hours consultants as a first responder. Executive team members commented that the MLU’s unique placement was within an acute hospital. This meant that in the event an emergency 999 call took longer to respond to other clinicians within the hospital were available. They would give their best endeavour to provide support as an interim measure when the patient needed urgent attention.

Transfers took place via the paramedic ambulance service accompanied by a midwife. Babies that required transfer were placed in a secure ‘pod’. Maternal transfer forms were completed and these recorded the reason for transfer. Transfer audits were completed. These recorded the time the decision was made to transfer the woman until care was taken over by staff at the receiving hospital.

When we spoke with an operational manager from South East Coast Ambulance
(SECAMB) they told us that their staff and Trust staff had clear guidelines as to what category of patient could be conveyed with what type of skilled ambulance staff. Where a patient did not meet the criteria specialist support from the Trust would be expected to accompany the patient. The operational policy for Children's and Neonatal Services also made clear the arrangements for patients unfit for immediate transfer or requiring specialist support. The SECAMB representative told us that they had noted no specific trends or issues arising from transfers since the reconfiguration.

Midwives were able to describe a recent event where a baby had been born suffering from the effects of the mother's painkiller. The baby received an injection to reverse the effects and was transferred as a precaution with the mother to Conquest Hospital but had recovered en-route.

Consultant paediatricians from Eastbourne had also expressed concern with the lack of onsite paediatric consultant cover out of hours. They told us that babies experiencing a peri-arrest may be at risk because staff on MLU may not have the appropriate training. Midwives spoken with on MLU told us they had undertaken training in relation to resuscitation for babies and adults. Resuscitation equipment was in place and available for use on MLU. We also checked staff training records to ensure that this training was maintained for staff.

Consultant paediatricians at Eastbourne had told us prior to our visit that they were concerned that the pods used to transport sick babies did not contain ventilator facilities. When we discussed this with Medical Directors and members of the executive team, it was made clear that any baby that continued to require ventilator support during transport would be collected by the retrieval team, and not by the standard ambulance team. In our discussion with the SECAMB representative they confirmed that this would be the arrangement for babies/children requiring this kind of support. They were not aware of any instances where this had been an issue since the reconfiguration. The operational policy for Children's and Neonatal Services made clear the procedure for dealing with sick children requiring ventilator support.

We spoke with senior Trust staff who made it clear that in the event that a baby/child who did not require ventilator support but was in need of airway support would be escorted by an appropriately trained professional. The on call consultant ensured that an experienced person travelled with the patient to provide this. Staff required to attend the patient were available from the Eastbourne and Conquest Hospitals. We saw that this procedure was also clearly documented in the operational policy.

Prior to transfer from MLU women and babies were assessed by the midwife as fit for transfer. Consultant paediatricians had expressed concern that the transfer of mothers could be delayed out of hours because no paediatric consultant was on site and available. We were informed by midwifery staff that paediatric checks were undertaken on the baby when paediatric cover was available from paediatric doctors or consultants from the short stay paediatric assessment unit. They said that outside of paediatric working hours, babies could be assessed following transfer by the GP or a return to the day unit. The Director of Nursing advised that the Trust had already identified a course at Brighton University for midwives which would enable them to undertake the neonatal checks and this was to start for the first tranche of midwives in autumn 2013.

Staff told us the MLU was a new way of working for some staff. They told us staff were aware that they needed to assess and plan deliveries in advance. All transfers to the Conquest Hospital were audited. This would enable staff to understand why transfers had
taken place and if any actions could be taken differently if the same situation arose.

Staff told us that debriefs took place following each birth. This took place as peer support and at handover. Monthly meetings also took place, these provided opportunity for debrief and feedback from incidents that had occurred. There was a manager on-call system and staff were aware who to contact.

Staff on MLU, the day unit and triage told us they were able to provide a personalised service for women. Although the service was new staff felt they provided a safe service.

We saw that one woman who had chosen to have her baby at the MLU had been transferred to Hastings due to issues that arose during labour. Following delivery this woman had chosen to be transferred back to MLU for her postnatal period.

Staff on the day unit told us they were supported by, and provided support for staff on the EPU. Staff were able to refer women to either clinic whichever was more appropriate to their needs.

Staff told us they felt supported by their colleagues. They told us they received annual appraisals and statutory supervision. They also received support through monthly meetings and handover. Staff told us they were able to access further support, for example following an incident, if they required it. This was available through their Supervisor of Midwives and colleagues.

PAEDIATRICS
On Friston, the short stay paediatric assessment unit (SSPAU) we spoke with parents of two children. This was because none of the patients were able to tell us of their experiences as they were both at varying stages of recovery following minor surgery.

One relative expressed satisfaction with the quality of care their child had received. They had attended a pre operation visit and everything had gone to plan, as discussed at that visit. They said that they were “Very happy with the care provided.”

Another relative was happy with the current care arrangements in place for their child but expressed a number of concerns about their previous experiences both within Eastbourne and the Conquest Hospital. We passed this information to the senior management who said that they would carry out an investigation into the issues.

A number of children were there for blood tests or complex tests and one child for inoculation and monitoring.

We looked at records held for a patient that had been treated the day prior to our visit. We saw that regular checks and observations were carried out for the patient. A surgical checklist was in place along with a copy of the parental consent form. A pain chart was completed following surgery and the discharge plan was also in place.

The ward had two playrooms and an adolescent room. In each area there were a range of age appropriate toys and games. These areas were not staffed and parents were asked to supervise their children.

We saw two versions of an information pack on the ward. One was a pictorial version that would be used to explain to young children what they could expect when they arrived in the ward both before and after their operation. The second was a guide for parents and
older children with information about the ward and what to expect over the course of their stay on the unit. Satisfaction forms were in place to the rear of the document for people to leave feedback about their stay on the unit. We spoke with one parent who said that they had not seen this document as they had received treatment as soon as they had arrived on the unit. However, they were aware that another patient had been given a copy of the document.

We were told that patients and their parents/carers were told in advance that if they had not recovered sufficiently by the end of the day they would need to stay overnight. However, they were not formally told that they would not be able to stay at Eastbourne and would need to be transferred to another hospital. This could affect practical arrangements for families particularly in relation to transport home.

Play staff funding had been withdrawn. However, nursery nurses onsite and nurses told us that they did play with children on the ward. We saw that an outside play area was no longer used as it had fallen into a state of disrepair. Staff told us that funds were not available to provide or replace the equipment and there was a reliance on volunteers to help with this.

We saw that patients were nursed in bays and beds suitable for their needs and age range but there was little documented regarding patient choice.

The paediatric consultants at Eastbourne had expressed concern that very sick children were still being brought into A&E at Eastbourne out of hours. We were informed by the Medical Directors that there was a clear agreement with South East Coast Ambulance service (SECAMB) that paediatric 999 calls would go to the Conquest Hospital. However, if a baby or child was in a state of peri arrest SECAMB had an agreement that if Eastbourne was the nearest A&E the patient would be brought there for first line treatment and to be stabilised. Again the procedure for the management of these occasional events was addressed in the operational policy for Children's and Neonatal Services document produced by the Trust.

It is also acknowledged that until families become familiar with the new arrangements on occasion very sick children may be brought into A&E by their parents. The operational policy makes clear that the child would be stabilised and then transferred from Eastbourne to Conquest Hospital or to another suitable hospital.

The consultant paediatricians also expressed concern at the frequency of locum changes in A&E and whether the middle grade doctors who provided paediatric support out of hours were appropriately qualified to manage children who required in particular, resuscitation or airways support. Through our discussion with executive team members including both Medical Directors, and our review of staff recruitment and training information, we were satisfied locums used had the appropriate skills to provide support in these areas.

Concern was expressed regarding the lack of clarity in relation to the chain of command for the A&E paediatric middle grade. The Trust had made clear that all cases seen in A&E were the responsibility of the A&E consultant. The out of hour's paediatric team at Conquest Hospital would be contacted for specialist advice as required.

The executive team assured us that the plan for A&E locums was initially a transitional arrangement to provide back up to A&E staff whilst they were refining their skills and competencies in relation to paediatric cases. The Trust used locums because the present configuration is a temporary arrangement and adjustments may need to be made to this
following the receipt of the RCPCH recommendations. The Trust had invited the RCPCH to review services and was awaiting their report. It was acknowledged that the initial plans that the A&E locums would provide more of a support role to A&E staff had not transpired, and that paediatric patients were being directed to them to treat. The RCPCH review recommendations would determine how A&E middle grades for paediatrics were used and whether extended locum contracts were issued.

We were assured by Medical Directors and other executive team members that the locums who provided this level of support were highly qualified and had all the appropriate qualifications to deliver care to paediatric patients. We checked the recruitment process for locum and permanent staff. This was to ensure that all appropriate checks were in place, and that staff had the relevant training. Line management for the A&E locums was initially through the A&E consultant who would make a judgement as to whether specialist consultant Paediatric input was required.

We were further informed by the Medical Directors that in the majority of cases resuscitation would fall to the anaesthetist on duty not a paediatrician. The cover provided to Eastbourne from anaesthetists had not changed following the reconfiguration.

We were informed that there were currently two trained paediatric nurses in A&E at Eastbourne. We were advised that the Trust had highlighted the risk of reduced numbers of paediatric nurses in A&E, and was seeking to provide A&E nurses with opportunities to undertake a paediatric training module.

Consultant paediatricians had expressed concern that under the new configuration the Trust was unable to meet sudden infant death protocols it had signed up to. This was because in the absence of an onsite out of hours paediatrician the required preliminaries for deceased infants brought into Eastbourne A&E could not be undertaken. We have been advised by the Trust that when the short stay assessment unit is open it is covered by a separate consultant rota from that of the Conquest Hospital site. When closed, advice was made available to A&E at Eastbourne from the paediatric team at Conquest Hospital and the on call consultant. In exceptional circumstances the Trust would arrange to move the child's body to the Conquest Hospital, with the coroner's agreement. In most instances the on call Paediatrician would attend or make arrangements for a suitably qualified colleague to attend. This ensured that local and national guidance was followed. We were informed that the present paediatric middle grade doctors based at Eastbourne A&E were competent to deal with these cases.

Concern was also expressed by consultant paediatricians that in the event that Kipling unit is closed there was a lack of clarity as to who was responsible out of hours for finding alternative beds for sick children. We have been advised that it is the responsibility of the paediatric staff at the Conquest Hospital to determine paediatric bed availability. Transport would then be arranged by the local team who were best able to provide details of the child's current status.
Safeguarding people who use services from abuse

Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Consultant paediatricians at Eastbourne had told us they were worried that the new on call rota and lack of onsite consultant cover was placing newborns at risk if they required resuscitation or airway support. They told us that they thought that some incidents had occurred since the reconfiguration.

During our visit our appointed specialists and compliance inspectors spoke with staff and checked incident recording. We found that there had been no clinical incidents in respect of resuscitation of the newborn at the Eastbourne Midwifery Unit. We were informed there had been transfers of women and newborn babies from Eastbourne Midwifery Unit to Conquest Hospital and these had occurred without incident. This view was supported from our conversation with a SECAMB operational manager. Staff said all transfers were audited.

We spoke with a midwife who worked on the triage telephone and completed documentation in relation to the women who telephoned in. When this was inputted to the computer if there were any known alerts in relation to safeguarding, child protection or abuse this was highlighted on the system.

Staff on the early pregnancy unit (EPU) had clear guidelines in relation to under 16 year olds who presented at the clinic. This included following ‘Fraser’ guidelines to assess whether the girl was competent to make her own decisions. No scans or examinations would take place without a responsible adult present. This would usually be a nurse from the ward. Referrals to GP’s and community midwives were made for all women who attended the clinic. Assessments were made on an individual basis in relation to whether further safeguarding referrals should be made. Staff were able to give examples of when they had done this.

Consultant paediatricians at Eastbourne had told us about their concerns that middle grade doctors providing paediatric support in A&E at Eastbourne may not have received the appropriate safeguarding training.

When we spoke with the Medical Directors they said that the locums used in A&E were
handpicked and had all the necessary required qualifications to undertake their role. When we looked at recruitment of locums and permanent staff we were satisfied that appropriate systems were in place to check qualifications and training to meet the requirement of the Trust. The Trust had made clear that any member of A&E who had concerns about a safeguarding issue could discuss this directly with the on call paediatric consultant.

We were further advised that locums used were a mix of substantive, bank and agency locums used in A&E. All substantive doctors and consultants would have been trained to level 3 in safeguarding, bank staff would have had access to training but this may not be level 3. Agency locum Curriculum Vitae would be viewed with regards to what training they had completed and this would include an understanding of safeguarding. All locums received an induction pack. There was also a file on A&E specifically for locums. The file sign posted them to safeguarding policies and contacts. In the event that a locum was unclear, they could refer to the A&E consultant, who in turn could refer the matter to the paediatric consultant on call. We were also advised that no child under one year would be discharged without being seen by a paediatrician who would be trained to level 3 in safeguarding.

All except one of the people that we spoke with during our inspection told us that they felt safe at the hospital and that they had been treated well. One person felt that this was not always the case and we had already passed their concerns to the management team who said they would investigate this.

We spoke with two paediatric staff who confirmed that they had received training in safeguarding and that this was updated annually. They were knowledgeable about the measures in place to keep children safe from harm. The staff spoken with demonstrated a clear understanding of the procedures that needed to be followed if they suspected a child had been abused or had any concerns about their care.

We spoke with staff about caring for patients and/or relatives who could be challenging. A staff nurse told us that this had been included in their paediatric nurse training and that it had also been covered as part of their induction week.
Requirements relating to workers

| Met this standard |

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

Patients and carers spoken with in maternity and paediatric services praised the quality of the care that staff had provided to them and to their children.

All of the staff spoken with had worked in the hospital for a long time. Staff told us that they had been provided with on-going training and that they felt well supported to provide care and treatment to patients. Staff stated that appraisals were carried out each year. The recent reconfiguration of the departments had caused some delay in the application of this, but this had been highlighted and there were plans in place to address this.

When we looked at staff records we found that there were effective recruitment and selection processes in place. We looked at fourteen staff files. The files related to staff who worked within maternity and paediatrics on either the Conquest or Eastbourne Hospital sites. We looked at a cross section of files from staff whose length of service ranged from recently started to those that had been at the Trust for several years. These included files for nurses, midwives, health care assistants, junior and middle grade doctors and consultants.

We saw files for locum staff that had been supplied to the Trust through recruitment agencies. Temporary staff were subject to the same level of checks and similar selection criteria as staff recruited directly, we saw that where possible the Trust attempted to use agency staff that had worked at the Trust previously. Overseas staff had information relating to their residency and employment status. We were informed that the CVs of middle-grade staff were vetted prior to appointment and that they were provided with a comprehensive induction pack to refer to.

There was evidence within all the files that employment history checks had been made. Employment references were seen and appropriate criminal record checks were evident. Application forms and interview notes were seen along with a photograph and proof of identity. In most files we saw there was a job description and a signed contract. Information related to the suitability of a member of staff based on their health assessment was included. Within the files for midwives we saw that test papers and scores from the interview process were evident.

All staff that were required to be registered with a professional body such as the Nursing...
Midwifery Council (NMC) had evidence of their personal identification number (PIN).

We saw the range of information staff were given whilst being inducted, this included, dress policy, IT policy and Corporate Governance.
Staffing

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people’s needs.

Reasons for our judgement

We looked at the staffing levels and the skills and knowledge of staff providing support to Maternity and Paediatrics across the Conquest and Eastbourne hospital sites.

Employment of locums was recognised as being of high risk particularly in maternity and paediatrics. The risk was recorded on the risk register. We saw that specific controls had been put in place. All locums were directly supervised regarding decision-making. All the applications submitted by locums for employment were scrutinised by consultants from within the department.

MATERNITY

In the midwifery led unit (MLU) we found that midwifery staffing was well managed. Staff were flexible in responding to the needs of women. There was evidence of midwives moving to clinical areas including moving from Eastbourne to Conquest Hospital where demand required. All midwives had annual mandatory training in respect of resuscitation of the newborn. The Nursing & Midwifery Council requires midwives to be competent in respect of providing care to newborns immediately following birth.

We spoke with the Head of Midwifery (HOM) who informed us that the unit had a busy night with one delivery on the unit and one unexpected and unattended high risk birth at home. This mother was brought into the MLU following the birth and mother and baby were being transferred to the Conquest Hospital.

On the MLU there were two midwives and one maternity support worker on duty. We were told this was the usual level of cover. We were told on occasions one midwife would be required to work at Conquest maternity unit. If this happened and a woman was admitted in labour a community midwife would assist on the unit. At the time of our inspection there were no women in labour. One midwife had accompanied a woman and baby being transferred to the Conquest Hospital.

On the day unit there was one midwife who was working on the triage telephone line. The day unit was open from 8.15am to 7pm. This was covered by two midwives between 11am and 4.30pm, at other times it was covered by one midwife. Pre-assessment clinics also took place on the day unit once a week. Staff told us, where possible the assessments were undertaken by an additional midwife. However, this was not always possible. Staff
told us there was medical cover available during the hours that the antenatal day unit was open. Staff at the MLU and antenatal day unit were unclear if they would routinely work at the Conquest Hospital unit to enable them to maintain a wide range of skills in relation to high risk deliveries. However, they were well aware of their own responsibilities in relation to their professional development.

In addition to formal training staff were engaged in multidisciplinary 'skills drills'. There were two types of these drills. The first were obstetric emergency scenarios using a maternity simulator. These incorporated current guidance from NICE and other regulatory bodies and learning from local clinical incidents. These drills consisted of a practical session, debrief, discussion, and a theoretical input and feedback. The second type of drill was a live, unannounced exercise within the hospital.

Birthrate Plus Midwifery Workforce Planning tool is a nationally recognised system of assessing and monitoring the provision of midwives in a service. It is based upon the principle of providing one to one care during labour and delivery to all women with additional midwife hours for women in the higher clinical need categories.

We looked at the 'Midwifery staffing action plan'. This had last been updated December 2012. It was not clear to what extent it reflected the new temporary maternity and paediatric configuration. The Trust had assessed itself against the standards of Birthrate Plus most recently in March and November of 2012.

The plan acknowledged that funding for midwifery staffing was beneath the recommended levels for Birthrate Plus in 2003 and had remained so since. However the Trust used the plan to maximise the existing midwifery resources to ensure safe staffing levels. The actions taken included increasing staff availability though measures such as; more flexibility in moving staff between sites and reducing midwifery presence in theatre. We saw examples of flexibility where staff had come from Eastbourne to support colleagues at the Conquest Hospital. Currently there was no use of midwives in theatre. Other actions were designed to reduce demand on staff such as the introduction of a telephone triage system and the employment of extra ward clerks.

There was a minimum staff plan for the new configuration. This reflected the need to support the changes. For example there was a midwifery matron working clinically on the early and late shifts at Eastbourne to help 'settle into the changes'. The need for leadership in the new scheme was specifically addressed in the appointment of two midwifery matrons working 9am ? 5pm in the ante and post natal wards. Equally one midwifery matron was working 9am ? 5pm to provide management support on MLU.

PAEDIATRICS
When we visited the paediatric short stay assessment unit on Friston we were told this had a bed capacity for 16 patients at any one time. Staff comprised of the matron, sister, two staff nurses and a health care assistant. We spoke with a staff nurse and a health care assistant. They said that staffing levels were sufficient. Two staff started their shift at 7am and worked until 7.30pm. Another two staff started at 9am and worked until 9.30pm.

Staff told us that at times staff had to work extended shifts if a patient had not recovered sufficiently to be discharged before the end of the day. At times, this necessitated a nurse travelling in the ambulance with the patient. We were told that the last admission for treatment was planned at 7pm. By 9pm the unit closed. We were told that the agreement with the ambulance service was that they would respond within four hours for a request for transport. On one occasion this meant that a nurse having been on duty for 12.5 hours
then had to work an additional four hours.

Staff told us that some staff had particular interests in specialist area like epilepsy and diabetes. They took a lead role within the team. These staff attended additional training and cascaded any information they felt might be useful to the staff team.

We were told that some staff training had been delayed due to the reconfiguration but that this had been identified and dates had been booked for staff to attend training.

The hospital had qualified staff on duty at all times to provide medical care and deal with any medical emergency. Staff told us that they were all trained in resuscitation. Staff said that that they felt confident to deal with an emergency situation should it arise.

Staff told us that they felt valued by colleagues and by senior professionals. All staff said that there was a good team of nursing staff and that they were well supported.
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

Reasons for our judgement

We looked at how clinical governance and quality monitoring was conducted for both maternity and paediatric services.

MATERNITY
A midwife told us about the electronic collection of feedback for mothers who had used the service. Information was collected remotely on the MLU. This information could not be accessed by staff on the unit. However, we were told that all comments received were fed back to the midwives. We saw a number of thank you cards sent to the unit following delivery. There was also a comment book and this was available for mothers to use. We saw one comment from a mother who had required transfer during labour from the MLU to the Conquest Hospital. The feedback was generally positive with one concern noted. This related to the lack of facilities at the Conquest Hospital for partners following deliveries during the night.

The provider may find it useful to note that telephone calls to the triage line were not all documented. There was no evidence that calls that were documented were audited. Telephone calls from women who required assessment and advice were recorded on triage consultation forms. When completed these were filed in the woman's notes. There was no evidence these were audited to highlight common themes and trends that may be emerging.

Staff told us that a number of telephone calls to triage were from other professionals, including GP's and community midwives. These were for a variety of reasons for example requesting contact telephone numbers. These calls were not recorded. Therefore, the volume of calls and the impact on staff time was not accurately measured.

We saw transfer audits. These showed how many women had been transferred, reasons for transfer, and how long the transfer had taken.

Staff at Eastbourne were promoting the MLU. Staff on the day unit encouraged women to visit the unit. There was an open day planned for July 2013. Women that had delivered their babies at the MLU had been invited to attend to promote the unit.
PAEDIATRICS
In the paediatric short stay unit our discussions with staff highlighted that they felt confident to raise issues without fear of blame or reprisal.

Staff told us that there were a range of audits undertaken. Infection control audits were displayed and all other audits were stored securely but the results were discussed at staff meetings.

One staff member told us that as they were now working across two hospitals, where possible, they attended staff meetings in both settings. Another staff member said that they could not attend both meetings but they always received an update of the outcome.

Clinical Governance arrangements for maternity and paediatric care were in place across both Conquest and Eastbourne hospital sites.

The Trust had in place a Trust wide system (Meridian) to collect information from patients, friends and family on compliments, concerns, comments and complaints. We spoke with the Patient Experience and Improvement Manager who demonstrated the system the Trust is currently using.

Patients, friends and family were able to record comments or complaints using electronic or paper based methods. We saw that patients were encouraged to use an electronic tablet to provide feedback on their experience. The patient had two options of a short questionnaire or a longer questionnaire. The Trust had trained a section of staff to be 'Patient Experience Champions'. These staff were tasked to improve the patient experience within the Trust Departments. We were told that the aim was to have these 'champions' for all wards, departments and services within the Trust by 2014. The questionnaire seen was clear and unambiguous and afforded the patient the opportunity to add additional comments if they wished. The patient's answers could remain anonymous. The tablets were left on wards and could be completed at any time. There were fixed standing larger consoles available outside of the ward environment. We were shown data that suggested that the Trust was performing above average nationally for the number of responses they were collecting.

We were shown evidence that data captured by the Trust was analysed and broken down into themes and trends. We were shown noticeboards which were being prepared to be placed around the Trust to show results of the data collected from patients, family and friends. These boards also show 'You Said' 'We Did' style captions.

From reports we were shown the Trust was able to evidence that they monitored the number and types of complaints they received. The Trust's target was to resolve concerns within two working days. Complainants were given the choice of following a formal or informal pathway. We were shown recent data that informed us that on average 66% of complainants used the formal pathway. We saw that learning took place from individual complaints and informed future clinical governance. We saw evidence that the Trust had surveyed mothers who gave birth within the Trust in February 2013. The Trust was currently analysing this data. Patients were also able to provide feedback to the Trust via the National NHS 'Choices' website.

Each clinical unit had a risk register and a monthly risk meeting. Matters raised at the risk meeting were dealt with at that level or, if necessary, escalated. The scheme of escalation was: to the divisional risk meeting, then to the a Health and Safety or Patient Safety Group dependent on the type of risk, then to one of four subgroups, again dependent on type of
risk. These groups included the Clinical Management Executive (CME), the Quality and Standards (Q&SC) Committee and the Patient Safety and Clinical Improvement Group (PSCIG). The final arbiter of risk was the Trust Board. At each of these levels there were risk meetings, some were conducted on a monthly basis and others quarterly. Trust wide risks were recorded on the high-level risk register.

Risks were scored between 1 and 25. There is a systematic approach to determining where any particular risk should be considered and this is set out in the Trust risk management policy and procedure policy (the risk policy). For example clinical risks, scored at 15 or above were referred to the CME.

We looked at the high-level risk register dated 14 June 2013. There were a number of entries concerning paediatrics or maternity. We saw that the concerns regarding the requirement for paediatric nurses in the accident and emergency unit at Eastbourne hospital were recorded. However in the column 'controls in place' the entry reads, 'risk added at the request of the assistant director nursing ? form not yet received'. The risk register noted that the controls for this risk were 'inadequate'. The register noted that paediatric policies were out of date. Measures taken to alleviate this included sending policies to the authors for review and the possibility of setting up a policies subgroup. It noted that these measures required commitment from the consultant body. Again the register noted that the controls were 'inadequate'. There was an entry concerning the employment of locum doctors, a number of controls were in place and these were deemed to be 'adequate'.

The Trust had an incident reporting and management policy (the incident policy) for ensuring that adverse incidents or serious incidents (SIs) were reported. There was a recognised process for investigating incidents ? root cause analysis (RCA). Many of these incidents resulted in entries on the clinical unit risk register some of which were escalated under the scheme outlined above. We examined six SI reports and their RCAs in detail. Some incidents included a review where professionals discussed and critiqued clinical decisions. In general we found that reports and reviews had been completed to a high standard.

We saw that as a result of RCAs some staff were made personally accountable. Staff had been challenged over mistakes they had made and there had been individual learning. We saw one case where a staff member has acknowledged an error and was having directed training. We were told that in maternity of the 17 submitted SIs there were seven which had action plans evidencing some personal accountability. In the children and young person's division of four submissions there was one such action plan.

There were meetings that examined the quality of reports and actions taken, for example the serious incident review group. We looked at the minutes of the group dated 29 May and 12 June 2013. We saw that the SI reports were given careful consideration. Where reports were not adequate this was addressed.

There were action plans arising from the RCAs. Generally the plans were relevant and had been completed. However some had not. Quality of notes was a recurrent theme and one action plan stated that there would be quarterly records' audits. We discussed this with the Head of Midwifery. She stated that 15 sets of notes should be audited monthly. There had been an audit in April but none since. This was consistent with the findings of South Coast Audit, the Trust's internal auditors, who reviewed the management of the SI process. South Coast Audit was able only to provide limited assurance that action plans were being completed. Their report made two recommendations one of which was 'Ensuring that
actions were implemented and monitored’.

The Trust analysed serious incidents. An annual report was presented to the Board. There had been a marked increase in the reporting of incidents during the second half of the financial year ending March 2013. It was evident that there had been an increase in awareness of the need to report incidents. The Trust compared its SIs with others and the national mean.

The Trust had to meet the standards set out by the Clinical Negligence Scheme for Trusts (CNST) - Maternity. There was a template to record the agreed assurance information about the Trust’s Maternity Services. The Trust has sought professional advice appropriately. In January 2013 The National Clinical Advisory Team (NCAT) conducted a review of maternity and paediatric services across the Trust. The review made recommendations which the Trust implemented. The Trust had also invited the RCPCH to review the services and were awaiting their report.

We looked at the minutes of the Patient Safety and Clinical Improvement group (PSCIG) for 3 April and 3 May. The PSCIG considered the move by maternity and paediatrics services to a single site. It required the service to report any incidents/actions and this was to remain in place until,’ the group received assurance that no adverse trends were evident and patients have not come to harm’. The group were aware of external factors, for example it was reviewing its terms of reference to reflect the findings of the Francis report.

The Trust’s main audit scheme was based around the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NCAPOP is a closely linked set of centrally-funded national clinical audit that collect data on compliance with evidence based standards. It provides Trusts with benchmarked reports on the compliance and performance. There were also audits arising from National Institute for Health and Care Excellence (NICE) and CNST. Additionally the Trust planned audits on the requirements of local commissioning groups and in areas which the Trust had itself identified as problematic. There was an audit committee to control and direct this activity. We looked at the minutes of this committee for 27 March 2013. We saw that the audit plan for 2013-14 included 168 audits carried forward from 2012-13 and eight carried forward from 2010-2011.

The Trust has an effective system to monitor care. Although our inspection had identified failings concerning the monitoring of plans, the Trust was aware of them and was addressing them.
We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as “government standards”.

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

<table>
<thead>
<tr>
<th>Met this standard</th>
<th>This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.</th>
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<tr>
<td>Action needed</td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
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<tr>
<td>Enforcement action taken</td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
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How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non-compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

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<th>Outcome 1</th>
<th>Regulation 17</th>
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<tr>
<td>Respecting and involving people who use services</td>
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<table>
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<tr>
<th>Outcome 2</th>
<th>Regulation 18</th>
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<tr>
<td>Consent to care and treatment</td>
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<tr>
<th>Outcome 4</th>
<th>Regulation 9</th>
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<td>Care and welfare of people who use services</td>
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<th>Outcome 5</th>
<th>Regulation 14</th>
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<td>Meeting Nutritional Needs</td>
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<th>Outcome 6</th>
<th>Regulation 24</th>
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<td>Cooperating with other providers</td>
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<tr>
<th>Outcome 7</th>
<th>Regulation 11</th>
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<td>Safeguarding people who use services from abuse</td>
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<th>Outcome 8</th>
<th>Regulation 12</th>
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<td>Cleanliness and infection control</td>
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<th>Outcome 9</th>
<th>Regulation 13</th>
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<td>Management of medicines</td>
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<th>Outcome 10</th>
<th>Regulation 15</th>
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<td>Safety and suitability of premises</td>
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<th>Outcome 11</th>
<th>Regulation 16</th>
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<td>Safety, availability and suitability of equipment</td>
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<th>Outcome 12</th>
<th>Regulation 21</th>
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<td>Requirements relating to workers</td>
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<th>Outcome 13</th>
<th>Regulation 22</th>
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<td>Staffing</td>
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<th>Outcome 14</th>
<th>Regulation 23</th>
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<td>Supporting Staff</td>
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<th>Outcome 16</th>
<th>Regulation 10</th>
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<td>Assessing and monitoring the quality of service provision</td>
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<th>Outcome 17</th>
<th>Regulation 19</th>
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<td>Complaints</td>
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<th>Outcome 21</th>
<th>Regulation 20</th>
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<td>Records</td>
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Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.