

East Sussex Healthcare NHS Trust

Eastbourne District General Hospital

Quality Report

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2015
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Inadequate	
Urgent and emergency services	Requires improvement	
Surgery	Inadequate	
Outpatients and diagnostic imaging	Inadequate	

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Eastbourne Hospital as part of the East Sussex Healthcare NHS Trust inspection on 24, 25 and 26 March 2015 and 10 April to follow up on serious concerns at our previous that we had identified at our previous comprehensive inspection in September 2014.

The trust serves a population of around 525,000 patients from across the East Sussex area. There are approximately 700 beds and 7,200 staff. The trust provides a full range of DGH services, although not all services are available at both acute hospital sites. The trust has links to Brighton, Tunbridge Wells and London for some tertiary services.

We found that whilst some fledgling improvements had been made to services provided at the hospital they remained inadequate for safety and leadership and required further improvements for effectiveness and responsive with particular concerns about the provision of services in Outpatients and Surgery .

We found that caring was largely good across the trust. However, the NHS Staff Survey 2014 demonstrated very low staff morale and we found high staff sickness levels at the trust. The

East Sussex Healthcare NHS Trust (ESHT) provides acute hospital and community health services for people living in East Sussex and the surrounding areas. The trust serves a population of 525,000 people and is one of the largest organisations in the county. Acute hospital services are provided from Conquest Hospital in Hastings and Eastbourne District General Hospital, both of which have Emergency Departments. Acute children's services and maternity services are provided at the Conquest Hospital and a midwifery-led birthing service and short-stay children's assessment units are also provided at Eastbourne District General Hospital.

The trust also provides a minor injury unit service from Crowborough War Memorial Hospital, Lewes Victoria Hospital and Uckfield Community Hospital. A midwifery-led birthing service along with outpatient, rehabilitation and intermediate care services are provided at Crowborough War Memorial Hospital. At both Bexhill Hospital and Uckfield Community Hospital the trust provides outpatients, day surgery, rehabilitation and intermediate care services. Outpatient services and inpatient intermediate care services are provided at Lewes Victoria Hospital and Rye, Winchelsea and District Memorial Hospital. At Firwood House the trust jointly provides, with Adult Social Care, inpatient intermediate care services.

Trust community staff also provide care in patients' own homes and from a number of clinics and health centres, GP surgeries and schools.

The trust employs almost 7,000 staff and has 820 inpatient beds across its acute and community sites. The trust serves the population of East Sussex which numbers 525,000.

We carried out this unannounced focussed inspection in March 2015. We analysed data we already held about the trust to inform our inspection planning. Teams, which included CQC inspectors and clinical experts, visited the two acute hospitals along with the Crowborough Birthing Centre and reviewed four of the eight core services that we usually inspect as part of our comprehensive inspection methodology. Service reviewed were maternity services, outpatient services, surgery and accident and emergency care; we reviewed these particular core services as in our comprehensive inspection in September 2014, we had identified serious concerns about the care and treatment provided. We spoke with staff of all grades, individually and in groups, who worked in these services. Staff from across the trust attended our drop in sessions on both sites.

Summary of findings

In September 2014 we identified concerns about the provision of pharmacy services. We looked at this in our unannounced visits by a CQC pharmacist. As the issues identified are across the whole hospital (rather than within one core service), we have included our findings on pharmacy as a trust wide service in the provider report. A large number of people from the local community and staff had contacted CQC after the previous inspection report was published to tell us it was an accurate reflection of the way the trust provided services.

It is important to note that in the past two years the trust had been through a period of significant change with reconfiguration of some key services across both acute sites. The trust had followed guidance on both consultation and reconfiguration set out by the Secretary of State for Health. The consultation process was led by the local Clinical Commission Groups and has been assessed by an audit of its corporate governance. The assessment of this process by internal audit company provided assurance to the board and stakeholders that “Corporate governance, in relation to the maternity project specifically, considered to be executed to a high standard and in compliance with the selection of Good Governance Institute outcomes examined”. It also set out that “Structures and decision-making processes clearly set out and followed”. We were aware that the reconfiguration was not universally accepted as a positive change by some members of the public and some staff.

During this unannounced follow up inspection and in the preceding comprehensive inspection we reviewed clinical services as they are currently configured. Our remit does not include commenting on local decisions about the configuration of services. We have, where pertinent, considered the safety and effectiveness of the services post reconfiguration and whether the trust is responsive to individual and local needs.

Our key findings from the unannounced follow up inspection were as follows:

- The trust board continues to say they recognise that staff engagement is an area of concern but the evidence we found suggests there is a void between the Board perception and the reality of working at the trust. At senior management and executive level the trust managers spoke entirely positively and said the majority of staff were ‘on board’, blaming just a few dissenters for the negative comments that we received.
- We found the widespread disconnect between the trust board and its staff persisted. This did not appear to be acknowledged by the senior management team.
- The NHS staff survey shows the trust below average for 23 of the 29 staff engagement measures and in the worst 20% for 18 of these.
- We saw a culture where staff remained afraid to speak out or to share their concerns openly. We heard about detriment staff had suffered when they raised concerns about risks to patient safety.
- Staff remained unconvinced of the benefit of incident reporting, and were therefore not reporting incidents or near misses to the trust. The trust was not able to benefit from any learning from these. This position had not improved.
- We found that management of outpatients’ reconfiguration has led to service deterioration with long delays in the referral to treatment time in some specialities. We did, however that local managers had taken some steps that had resulted in an improved patient experience.
- In surgery and OPD there was clear evidence of significant underreporting of incidents through the correct system. This related to high tolerance or thresholds in the surgical clinical unit and a management decision to prevent staff reporting OPD reception incidents through the proper channels.
- We saw low staffing levels that impacted on the trust’s ability to deliver efficient and effective care.
- We remained concerned about medicines management and pharmacy services.
- The trust was breaching the provision of single sex accommodation requirements frequently and regularly but not identifying or reporting these. Women and men were both accommodated overnight in the clinical decisions unit and had to walk past people of the opposite sex to use the lavatories and washing facilities.
- The trust was sometimes failing to consider the impact of moving patients between wards and discharging patients through the night. We heard from one patient who told us that they were moved to a different ward in the middle of the night without being informed as they were sleeping.
- The poor quality of health records and frequent lack of availability continued to pose a risk.

Summary of findings

- Storage and operational arrangements did not ensure that people's personal information remained confidential.
- The referral to treatment times in a number of specialities continued to be significantly worse than expected when compared nationally.
- Short notice cancellations of outpatient clinics continued to be a problem. Large numbers of appointments were cancelled at very short notice. In some cases, people arrived for the appointment unaware it had been cancelled.

We saw several areas where good practice was identified including:

- The telephone triage system provided a high standard of information, guidance and support to women, without them necessarily needing to come into hospital.

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

Importantly, the trust must:

- Make sure the privacy and dignity of patients is upheld by avoiding same-sex breaches in the clinical decision unit (CDU) and other areas of the trust. Breaches of same-sex accommodation must be reported accurately.
- Review the arrangements for protecting the privacy and dignity of patients attending the radiology department and the OPD.
- Improve the management of medicines in the ED to promote patient safety.
- Review occupational health and human resources support and resources in place for staff who are on long-term sick leave or who need support, to ensure the trust can meet its duty of care to its workforce.
- Conduct a trust-wide review of staffing levels to ensure that patient acuity and turnover is taken into consideration.
- Give serious consideration to how it is going to rebuild effective relationships with its staff, the public and other key stakeholders. This was a requirement following our inspection on September 2014 but we are not yet assured from the action plan and speaking with the lead executive officer that this has been addressed.
- Create an organisational culture which is grounded in openness, where people feeling able to speak out without fear of reprisal. This was a requirement following our inspection on September 2014 but we are not yet assured that staff feel able to speak out without suffering detriment.
- Undertake a root and branch review across the organisation to address the perceptions of a bullying culture, as required in our previous inspection report.
- Review and improve the trust's pharmacy service and management of medicines.
- Review the reconfiguration of outpatients' services to ensure that it meets the needs of those patients using the service.
- Review the length of waiting time for outpatients' appointments such that they meet the governments RTT waiting times.
- Ensure that health records are available and that patient and staff data is confidentially managed.
- Give full consideration to whether there have been any breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5 (3)(d) Fit and proper persons: directors

In addition the trust should:

- Ensure that staff fully and accurately complete documentation.
- Ensure that fridges used for the storage of medicines are kept locked and are not accessible to people and that medicines are secured in lockable units. This is something that is required as part of Regulation 13 in relation to the management of medicines but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the Regulation overall at the location.
- Develop sustainable systems for the review and monitor compliance with national guidance on VTE risk assessments.
- Develop sustainable systems for ensuring that emergency equipment is checked in accordance with trust policy and national guidance.

Summary of findings

- The trust should ensure that the room in the ED designated for the interview of patients presenting with mental health needs has a suitable design and layout to minimise the risk of avoidable harm and promote the safety of people using it.
- The trust should review the number and skill mix of nurses on duty in the ED department to reflect NICE guidelines to ensure patients' welfare and safety are promoted and their individual needs are met.
- The trust should review the number of consultant EM doctors in the ED and how they are deployed to reflect the College of Emergency Medicine (CEM) recommendations.
- The trust should improve the uptake of mandatory training amongst staff working in Urgent Care.
- The trust should make sure there are enough competent staff working in Urgent Care to respond to a major incident.
- The trust should review the arrangements for monitoring pain experienced by patients in the ED to make sure people have effective pain relief.
- The trust should review their arrangements for assessing and recording the mental capacity of patients in the ED to demonstrate that care and treatment is delivered in patients' best interests.
- The trust should make arrangements to ensure contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- The trust should review some areas of the environment in the ED with regard to the lack of visibility of patients in the children's waiting area; the arrangements for supporting people's privacy at the reception and triage bay and the suitability of the relatives' room
- The trust should review the provision of written information to other languages and formats so that it is accessible to people with language or other communication difficulties.

Subsequent to this inspection visit a warning notice served under Section 29a of the Health and Social Care Act 2008. This warning notice informed the trust that the Care Quality Commission had formed the view that the quality of health care provided by East Sussex Healthcare NHS Trust requires significant improvement:

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement



Rating

Why have we given this rating?

The Emergency Department required improvement to ensure that patients are protected from avoidable harm.

The management of medicines within the Emergency Department (ED), including storage and recording of temperatures, was not being carried out in accordance with national guidelines. The trust did not meet The Royal College of Emergency Medicine (CEM) recommendation that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week. This compromised senior clinical decision making which could negatively impact the patient's pathway of care. High levels of absence due to sickness meant there was not always enough nurses on duty in the ED to care for patients safely given the acuity of patients and the extended geographical layout of the department.

There were insufficient paediatric nurses to provide the cover recommended in the national guidance for urgent care settings for children and young people. Parents of children attending the ED at Eastbourne hospital could not be assured that their child would be seen by suitably qualified and skilled staff across the full 24 hour period.

Incident reporting and reviewing was inadequate. Incidents that met the criteria for reporting through STEIS as a serious incident were downgraded and not subject to a sufficiently rigorous investigation and as a direct consequence the opportunity such investigations gave for service improvement was lost. The limited learning from incidents was demonstrated by recurrence of similar incidents within a short period (such as transferring stroke patients to another hospital because the ED staff had assumed a head injury).

The recognition and management of deteriorating patients was not consistently good and there were a significant number of incidents where the care of seriously ill patients was compromised by poor management of their condition.

The ED required improvement to ensure it provided effective care and treatment.

Summary of findings

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Care assessments did not always consider the full range of people's needs. In general, people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. There were notable exceptions to this documented in the incident log where people suffered significant harm due to lapses in care and treatment.

The outcomes of people's care and treatment was not always monitored regularly or robustly.

Participation in external audits and benchmarking was limited. The results of monitoring were not always used effectively to improve quality.

Eastbourne hospital ED was not proactive in completion of audits at national and local level and we could not see specific improvements related to these.

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

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

There are gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. The Urgent Care Directorate nursing staff appraisal rate was the worst across the trust.

The ED provided a compassionate and caring service.

Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Staff treated patients with respect.

Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

The ED required improvements in the way services are organised and delivered so people's individual needs are met.

Summary of findings

The facilities and premises did not always promote people's privacy, dignity and confidentiality. It was accepted practice for male and female patients to share toilets and overnight sleeping accommodation in the Clinical Decisions Unit (CDU).

The needs of the local population were not fully identified or understood or taken into account when planning services which resulted in shortfalls to the provision for specific groups. The needs of children were not well catered for and the provision failed to meet the standards of the national guidance for urgent care settings for children and young people. Whilst the trust had a facility for providing translation services this was not used in practice and staff relied on family members and friends to interpret what was being said which could lead to misrepresentations and misunderstandings.

The flow of patients from the department into other parts of the hospital was generally good which meant patients were transferred to areas treating their speciality and were not accommodated in the A&E for longer than necessary.

Complaints were not used as an opportunity to learn. The complaint spreadsheet shared with us could not be split by location and so was of limited use when identifying trends about the service. However, complaints about the ED were responded to in a timely manner.

The ED required improvements to leadership and culture so the delivery of high quality, person centred care is supported.

The local vision and values were not well developed and did not encompass areas such as compassion, dignity and equality. There was no local vision: Managers and staff were unable to describe the way they wanted the service to move forward from the reconfiguration.

The arrangements for governance and performance management were not effective. The directorate governance meetings posed little challenge to staff and managers and failed to monitor patient care through the reporting systems that were in place. Risks, issues and poor performance were not always dealt with appropriately or in a timely way. The management of risks in the ED needed to be strengthened to support the delivery of safe and

Summary of findings

effective care. The ED had not responded to the breaches of regulation identified at the inspection of September 2014 which meant patient experience has not been improved.

There were clear examples of where identified risks sat on the risk register with little or no review over a period of time. There were also examples of incidents where very poor clinical practice was recorded but there was no evidence of action being taken.

Data and notifications are not submitted to external organisations as required. Incidents that met the criteria for reporting through STEIS were downgraded locally and not reported.

Staff satisfaction was mixed and not all staff felt actively engaged.

There was a limited approach to obtaining the views of people using the service and no evidence that changes were made as a consequence of patient feedback. There is minimal engagement with people who use services, staff or the public. The trust was dismissive about what the public say and feel.

Surgery

Inadequate



Our inspection found the theatre and recovery areas to be complaint with key trust policy in relation to the checking of emergency equipment and CD (Controlled Drug) checks.

However, the surgical wards and private wing we visited in Eastbourne raised serious concerns that basic safety checks were not instilled into daily practice. The emergency equipment logs we reviewed showed large gaps in the frequency of equipment checks, and the CD registers demonstrated that daily checks were missed on several occasions every month. There was no evidence of pharmacy audit activity and one CD register even noted that drugs were “missing”, but this had not improved the checking frequency. The fridge temperature checks were also found to be incomplete.

We identified a high tolerance levels to incident reporting at Eastbourne. The trends and themes identified across both hospital sites during the inspection was that staff neither had the time to complete forms nor felt that anything would change as a result.

Summary of findings

Safety thermometer boards were available in each ward area but we noted that they were either blank or displayed outdated information. Therefore, important safety information was not available for patients and their relatives to view.

We have identified a significant concern that standards of cleanliness were not being achieved or audited in line with the National Standards of Cleanliness.

The trust continued with the struggle to meet referral to treatment times. We were aware that the trust board has an action plan in place and are receiving support from the TDA (Trust development Authority) to reduce waiting times. However, we remain concerned about the sustainability of the progress currently being made.

During the inspection we looked at how the prevention of post-operative DVT (Deep Vein Thrombosis) was being managed. We were alarmed by the amount of patients on one ward that did not have the assessments in place. Data for February and March 2015 indicated a significant number of patients did not have their VTE risks assessed as indicated by national guidance.

Staffing shortages continued to be a worrying trend and theme on the Eastbourne site. Staff told us that they were under continuous pressure to cope with the staffing shortfall. The trust was heavily reliant on agency and bank temporary staff to back fill posts. We found no evidence in clinical areas that these staff had received a formal induction to their clinical areas before commencing work.

We have continued concerns regarding the culture and staff welfare. We found morale at this site to be alarmingly low. The results of the recent staff survey findings were very negative and inspectors were aware that a significant number of the staff we talked with did not complete it as they felt it was a futile exercise. Staff continued to tell us that they felt unable to raise concerns for fear of retribution and felt disconnected from the senior and board level management. They continued to tell us they felt very over worked and undervalued in the organisation. We received some concerning information during the inspection regarding the quality of care on a ward at Eastbourne District hospital. We reviewed the information thoroughly during the inspection

Summary of findings

Outpatients and diagnostic imaging

Inadequate



and widened our search from the ward named in the alert to other clinical areas. We reviewed multiple case notes, spoke with patients and staff and found the allegation to be unsubstantiated.

During our last inspection we found that the condition and availability of patient's health records was inadequate. At this inspection we found that no progress had been made and staff were still managing high levels of health records not being available for clinics, poor tracking of health records and health records which were oversized and in poor condition.

We also found that in some instances patient's confidential information was not stored securely. When we met with trust executive representatives they told us about plans for improvements in the management of records across the organisation. The Private Trust Board Minutes dated November 2014 showed that the board had approved the business case for an Electronic Document Management/ Clinical portal and medical record scanning system that required TDA approval due to the scale of the financial commitment involved. The trust was aware that there were current problems in the safe and effective management of records and felt that the proposed system would improve the situation significantly.

We found that the OPD was not being cleaned or audited in line with the National Specifications of Cleanliness and trust policy.

There was no clinical triage of the impact of cancellation of clinics. Cancellation was performed as an administrative task with no clinician making decisions about the impact of cancellation on the patients wellbeing.

The call centre was not fit for purpose with a shortage of skilled staff and operating systems that were not working to advantage patients. As a result of these issues patients and staff were often unable to contact the call centre when they needed to. At our last inspection GP letters were not being sent consistently within the five days allocated for this task. This was because of a lack of staff, and issues with the quality of the letters being translated

Summary of findings

abroad. This had not improved since our last inspection and medical secretaries were still experiencing the same difficulties in performing their roles.

At our last inspection the trust was not able to evidence that they were meeting with RTT NHS standard operating procedures across all specialities for either 2 week or 18 week targets. At this inspection the trust was still not able to evidence that they were meeting with these targets consistently across all specialities.

The trust was not meeting the targets set to reduce the backlog of patients on the waiting list for both admitted and non admitted pathways.

The team responsible for informing patients when clinics were cancelled had a backlog of work and were struggling to meet with the demands of the role. Many patients were being informed at short notice when appointments were cancelled even when clinics were cancelled with the required six weeks' notice. Many patients had not been notified when their clinic appointments had been cancelled and were arriving at the department to be sent away.

We found that medicines management had improved since our last inspection.

We saw caring and compassionate care delivered by all grades and disciplines of staff working in OPD.

Radiology staff told us that across the trust there were several vacancies in magnetic resonance Imaging (MRI) computerised tomography (CT) and Ultrasound (US). We were told that CT and MRI vacancies were due to the trust introducing a seven day service with staff working excessive hours to meet this commitment; staff described the pressure they felt due to poor staffing levels.

There were four vacancies across the Consultant Radiologist workforce. Locum consultant Radiologists had been in post for over two years to support the service. Radiology registrars were part of the medical workforce. However there was a shortage of trainees, with the trust having only two registrars instead of five. The outcome of below establishment Consultant Radiologist posts and training registrar posts was that the trust's out of

Summary of findings

hours reporting service was outsourced and the capacity of the department was diminished resulting in extended reporting times which was identified on the Trust Risk Register.

The trust was struggling to recruit to consultant posts in Ophthalmology, Rheumatology and in pathology. Ophthalmology had considered new ways of working to manage this situation. Rheumatology had used locum cover to clear waiting lists and pathology was also covering workloads using locums. The trust was unable to evidence that this cover would be sustainable in the long term.

At this inspection we found that patient's experiences upon entering the department had improved. Systems had been put in place to ensure that patients were directed to the correct areas, and IT systems now informed staff when patients had arrived in the hospital. This meant that if a patient did go to the wrong department staff would be aware of this. The queue at reception had reduced and the area was calm and ordered throughout our inspection. This was not the case in the radiology department where patients arriving in the department were not always supported through a booking in process due to a lack of staff. The departments waiting areas were not fit for purpose as they did not provide space and privacy for patients in gowns to maintain their dignity. Nursing staff had made great improvements in service delivery since our last inspection. However, administration staff were still unsettled and unhappy about the changes that had been made to their department. They had experienced changes in management since our last inspection but felt that the service had not improved as a result.

Eastbourne District General Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Surgery; Outpatients and diagnostic imaging

Detailed findings

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Background to Eastbourne District General Hospital

Eastbourne District General Hospital is located in the town of Eastbourne and geographically serves the population of Eastbourne, Polegate and Hailsham. Merged with Conquest Hospital and the Community locations to form East Sussex Healthcare Trust, healthcare is provided to the whole population from this and other trust locations.

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

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

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

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

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

* rate per 100,000 population

Our inspection team

Our inspection team was led by:

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

The team included a CQC manager and CQC inspectors and a variety of specialists: The team of 29 that visited

across the Trust on 24, 25, 26 March 2015 included senior CQC managers, inspectors, data analysts, inspection planners, registered general nurses, two consultant midwife, theatre specialist, consultants grade doctors, a pharmacist, experts by experience and senior NHS managers.

Detailed findings

How we carried out this inspection

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

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

The inspection teams inspected the following four core services across East Sussex Healthcare NHS Trust acute hospital sites.

- Accident and emergency services
- Surgery
- Outpatient services

The visit was unannounced with the Head of Hospital Inspection making a telephone call to the senior executive officer available on Tuesday 24 March 2015, about an hour ahead of our arrival.

Before the announced inspection we reviewed the information we held about the Trust

We made an unannounced inspection of the Trust services on 24, 25, 26 March 2015 and an additional unannounced inspection visit to both acute hospitals on 10 April 2015. We interviewed clinical and non-clinical staff of all grades, talked with patients and staff across all areas of the hospitals and in the community. We observed staff interactions with each other and with patients and visitors. We reviewed records including staffing records and records of individual patient's care and treatment. We observed how care was being delivered. We held drop in sessions to listen to staff working in different areas of the Trust and met with staff individually.

On 10 March 2015 we looked in depth at how medicines were being managed.

During and subsequent to the unannounced visits we requested current data from the trust and reviewed this along with our findings from the visits.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Notes

Urgent and emergency services

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

Information about the service

The emergency department at the Eastbourne District General Hospital is also known as the accident and emergency (A&E) department. The A&E saw 41,921 adult patients and 8,406 children between 1 April 2013 and 31 March 2014.

The department is divided into areas depending on the acuity of patients. The resuscitation (resus) area has four adult bays, one paediatric bay and one neonate bay. There are eight spaces for treating major cases (Majors) and six spaces, including two rooms for isolation or privacy, for treating minor cases (Minors). In addition, there is a 10-bed clinical decision unit (CDU) which has two bays of five beds each. There is a room near the reception for the assessment and triage of non-ambulance patients and a room which the Emergency Nurse practitioner (ENP) worked from. There were two additional examination rooms off the waiting area.

The trust's paediatric inpatient, general surgery, emergency and high-risk services, along with orthopaedic emergency and high-risk services are centralised at Conquest Hospital in Hastings. The trust's Conquest Hospital in Hastings is a designated Trauma Unit and therefore Eastbourne DGH does not routinely receive trauma patients.

Eastbourne Hospital has a short stay paediatric assessment unit but paediatric inpatient services were centralised at Conquest Hospital in Hastings in May 2013. Paediatric patients presenting at Eastbourne who require admission and overnight stay are transferred to Conquest. Parents are able to self present with their sick or injured children and

are not advised not to attend the emergency department so the expectations of the level of staffing and training are the same as all emergency care settings where children are seen.

General surgery emergency and high-risk services, along with orthopaedic emergency and high-risk services were centralised at Conquest Hospital in Hastings in December 2013 and May 2014 respectively. Patients presenting at Eastbourne who require these services are transferred to Conquest.

We visited the ED on two weekdays during our unannounced inspection. We observed care and treatment and looked at 32 treatment records. During our inspection, we spoke with 23 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We spoke with 19 patients and their relatives. We received comments from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

Urgent and emergency services

Summary of findings

The Emergency Department required improvement to ensure that patients are protected from avoidable harm.

The management of medicines within the Emergency Department (ED), including storage and recording of temperatures, was not being carried out in accordance with national guidelines. The trust did not meet The Royal College of Emergency Medicine (RCEM) recommendation that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week. This compromised senior clinical decision making which could negatively impact the patient's pathway of care.

High levels of absence due to sickness meant there was not always enough nurses on duty in the ED to care for patients safely given the acuity of patients.

There were insufficient paediatric nurses to provide the cover recommended in the national guidance for urgent care settings for children and young people. Parents of children attending the ED at Eastbourne hospital could not be assured that their child would be seen by suitably qualified and skilled staff across the full 24 hour period.

Incident reporting and reviewing was inadequate. Incidents that met the criteria for reporting through STEIS as a serious incident were downgraded and not subject to a sufficiently rigorous investigation and as a direct consequence the opportunity such investigations gave for service improvement was lost. The limited learning from incidents was demonstrated by recurrence of similar incidents within a short period (such as transferring stroke patients to another hospital because the ED staff had assumed a head injury).

The recognition and management of deteriorating patients was not consistently good and there were a significant number of incidents where the care of seriously ill patients was compromised by poor management of their condition.

The ED required improvement to ensure it provided effective care and treatment.

Care and treatment did not always reflect current evidence-based guidance, standards and best practice.

Care assessments did not always consider the full range of people's needs. In general, people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. There were notable exceptions to this documented in the incident log where people suffered significant harm due to lapses in care and treatment.

The outcomes of people's care and treatment was not always monitored regularly or robustly. Participation in external audits and benchmarking was limited. The results of monitoring were not always used effectively to improve quality. Eastbourne hospital ED was not proactive in completion of audits at national and local level and we could not see specific improvements related to these.

There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals. Patients were given timely pain relief although pain scoring tools were not consistently used.

There are gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. The Urgent Care Directorate nursing staff appraisal rate was the worst across the trust.

The ED provided a compassionate and caring service.

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

The ED required improvements in the way services are organised and delivered so people's individual needs are met.

The facilities and premises did not always promote people's privacy, dignity and confidentiality. It was accepted practice for male and female patients to share toilets and overnight sleeping accommodation in the Clinical Decisions Unit (CDU).

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The needs of the local population were not fully identified or understood or taken into account when planning services which resulted in shortfalls to the provision for specific groups. The needs of children were not well catered for and the provision failed to meet the standards of the national guidance for urgent care settings for children and young people.

Whilst the trust had a facility for providing translation services this was not used in practice and staff relied on family members and friends to interpret what was being said which could lead to misrepresentations and misunderstandings.

The flow of patients from the department into other parts of the hospital was generally good which meant patients were transferred to areas treating their speciality and were not accommodated in the A&E for longer than necessary.

Complaints were not used as an opportunity to learn. The complaint spreadsheet shared with us could not be split by location and so was of limited use when identifying trends about the service. However, complaints about the ED were responded to in a timely manner..

The ED required improvements to leadership and culture so the delivery of high quality, person centred care is supported.

The local vision and values were not well developed and did not encompass areas such as compassion, dignity and equality. There was no local vision: Managers and staff were unable to describe the way they wanted the service to move forward from the reconfiguration.

The arrangements for governance and performance management were not effective. The directorate governance meetings posed little challenge to staff and managers and failed to monitor patient care through the reporting systems that were in place.

Risks, issues and poor performance were not always dealt with appropriately or in a timely way. The management of risks in the ED needed to be strengthened to support the delivery of safe and

effective care. The ED had not responded to the breaches of regulation identified at the inspection of September 2014 which meant patient experience has not been improved.

There were clear examples of where identified risks sat on the risk register with little or no review over a period of time. There were also examples of incidents where very poor clinical practice was recorded but there was no evidence of action being taken.

Data and notifications are not submitted to external organisations as required. Incidents that met the criteria for reporting through STEIS were downgraded locally and not reported.

Staff satisfaction was mixed and not all staff felt actively engaged.

There was a limited approach to obtaining the views of people using the service and no evidence that changes were made as a consequence of patient feedback. There is minimal engagement with people who use services, staff or the public. The trust was dismissive about what the public say and feel.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



The ED required improvement to ensure that patients are protected from avoidable harm.

The management of medicines within the ED, including storage and recording of temperatures, was not being carried out in accordance with national guidelines

The trust did not meet The Royal College of Emergency Medicine (CEM) recommendation that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week. This compromised senior clinical decision making which could negatively impact the patient's pathway of care. There were days when the department was led by a middle grade locum doctor.

Information about safety was not always comprehensive or timely. Safety concerns were not consistently identified or addressed quickly enough. There was limited use of systems to record and report safety concerns, incidents and near misses. Some staff were not clear how or when to do this. Incidents reported on the directorate incident log were not always escalated or subject to adequate review. Incidents were not always acknowledged as being a reportable serious incident and senior staff were quick to downgrade the incident.

When things went wrong, reviews and investigations were not always sufficiently thorough or did not include all the relevant people. Necessary improvements were not always made when things go wrong. Despite asking for all RCAs for the period since our inspection in September 2014, very few were provided. None were provided for the more serious incidents and there was little evidence that even where senior medical staff were suggesting comprehensive review and escalation of incidents that this was acted upon.

There were periods of understaffing or inappropriate skill mix, which are not addressed quickly. The way that agency, bank and locum staff was used did not ensure that people's safety was always protected. There were several incidents that were attributed to inadequate staffing levels and the use of agency nurses.

Child safeguarding was not given a sufficiently high priority within the department. Only one staff member across the trust had completed level 3 child safeguarding training. There was a report from the NHS choices website that suggested that not all attendances at ED were notified to the child's GP.

High levels of absence due to sickness meant there was not always enough nurses on duty in the ED to care for patients safely given the acuity of patients and the extended geographical layout of the department.

There were insufficient paediatric nurses to provide adequate cover for the care of sick or injured children.

Incidents

- There were no Never Events in the ED at this hospital in the last 12 months. (A Never Event is a serious, largely preventable patient safety incident that should not occur if the available, preventative measures have been implemented by healthcare providers.)
- We spoke with medical, nursing and allied health professionals who told us they knew how to report incidents and they were given feedback about the outcome.
- Information requested from the trust showed the ED reported no serious incidents to the Strategic Executive Information System (STEIS) since 1 October 2014. Information provided by our analysts through the STEIS showed 3 incidents reported for the same period - although one of these was in March and may not have happened at the point of the inspection visit.
- For the year 1 April 2014 - 31 March 2015 there were 658 incidents reported through the National Reporting and Learning System (NRLS). 1 was graded severe and 35 as moderate. The NRLS does not break the data down by site but reports across the trust.
- A total of 257 incidents were recorded on the Urgent Care Directorate incident log provided by the trust that related to incidents at Eastbourne hospital since September 2014. Two of these were graded level 4 severity and 26 as level three severity (on a scale of 1-4 with 4 being the most severe).
- Some of these appeared serious incidents using the NHS England Framework definition that a serious incident was one where unexpected or avoidable harm that required further treatment by a healthcare

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professional was necessary to prevent serious harm. The definition also encompasses any scenario that prevents or threatens to prevent an organisations ability to deliver healthcare services.

- We were aware that the trust had declared a 'code black' major incident due to excessive demand on services at least twice in the period September 2014 to March 2015. One in January was recorded on the incident log where patients were being cared for in an overflow area and with one RN to 10 acutely unwell patients. We witnessed another during our inspection visit in March 2015, these are declared trust wide.
- None of the incidents relating to staffing appeared to have been addressed. We saw incidents recorded in the incident log that showed staffing levels continued to cause concern but the risk of this was not sufficiently mitigated.
- One such record showed the use of an agency staff nurse who failed to provide adequate or safe care. They failed to handover a patient who had fitted, another with a NEWS score of 11 was not reported or escalated, two patients had not had their blood sugar levels recorded and two others had not had their admission paperwork completed. Three patients had not had their morning dose of antibiotics. One patient was found by the oncoming staff to still be in their day clothes and they had been incontinent and not assisted to clean up or change; they had non blanching pressure damage to their sacrum and thigh. The comment in the log simply said the nurse had been busy and that the matron had written to the agency bureau about the nurses skill levels.
- A recorded incident showed that in March 2015 the ED staff failed to respond to a diagnosis of sepsis. The patient was not treated in accordance with the sepsis pathway in the ED and was transferred to the Conquest for surgery without having been given antibiotics. The patient required transfer to intensive care from recovery and was only then commenced on intravenous antibiotics. There was no evidence of an adequate review of this incident nor could we see that it was being considered as an SI.
- In another incident, dated November 2014, a patient was referred to the medical team. A consultant who came to review the patient in the ED intubated the patient without sedation when the patient was readily rousable, with no cricoid pressure being applied and no supplementary oxygen being used. The situation was resolved when an anaesthetist was bleeped and the consultant removing the tube. The consultant anaesthetist made it clear this was not good practice and suggested it was discussed at the Urgent Care Clinical Governance Meeting but there was no evidence that this was done. We were not provided with the RCA for this incident despite asking for all RCAs completed in the directorate since September 2014.
- We requested a list of incidents in the emergency department which were reported using the electronic reporting system between since 1 October 2014, broken down by type and root cause analyses for any of these incidents that were investigated. There were several readily identifiable trends in the incidents reported that related to care failings particularly of in the management of acutely unwell patients, staffing shortages impacting upon care and duplicate records.
- There was very limited learning from incidents and many did not appear to have been investigated or reviewed at the clinical governance meetings.
- There were three of incidents relating to stroke patients being transferred from Eastbourne hospital to Conquest Hospital due to misdiagnosis as a head injury and several where stroke patients were moved to the wards with no handover and no discussion with the ward staff regarding the transfer.
- We requested RCAs for the period since our inspection in September 2014. Four were provided but other reports were still in the process of being finalised so were not available to the inspection team. The trust provided the RCA report for four incidents (from both acute sites) which related solely to pressure wounds and falls. For example, in November 2014 when a person was transferred out with developing sepsis and who should have been admitted by the medical team at Eastbourne.
- Mortality and morbidity (M&M) meetings were held monthly to review the care of patients who had had complications or an unexpected outcome, to share learning and inform future practice.
- The minutes of the Urgent Care Clinical Governance Group (which covered both acute sites) showed a different picture. There was a lack of clarity about where responsibility for M&M sat with the clinical governance representative saying it was not their job and acknowledgement that the M&M reviews were not being entered onto the database.

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- There was also concern identified that the consultants reviewed deaths from their own patients and acknowledgement that this would not stand up to external scrutiny.
- There were no minutes from recent M&M meetings.

Cleanliness, infection control and hygiene

- The department was clean and tidy. A labelling system was in use to indicate that an item had been cleaned and was ready for use. The equipment we looked at was clean.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel. The 'bare below the elbows' policy was observed by all staff.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- Side rooms were available for patients presenting with a possible cross-infection risk.
- The trust's integrated performance report for December 2014 showed 75.1% of staff working in urgent care had attended infection control training against the trust's target of 85%.
- Eastbourne hospital scored 96.69% for patient satisfaction with cleanliness in the patient-led assessment of the care environment (known as PLACE) 2014 surveys, which is around the national average.
- Information requested from the trust showed monthly hand hygiene audits for A&E demonstrated 100% compliance between September 2014 and March 2015.
- We requested hospital acquired infection rate data for the ED (C.Diff, MRSA) broken down by month. The trust had not provided the information at the time of writing the report.
- We requested infection control audits including environmental assessment, undertaken since 1 October 2014. The trust provided us with information that showed poor compliance with the National Specification for Cleanliness in the NHS. At Eastbourne Hospital the auditing was not carried out at the correct frequency for a very high risk area with 5 completed audits against a target of 40 in January 2015. The scores for the key indicators were low, particularly in areas

where nursing staff had responsibility rather than housekeeping staff. The audits continued to show poor compliance across the period the audits that were provided covered with no evidence of improvement.

Environment and equipment

- The design of the waiting area did not allow the triage nurse or receptionist direct line of sight to patients in the waiting area. This meant that the condition of patients in the waiting area could deteriorate without staff being aware.
- The department did not have a room specifically identified for accommodating patients presenting with mental health needs. Staff told us they would use the relatives' room and patients would not be left alone in the room. The relatives' room was not an appropriate area for interviewing patients with mental health needs as it presented several risks such as ligature points and loose objects, including furniture, which could be thrown and used as weapons.
- The triage room was in a busy corridor and throughout our visit we observed the door was left open when patients were being assessed.
- X-ray and CT scanning facilities were adjacent to the A&E.
- There was adequate resuscitation and medical equipment. This was clean, regularly checked and ready for use.
- Each bed space within the resuscitation area was designed and configured in the same way, which allowed staff working within that area to be familiar with the bed space, which contributed to improved efficiency during trauma and resuscitation events.
- There was a specific area for the resuscitation of children. This contained a wide range of equipment so that children of all ages could be immediately resuscitated.
- There was a dedicated ambulance entrance and an area to accommodate a handover of patients arriving by ambulance.
- There was no designated area for relatives to spend time with their loved one in the event of their death. This took place in bays or a side room if available.

Medicines

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- Poor practice had been identified in respect of medicines management at our inspection in September 2014 but no improvement in the management of medicines was seen as a consequence of this.
- The medicines fridge in majors, which contained medicines including insulin and sedatives for injection, was unlocked on both days of our announced inspection visit. A cupboard containing intravenous (IV) fluids was unlocked on both days of our inspection. The fridge and IV fluid cupboard were in areas easily accessible by members of the public. This increased the risk of unauthorised access to medicines and compromised medicine safety.
- Fridge temperature checks were not consistently recorded daily. In the month before our inspection visit, the fridge temperature was recorded 9 times. This meant staff could not demonstrate that medicines were stored at the recommended temperatures to maintain their efficacy.
- Daily checks of controlled drugs between shift handovers were not consistently done. For example, records showed the daily check was not signed for 12 days in February 2015 and for 6 days between 1 and 23 March 2015. This increased the risk of undetected medicine misuse.

Records

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'CAS card') was generated by reception staff registering the patient's arrival in the department to record the patients' initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- An 'integrated patient care' document was available for patients in the CDU, or where admission to the hospital was anticipated which included an assessment of risks, investigations, observations, advice and treatment and a discharge plan. The pathway document was not implemented in eight out of the 10 patient records we looked at in the CDU. There was also recorded incidents where the failure to use the integrated patient care document had led to shortfalls in the care provided. The lack of an integrated patient care document posed a risk

that there was a potential lack of oversight of care and that either risk assessments (such as pressure wound risk or mobility risk) were incomplete or not handed over when patients were transferred.

- The trust's integrated performance report for December 2014 showed 62.6% of staff working in urgent care had completed information governance training against a trust target of 85%.

Safeguarding

- Information requested from the trust showed 82.9% of medical and nursing staff working in the ED across both sites had completed training in safeguarding children at level 2.
- Information provided by the trust subsequent to the inspection showed that 13 registered nurses had completed level 3 safeguarding children training and a further 29 registered nurses had not. None of the staff recorded as 'additional clinical services' had completed the training. The recommendation made in the intercollegiate document, 'Safeguarding Children and Young People; roles and competencies for healthcare staff' is that all clinical staff who are working with children, young people or their families should have completed level 3 training.
- There was no system in place to ensure that children attending the department were always cared for by a registered nurse with level 3 safeguarding children training.
- The recommendation made in the intercollegiate document, Safeguarding Children and Young People; roles and competencies for healthcare staff is that all clinical staff who are working with children, young people or their families should have completed level 3 training.
- 45.5% of senior ED medical staff (speciality registrar and above) across both sites had undertaken training in safeguarding children training at level 3, which means the trust cannot demonstrate they meet the recommendation that all senior emergency medicine (EM) doctors (ST4 and above) are trained in safeguarding children at level 3 as a minimum.
- Staff had access to patients' previous attendance history and to the child risk register. Electronic flags identified children 'at risk' when they booked in.

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- The ED had a further paper system to support child safeguarding, which consisted of giving parents a safeguarding sheet to complete. We found these forms were not consistently completed when we checked children's notes.
- ED staff were represented at a weekly multidisciplinary child safeguarding meeting.
- The ED had a nominated lead consultant and nurse responsible for safeguarding children across both sites.
- Information requested from the trust showed 69% registered nurses working in the ED had completed training in safeguarding vulnerable adults at level 2.
- Nursing, medical and ancillary staff spoken with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- The trust have told us that there have been no safeguarding referrals made by ED staff since 1 October 2014. Four referrals were made by wards within the directorate during this period.

Mandatory training

- At our last inspection in September 2014 we found the ED's compliance with mandatory training required improvement. There was limited evidence that this had been achieved. For example, the trust's integrated performance report for December 2014 showed 66.4% compliance with manual handling training, 54.5% compliance with health and safety training and 74.9% compliance with fire safety training for staff working in the Urgent Care Directorate. These figures were slightly better than in September 2014, but were still short of the trust's own target of 85%. The trust did not provide us with data separated by location, as requested.
- The trust provided us with data that showed that mandatory training completion rates by junior doctors was good.
- Information from the trust demonstrated 72.4% nursing staff had current BLS, APLS or PILS training. This was not separated into adult and child life support training rates but shows overall compliance levels that fall short of the trust target and national recommendations that all staff complete basic life support training.
- The trust did not provide us with data separated by location, as requested. This limited the opportunity for effective governance and monitoring that could identify specifically where the service was falling short of the target.

- Since September 2014 11 staff had completed PILS training including several healthcare assistants. PILS is a level 3 course designed to allow staff to understand roles and responsibilities in the management of paediatric peri-arrest, cardiac arrest and post arrest situations and not appropriate for healthcare assistants, according to Resuscitation Council Guidance.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
- Patients arriving by an ambulance were assessed by the Shift Co-ordinator. The nurse was given patient handover information by the ambulance crew in the corridor outside the Majors area. Based on the information received, a decision was made regarding which part of the department the patient should be treated. Once transferred to a treatment bay, baseline observations were carried out and a triage category was calculated.
- We observed National early warning score (NEWS) and paediatric early warning score (PEWS) were used appropriately whilst we were in the department although the incident log suggested this was not always the case.
- In October 2014 we saw that a very ill patient was admitted with a NEWS Score of 6. At 5pm but at 10pm they had no further observations recorded, no urine output and only 600mls of fluid given intravenously. The patient was initially being cared for in the minors area of the ED but on eventual review required transfer to ITU. The comment in the investigation and action section of the incident log said, "The nurse was busy" and that the matron would make a note in the communication book to remind staff to escalate increased NEWS scores.
- The incident log provided by the trust showed that in November 2014 a very ill patient was admitted to the ED and transferred to the CDU. Whilst on the CDU there blood oxygen saturation levels were recorded as between 80% and 55% but they were being cared for without any supplementary oxygen. The national

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guidance is that where saturation levels fall below 95% oxygen should be administered. There was no medical intervention for this patient and no analgesia between 12.30pm and 10.30pm.

- In January there was an incident where there were serious and significant failure to manage and acutely ill patient with a NEWS score of between 10 -17. They were not treated as per the Sepsis Pathway guidance, the elevated NEWS score was not escalated, there was no consultant review, no treatment for an acute kidney injury whilst the patient remained in the department. The patient required transfer to ITU within 10 minutes of referral to the ITU team but some 11 hours after admission to the ED.
- The trust consistently met the target to receive and assess ambulance patients within 15 minutes of arrival in the 12 months leading up to October 2014.
- Patients who walked into the department, or who were brought in by friends or family were directed to a receptionist. Once initial details had been recorded, the patient was asked to sit in the waiting room. These non-ambulance patients were assessed by a triage nurse in order of arrival unless the receptionist thought that a patient needed to be seen urgently. If so, the patient was transferred to the resuscitation or a more appropriate area.
- The trust's time to treatment time for all attendances was consistently better than the national target of 60 minutes.
- The trust had risk assessment tools available for risks associated with developing pressure sores, falls, manual handling and poor nutrition. In most of the 30 patient records we looked at, risk assessments had not been undertaken. This meant the trust could not demonstrate that risks were identified and action implemented to mitigate.

Nursing staffing

- High levels of absence due to sickness meant there was not always enough nurses on duty in the ED to care for patients safely given the acuity of patients and the extended geographical layout of the department.
- The nursing establishment for the ED trust wide was: 86.6 WTE at Band 5 and above. The vacancy rate for ED nursing staff at Band 5 and above was 5.6%
- On a typical 24 hours in the department, the trust planned for the following number of nurses on duty:

- 9 registered nurses (RN) and four health care assistants (HCA) between 7am and 7pm.
- 6 RN and 3 HCA between 7pm and 7.30am
- An additional ENP between midday and half past midnight.

These staff covered the main A&E (resuscitation, Majors and Minors), triage and the CDU.

- The skill mix for each shift included band 7 sister/charge nurse grades, who were in charge of the shift, with band 6 and band 5 nurses and healthcare assistants. Staff were allocated to specific areas of the department for their shift, but could be moved around if one area became busier than another.
- Although the trust reviewed hospital nurse staffing levels in December 2014, A&E and CDU were not included in the exercise. There were no plans in place to review the staffing but the trust told us that they awaited National Institute of Clinical Excellence (NICE) draft guidance, which was published in February 2015. There were no steps to mitigate the risks of low staffing levels and a local acuity tool was not in place.
- Nursing staff said the department often worked short of nursing staff in the event of short notice absence, for example, due to nurses 'phoning in sick'. We were told it was not always possible to get replacement bank or agency staff at short notice. At 9am on the second day of our inspection at EDGH we observed one trained nurse and one HCA in resuscitation with a middle grade doctor caring for an acute admission and two existing patients. The nurse in charge told us they were working with one nurse short between 8am and 1pm due to sickness. Nursing staff said the department was regularly short of nurses for around two days every week. We asked the trust for specific information about how frequently the department worked 'short' of nurses) but were told by the trust that they were unable to provide this information.
- The trust's integrated performance report for December 2014 demonstrated an annual sickness rate of 5.1% for staff working in Urgent Care. This compared unfavourably to the trust's overall annual sickness rate of 4.79%.
- We requested information about the ED's bank and agency use for nursing staff in the year to date . The trust provided us with data that showed very high levels of agency and bank use. We requested the rotas for the

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month preceding the inspection but were not provided with those that showed nursing staffing levels and actual deployment of staff. We were provided with the medical staff rota's for the Conquest hospital.

- The trust's integrated performance report for December 2014 demonstrated an annual sickness rate of 5.1% for staff working in the Urgent Care Directorate across both sites. This compared unfavourably to the trust's overall annual sickness rate of 4.8%.
- Between September 2014 and February 2015 the sickness rate amongst registered nurses in ED varied between 2.0% and 5.9% with a six month average of 4.4%. Unqualified nursing staff had a higher sickness rate with a six month average of 10.4% for the same period and a peak in January 2015 of 12.2%. The combined average for all nursing staff is 6.1% which was higher than the annual rate for the Urgent Care Directorate and 27% higher than the trust average.
- The figures provided by the trust were not split such that we could see the site level figures, as requested. This limited the opportunity for managers to effectively monitor the levels by location and so identify any areas of particular concern.
- The rate of turnover for nursing staff amongst registered nurses in the ED trust wide in the last 6 months was 5.5%. This compared favourably to the trust wide annual turnover of 13.5% for nursing and midwifery staff.
- Two band 7 nurses with both adult and child registration were employed in the department at Eastbourne Hospital. This meant Eastbourne Hospital did not meet the Standards for Children and Young People in Emergency Care settings standard for at least one paediatric trained nurse to be on duty over 24 hours. This was included as a moderate risk on the Urgent Care Risk Register and partially mitigated by 8 staff having attended the paediatric module in either emergency care or assessment (continued on a rolling programme). However there were still insufficient numbers of registered children's nurses available to cover the times the unit was open. The requirement to have one paediatric nurse on duty at all times required there to be an establishment of 4.2WTE, according to the Nuffield Institute for Health.
- We requested the trust staffing escalation policy for the ED but this was not provided.
- We were told whilst on site that consultant cover was provided daily from 8am until 7pm on weekdays and for six hours on Saturday and Sunday with an on-call rota for outside of these hours but it was not clear from the rotas provided by the trust that this was the case.
- The rotas provided related to the Conquest hospital site. We were not provided with rotas for the Eastbourne Hospital ED. The Conquest hospital rotas showed significantly less consultant cover than we were told was provided. The rotas for the Conquest hospital showed no consultant presence at weekends. We were not provided with any evidence to show that the ED in Eastbourne Hospital was better staffed.
- In September 2014 the trust's risk register identified there were insufficient consultants to provide staffing levels and extended hours cover in line with the College of Emergency Medicine recommendations. The trust recognised this would compromise senior decision making which could negatively impact the patient's pathway of care. At this inspection we found the trust continued to identify this as a high risk, but has made no progress against the objectives to recruit more consultants.
- 15% of the 39 WTE medical staff employed by the trust were consultant grade compared to the England average of 23%. This equated to a consultant establishment of 5 WTE, of which 3.5 WTE consultants were in post.
- We discussed medical shift patterns with a middle grade doctor, FY2 doctor and a consultant. They told us two consultants worked 8am to 7pm, although they often stayed longer; sometimes until 10pm. One consultant was 'on call' overnight. Weekend consultant 'on call' was for 48 hours, with a 'shop floor presence' of six or more hours each day.
- We were told that the registrar rota was four 8-hour shifts during the day (with staggered starting times at 8am, 10am, 2pm, 4pm) plus one 10pm to 8am shift. On the weekends there were three 12 hour shifts 8am, 11am and 8pm. The SHO rota covered 24 hours a day with shifts: 8am to 5pm, 10am to 7pm, 6pm to 4am.
- The medical staffing rotas for Eastbourne ED provided by the trust showed a different picture from what we were told. pm to 8am.
- The rotas provided showed no consultant cover at the weekends and a working day from 9:00am to 5:00pm.
- The same rota showed shortfalls in the middle grade staffing against what we had been told. The rotas had

Medical staffing

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numerous crossing outs and alterations so were difficult to interpret but appeared to show that on Monday 23 January they showed just two staff grade doctors working - one from 8:00 - 16:00 and one from 16:00 - 24:00.

- On Thursday 26 January 2015 there was a single consultant grade doctor working in the afternoon. There were four staff grade doctors working during the day but one of these was on a course so until a locum arrived at 14:00 there was a single locum grade from 10am.
- Overnight on the 26th January 2015, there was a single SHO working from 22:00 - 08:00. This SHO had been on a course on during the day so would have been very tired whilst working the night shift with little support.
- The rota appeared to show that on Friday 27 January 2015 there were just one SHO from 08:00 - 15:00 and one staff grade from 08:00 - 10:00.
- EDGH did not provide overnight care for sick children, but during the day children were cared for in the short stay paediatric assessment unit (SSPAU). Children requiring overnight care were transferred from EDGH to Conquest. ED staff could access a paediatric consultant, who was available between 9am and 9.30pm in the SSPAU.
- A senior paediatric registrar was available until midnight in A&E. There was a paediatric registrar on call 24/7 but there was limited medical support for the management of an acutely unwell or deteriorating child at the hospital. Any child who required paediatric support in an emergency would be transferred by ambulance to Conquest Hospital.
- We asked the trust for specific information to confirm the establishment for medical staff in the department (which grades of staff for how many hours in each 24 hour period). The trust told us they have an establishment of 10 WTE Consultant posts, 16 WTE SpR/ Speciality doctors and 18 WTE Junior doctor posts across both sites.
- We asked the trust to provide information about how frequently the department worked with less than the planned complement of doctors and we asked for a copy of the actual duty rota worked in the last full calendar month before this inspection. The trust had worked with less than the full medical staffing complement the majority of the time with 67% of shifts being incompletely staffed at Conquest although the figures for Eastbourne hospital were not available.

- We asked the trust for details of locum usage in the ED in the year to date. The trust told us that 13.6% was spent on locum staff but did not provide us with figures about the actual number of shifts covered by locum medical staff.
- The trust did have a generic Induction Planner Tool, that was used on both sites, to support the local induction of locum staff. Information from the trust said, "The induction process for locums follows the trust induction policy and procedure which is available on the Trust extranet guided by the Locum Induction Planner. We aim to use locums that are known to us and are hence familiar with the working environment and clinical systems. New locums in the daytime are met by the consultant and then given a tour of the unit and made aware of the key areas by a middle grade. The workings of the bleep and emergency systems are also highlighted as well as the location of guidelines on the intranet. We try to avoid having a new locum for the first time at night. If this is necessary they are asked to attend prior to the shift and meet with the consultant or registrar for a similar induction."

Major incident awareness and training

- We looked at the trust's Major incident plan which was reviewed and revised since our last inspection in September 2014.
- The trust's annual business plan December 2014 update indicated major incident training would be planned for staff. Information requested from the trust showed 32.7% staff working in the ED (including administration staff) had completed the training.
- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (HazMat).
- We requested information about numbers staff working in the ED who had attended HAZMAT training and the frequency of training updates. The trust informed us that 64% of nursing staff had completed training. We were not provided with figures for medical staff who had completed training.
- SIA licensed security staff were contracted by the trust. They patrolled the A&E department regularly.

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- The department was not secure. All areas of the department were accessible by the public. There was no facility to 'lock down' the department to isolate it in the event of an untoward incident. Hospital security staff were based in a small room near the reception area.

Are urgent and emergency services effective?
(for example, treatment is effective)

Requires improvement



The ED provided effective care and treatment.

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Care assessments did not always consider the full range of people's needs. In general, people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. There were notable exceptions to this documented in the incident log where people suffered significant harm due to lapses in care and treatment.

The outcomes of people's care and treatment was not always monitored regularly or robustly. Participation in external audits and benchmarking was limited. The results of monitoring were not always used effectively to improve quality. Eastbourne hospital ED was not proactive in completion of audits at national and local level and we could not see specific improvements related to these..

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

Patients were given timely pain relief although pain scoring tools were not consistently used. There were recorded incidents where pain relief was not readily available due to staffing shortages, although we did not observe this.

There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. The Urgent Care Directorate nursing staff appraisal rate was the worst across the trust.

Evidence-based care and treatment

- The department used a combination of the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided and a range of clinical care pathways had been developed in accordance with this guidance. Relevant guidance was collated in the trust's ED handbook.
- We observed clinical pathway diagrams showing the decision points and routes of care for the most common conditions such as acute headache and Chronic Obstructive Pulmonary Disease (COPD)
- Specialities had access to care bundle/pathway documentation for some conditions, such as fractured neck of femur and sepsis.
- We saw guidelines for admitting patients to the clinical decisions unit.
- Comprehensive antimicrobial guidelines were available.
- We saw current ALS guidelines clearly displayed in the resuscitation area.

Pain relief

- The trust performed about the same as other trusts in the CQC A&E survey responses to effective pain management.
- We observed that an assessment of pain undertaken on a patients' arrival in the department. All of the patients we spoke with told us that they were offered and/or provided with appropriate pain relief. Patients' records confirmed this.
- Age appropriate pain scoring tools were used in the department; a score was recorded in 50% of the records we looked at. We found no improvement in the inconsistent use of pain scoring tools evidenced during our inspection in September 2014.
- We did not see any patient displaying verbal or non-verbal signs of pain during our inspection that was not being addressed by the staff. However there were several incidents where pain relief had not been provided because the staff were too busy.

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection.
- The integrated patient care documentation booklet provided staff with a prompt to carry out a nutritional risk assessment using the malnutrition universal screening tool (MUST), although these were not completed in most of the records we looked at.

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- Following the assessment of a patient, intravenous fluids were prescribed and recorded, as appropriate.

Patient outcomes

- The mortality rates for the trust did not raise any cause for concern during the national monitoring process in December 2014.
- The hospital performed poorly on the Severe Sepsis and Septic Shock Audit 2013-2014. Before leaving the ED the RCEM standards suggest 100% of patients with a potential diagnosis of sepsis should be on high flow oxygen, have their serum lactate levels measured, have blood cultures taken and have had the first doses of antibiotics. The results showed the figures for Eastbourne Hospital were 40%, 46%, 62% and 70% respectively.
- In the Care of Older People Audit 2013-2014 the ED missed the fundamental standard that 100% of all elderly people admitted via the ED should have an early warning score recorded with a score of 77%. Cognitive assessment only took place in 54% of patients against a RCEM target of 100%.
- In the 12 months up to September 2014 and the unplanned re-attendance rate to the ED within seven days was consistently between the England average (7% - 7.5%) and the CEM standard (5%).
- In the year to date the attendances resulting in admission (20.7%) were slightly less than the national average (21.9%).
- The department participated in local audits; examples included care and treatment around paracetamol overdose and aneurysmal subarachnoid haemorrhage. The results of these were not provided.

Competent staff

- Children requiring specialist paediatric services were treated by paediatric doctors from the paediatric day unit. A consultant paediatrician was on duty between 9am and 9.30pm. Outside of these hours, children were seen by an on-call middle grade paediatrician. Medical staff told us this shift was sometimes not covered, which meant children were seen by the ED middle grade with less paediatric experience.
- A post on the NHS choices website describes the care of a 5 month old baby where medical and nursing staff failed to identify whooping cough and where staff did not inform the GP of the baby's attendance at ED.

- EDGH did not meet the Standards for Children and Young People in Emergency Care settings standard for at least one paediatric trained nurse to be on duty over 24 hours. This was included as a moderate risk on the Urgent Care risk register and mitigated by staff attending the paediatric module in either emergency care or assessment (continued on a rolling programme) and having the paediatric day unit at the providing support where needed.
- Information from the trust demonstrated 60.9% registered nursing staff in the ED had received an appraisal. This was the lowest performance for appraisal amongst directorates within the trust.
- The trust's integrated performance report for December 2014, showed the medical appraisal status for clinical staff in the trust was between 81 and 88%.
- Junior doctors told us they were well supported and had weekly training sessions.
- A Quality and Practice Development nurse worked full time in the department to support nursing staff with their professional development. Nursing staff told us they had good opportunities for learning.

Multidisciplinary working

- Medical and nursing staff worked across A&E with other specialists and therapy staff to provide multidisciplinary care. We observed team working between medical and nursing staff throughout our inspection.
- The trust's Hospital Intervention Team, consisting of a nurse, physiotherapist and occupational therapist provided a seven day service to promote discharge with appropriate support. The team assessed patients who required packages of care or specialist equipment.
- The A&E was well supported by the adjacent radiology department for X-ray and most requested CT scans were performed within one hour.
- Staff had access to the mental health crisis team to assess and treat patients with acute mental health needs, 24 hours a day.

Seven-day services

- All areas of the A&E department were open seven days a week. Support services were also available seven days a week including for example x-ray, scanning and pathology.
- Physiotherapists and occupational therapists offered a seven day service to patients.

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- An ED consultant 'on call' rota was available to support out of hours and seven day working. Middle grade doctor cover was available all of the time.

Access to information

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'cas card') was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- Staff could access records including test results on the trust's computerised system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before they were carried out.
- The trust's integrated performance report for December 2014 showed 83.61% staff working in the Urgent Care Directorate across the trust had completed Mental Capacity Act (MCA) training against a trust target of 85%. There was no breakdown of training completion by site in information provided by the trust.
- We found no improvement in the way patients' capacity and best interest decisions were recorded since our last inspection in September 2014. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment but patients' capacity and any best interest decisions were not recorded in the patient records we looked at (where it was clear the patients lacked capacity to make some decisions due to their condition).
- The trust used privately contracted security staff. We spoke with security staff about their role in the ED. They described the supervision of patients presenting with challenging behaviours, such as those intoxicated by substance misuse and patients with mental health need. Security staff received training in control and restraint under their Security Industry Authority (SIA) licences for 'manned guarding', 'door supervision' or 'security guard' (SIA is the organisation responsible for

regulating the private security industry in the UK). Security staff had no patient specific training to promote awareness of the needs of specific patients, such as those with dementia needs.

- We requested information about training for security staff for the patient groups they worked with in A&E (i.e. restraint, conflict resolution, MCA/DoLS and safeguarding outside of their SIA licences to support them to deal with vulnerable patients. The trust told us that security guarding was contracted and the contractor held the training records. They said that as part of the contractual arrangement there is a requirement for all the security staff to receive control and restraint and conflict resolution training although we were not provided with records to support this assertion.
- We requested information about the number of Deprivation of Liberty Safeguards applications and authorisations in the year to date. The trust told us there had been none made directly by the ED but that there had been 2 applications from MAU. These were low levels and suggested the staff working in the department were not fully conversant with the requirements of the DoLS legislation.

Are urgent and emergency services caring?

Good



The ED provided a compassionate and caring service.

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

Compassionate care

- The trust's integrated performance report in December 2014 showed the scores from the NHS Friends and Family Test (FFT) in ED for both sites were lower than the target of 46 for six out of the nine months, ranging between 37 and 54. The target of 46 was below the England average for the same period.

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- Throughout our inspection of the ED, we observed staff treating patients with compassion, dignity and respect. Patients' privacy was respected by curtains being drawn when personal care was given. Staff lowered their voices to prevent personal information being overheard by other patients.
- During our inspection, demand for beds increased it was necessary to declare an internal incident (code black). It was commendable that despite the extra pressure put on all staff during this period, patients and relatives told us staff continued to be caring and compassionate.
- Patients responding to the CQC A&E survey 2014 said they were treated with respect and dignity while they were in the A&E department, which was about the same as other trusts nationally.
- The patients and relatives we spoke with during our inspection were positive about the way staff treated them. Their comments included:
 - "Staff have been fantastic. Very professional."
 - "The nurses are very attentive."
 - "The staff were very thorough and have explained everything that's happening."

Understanding and involvement of patients and those close to them

- Patients responding to the CQC A&E survey 2014 said they were given information about their condition or treatment and they felt involved in decisions about their care, which was about the same as other trusts nationally. However, the trust performed worse than other trusts nationally when asked about relatives being given an opportunity to talk to a doctor if they wanted to.
- Patients and relatives told us that their care and treatment options were explained to them in way they could understand.
- Since October 2014, the Urgent Care Directorate across both sites recorded nine complaints about staff attitude and five complaints about communication. The spreadsheet provided did not allow us or the trust to break them down by site so it would be difficult to see if one site had more complaints than the other.

Emotional support

- We spoke with staff about caring for the relatives or others close to them when patients died in the department. They said family members were taken to

the relatives' room to be informed of the death in private. Where possible, relatives were given the opportunity to spend time with the deceased person if they wished to.

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

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement



The ED required improvements in the way services are organised and delivered so people's individual needs are met.

The facilities and premises did not always promote people's privacy, dignity and confidentiality. It was accepted practice for male and female patients to share toilets and overnight sleeping accommodation in the Clinical Decisions Unit (CDU).

The needs of the local population were not fully identified or understood or taken into account when planning services which resulted in shortfalls to the provision for specific groups. The needs of children were not well catered for and the provision failed to meet the standards of the national guidance for urgent care settings for children and young people.

Whilst the trust had a facility for providing translation services this was not used in practice and staff relied on family members and friends to interpret what was being said which could lead to misrepresentations and misunderstandings.

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The flow of patients from the department into other parts of the hospital was generally good which meant patients were transferred to areas treating their speciality and were not accommodated in the A&E for longer than necessary.

Complaints were not used as an opportunity to learn. The complaint spreadsheet shared with us could not be split by location and so was of limited use when identifying trends about the service. However, complaints about the ED were responded to in a timely manner.

Service planning and delivery to meet the needs of local people

- NHS England winter pressures daily situation reports (SITREP) data for the trust between 3 November 2014 and 29 March 2014 showed there were zero occurrences when ambulances waited more than 30 minutes to hand over. This was better than other trusts nationally.
- A mental health liaison team provided by a mental health trust had an office based in the ED on both sites, with a presence between 8 am and 8 pm Monday to Friday.
- ED staff could refer patients to a specialist mental health team from another trust during the night.
- Delays for patients attending A&E was identified as a high risk on the Urgent Care risk register. This was because patients were very often anxious or agitated and may wait long periods of time before they were seen by a mental health specialist, which could compromise their quality of care and the wellbeing of staff and of other patients in the department.
- The Intercollegiate Standards for Children and Young People in Emergency Care Settings recommend at least one clinical cubicle or trolley space for every 5,000 annual child attendances is dedicated to children. EDGH had 8,406 child attendances in 2013/14. They also recommend young people have access to quieter waiting and treatment areas, and age-appropriate games, music or films. There was a separate, small children's waiting room adjacent to the paediatric cubicle in the treatment area. During our inspection the waiting area was used for treating children as the light in the paediatric cubicle was broken; this situation persisted for both days of our site visit. There was no space to put a bed or trolley in the area and young children sat on parents knees whilst being examined or treated.

- On the day of our inspection, the children's waiting room was being used to treat children because the light fitting in the paediatric cubicle was broken. This area had insufficient space for a bed to be accommodated and this resulted in children needing to sit on their parent or carers knee whilst being examined or treated. Older children who needed to lie down were put in the adult area. The situation persisted for the two days we were on site.
- Patients who attended the department spoke many languages. Most went to the hospital with a family member who acted as an interpreter. This is recognised as not good practice. Telephone translation services were available for patients for whom English was not their first language and some staff spoke more than one language. Patient information and advice leaflets were available in English, but were not available in any other language or format.

Meeting people's individual needs

- During our last inspection we identified mixed sex breaches in the Clinical Decisions Unit (CDU). We found no improvement at this inspection.
- The CDU comprised two five-bed bays. Staff told us they "do their best" to avoid mixed-sex accommodation and maintain single-sex bays, but said it was "sometimes necessary" to place men and women in the same bay. During our inspection we saw male and female patients accommodated in the same bay. Records of admission times to the CD demonstrated that male and female patients had shared sleeping accommodation in these areas overnight. This arrangement did not comply with standards set out by the Department of Health's Chief Nursing Officer in 2009.
- On 26 March 2015 at 10:10am we found that 3 women and 2 men had been accommodated in Bay 1 overnight.
- There appeared to be an acceptance of mixed sex accommodation in the CDU. Nursing staff told us they 'do their best' to avoid mixed-sex accommodation by separating male and female patients but said they did not complete an incident report or keep a local record of any breaches. The trust's integrated performance report for December 2014 recorded no breaches of mixed-sex accommodation in the CDU. The general manager for Urgent Care told us mixed sex breaches

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were identified and reported at midnight by the clinical site manager. We requested information about breaches and were given assorted lists showing nil returns. No breaches were recorded for the CDU.

- Trust guidelines for the CDU indicated a maximum 24 hour stay. An audit of length of stay in the CDU undertaken by the HIT team showed extended lengths of stays for some patients between October and December 2014. Between 13% and 32% of patients were in the CDU for 24-48 hours; between 2% and 12% patients were in the CDU for 48-72 hours and between 1% and 4% patients were in the CDU for in excess of 96 hours.
- The privacy and dignity of patients in the ED was compromised by poor departmental design. Computer screens could be seen by patients and phones are all near patients so conversations could not take place privately. This issue was included in the department's risk register.
- We observed that the door to the triage room was left open during the majority of patient consultations. The triage room was in a busy thorough fare corridor of the department so consultations could be seen and overheard. This did not support patients' privacy or confidentiality.
- There were Dementia Friends Champions identified among the nursing staff to offer training support and advice to other staff in the department to support the needs of people living with dementia.
- Staff had not received training in meeting the needs of people with learning difficulties; however, staff spoken with were aware of 'passports' which included details of a patient's health and care needs, so that staff could provide prompt and appropriate care and treatment in an emergency. We observed sensitive and appropriate responses from staff when a patient with learning difficulties arrived in the ED with their carer.
- We looked at the relatives' room where people waited while their seriously ill relatives were being cared for, or where people were informed that a relative had passed away. Comfortable furniture was provided with a kitchenette where people could make tea and coffee. There was access to a small patio area.
- The trust scored about the same as other trusts in the 2014 A&E patient survey about whether patients were given enough privacy during discussions with the receptionist and during examinations and treatment.

- There were no appropriate areas where mental health patients could be accommodated. The relatives' room was used for interviews. Patients who were at risk of harm or at risk of absconding were cared for in the majors area where they were supervised closely. Staff told us that additional nursing staff or security staff could be called to assist with patient supervision and to prevent them from absconding.

Access and flow

- The flow of patients from the department into other parts of the hospital was generally good and was facilitated by a number of pathways the trust had put in place to ensure that patients spent as little time as possible in the department or bypassed it altogether. The trust had introduced the role of Pathways Manager (2WTE) to promote this.
- Information from the trust demonstrated the month on month average patient 'time to treatment' was usually less than 60 minutes since October 2015.
- The trust consistently performed better than the England average for patients waiting less than four hours to be admitted, transferred or discharged. Between October 2014 and December 2014 (Q3) 92.9% patients waited less than four hours to be admitted, transferred or discharged against the England average of 92.6%. Between January and March 2015 (Q4) 92% patients waited less than four hours to be admitted, transferred or discharged against the England average of 91.2%.
- The trust consistently performed worse than the England average for the total time (average per patient) spent in A&E.
- The percentage of patients leaving the department before being seen is recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait. The number of patients leaving before being seen in the 12 months up to February 2015 ranged between 0.5 and 2.5%. The trust consistently performed better than the England average.
- The percentage of emergency admissions via A&E who waited between four and 12 hours from the decision to admit until being admitted was consistently less than the national average (month by month for the year ending January 2015).
- The trust had an escalation plan needed to be followed if the demand for beds increased. This covered the

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normal steady state (green) and escalated to the declaration of critical status (black) when the trust is unable to provide a safe level of care due to lack of capacity. A critical (black) status was declared during our inspection due to a lack of capacity in the trust.

Learning from complaints and concerns

- Information about how to complain was displayed in the department. Information leaflets were available to all patients. They contained helpful information about how to access the Patient Advice and Liaison Service (PALS) and how to make a complaint. The department followed the trusts complaints policy.
- Informal complaints could be received by any member of the team. These were dealt with by the most appropriate person. Staff were aware that if they could not resolve an issue they should advise the patient/relative how to use the formal complaints policy.
- Information received from the trust showed 52 complaints were received by the Acute and Emergency Medicine division since October 2014. The top areas of complaint were care (27), attitude (9), pathways (8) and communication (5).
- The trust's complaints report for 2013/14 complaints showed the trust responded to complaints in a timely manner, with 86% responded to in time.
- There was little evidence of learning from complaints.

Are urgent and emergency services well-led?

Requires improvement



The ED required improvements to leadership and culture so the delivery of high quality, person centred care is supported.

The local strategy and values are not well developed and do not encompass areas such as compassion, dignity and equality. There was no local vision: Managers and staff were unable to describe the way they wanted the service to move forward from the reconfiguration.

The arrangements for governance and performance management were not effective. The directorate governance meetings posed little challenge to staff and managers and failed to monitor patient care through the reporting systems that were in place.

Risks, issues and poor performance are not always dealt with appropriately or in a timely way. The management of risks in the ED needed to be strengthened to support the delivery of safe and effective care. The ED has not responded to the breaches of regulation identified at the inspection of September 2014 which means patient experience has not been improved. There were clear examples of where identified risks sat on the risk register with little or no review over a period of time. There were also examples of incidents where very poor clinical practice was recorded but there was no evidence of action being taken.

Data and notifications are not submitted to external organisations as required. Incidents that met the criteria for reporting through STEIS were downgraded locally and not reported.

Staff satisfaction was mixed and not all staff felt actively engaged.

There was a limited approach to obtaining the views of people using the service and no evidence that changes were made as a consequence of patient feedback. There is minimal engagement with people who use services, staff or the public. The trust was dismissive about what the public say and feel.

Vision and strategy for this service

- The ED did not have an individual vision or values that was known or understood by staff. The reconfiguration had resulted in significant changes and yet the ED management team could not verbalise the way the service was going to move forward.
- The trust defined their mission was to: "Deliver better health outcomes and an excellent experience for everyone we provider with healthcare services." The trust's defined objectives are to:
 - "Improve quality and clinical outcomes by ensuring safe patient care is our highest priority.
 - Play a leading role in local partnerships to meet the needs of our local population and enhance patients' experiences."
 - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable."
- Staff we spoke with during the course of our inspection were not aware of the mission or objectives of the trust

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when we asked them about vision and strategy. Staff had not been engaged in the development of the values and there was no objective setting to ensure staff were onside.

- Staff were aware of the trust's values (Working together; Engagement and Involvement, Respect and Compassion and Improvement and Development) which were displayed publically throughout the hospital. We found an improvement in the number of staff who were able to tell us about or sign post us to the trust's values compared to our inspection in September 2014.

Governance, risk management and quality measurement

- The trust maintained a system of scorecards for monitoring targets; for example, national performance targets, patient experience and clinical quality.
- The trust's Audit Committee report for the February Board meeting stated the Urgent Care Clinical Unit had 13 risks open, of which six were identified as inadequate controls and related to medical staffing, mental health assessments, lack of integrated IT services and ambulance offloads.
- The Urgent Care risk register provided by the trust at our request showed five risks: delays for patients with mental health needs, consultant vacancies, middle grade vacancies, lack of integrated IT services and shortage of paediatric nurses resulting in non-compliance with the Standards for Children and Young People in Emergency Care Settings.
- With the exception of an increased capacity which helped minimise ambulance off loading, there was no evidence of action in the Urgent Care Clinical Unit to address the risks since our inspection in September 2014. For example, the ED continues not to meet The Royal College of Emergency Medicine (RCEM) recommendations for consultant cover, continues to have mixed sex breaches in the CDU and medicines are not stored securely.
- There were actions on the incident log where senior staff have suggested something is added to the risk register but this had not been done. For example, there were no entries relating to nursing staff shortages, a lack of x ray equipment resulting in delays and missed diagnoses(as identified on the incident log).

- There appeared to be limited use of the risk register as a dynamic tool to drive and monitor improvements. Month on month the comments made at the directorate governance and risk meetings appeared to be 'no change'.
- There was no local ownership of the directorate risk register. Issues such as a failure to review x-rays and consultant cover shortfalls were very much seen as a 'trust' problem and ignored rather than the ED team looking to solutions locally.
- The trust has failed to comply with the breaches of regulation identified during the inspection in September 2014.
- There was consistency between what frontline staff and senior staff said were the key challenges faced by the service. The risk register reflected what individuals raised as their key concerns for the service. Staff were clear on the risks and areas in the department that needed improvements but failed to take the ownership necessary to effect change.

Leadership and culture within the service

- A general manager had oversight for management of acute and emergency medicine for Eastbourne District General Hospital and Conquest Hospital, which included ED and the medical assessment units.
- Cross-site nursing leadership in the ED was provided by a senior (band 8b) Head Nurse. Two nurse service managers were accountable to the head of nursing. At our last inspection in September 2014, the nurse service managers were allocated service-specific rather than site-specific responsibilities. This had been reorganised since September 2014 so each nurse service manager was responsible for a site; one at Conquest Hospital and one at Eastbourne District General Hospital. Nursing staff we spoke with were clear as to their lines of supervision.
- The general manager and head nurse of the urgent care directorate had been in post for several years and understood the current and future needs of the service, including the number of leaders, qualities and skills required.
- The clinical lead for the Urgent Care directorate across the trust's sites was job shared by two consultant acute physicians. Senior clinical ED staff expressed concern that there was no longer an Emergency Care Consultant lead in the department as this post was lost in the recent restructure. From speaking with medical staff,

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there appeared to be resistance from some consultants cross-covering both sites, which would allow for a less punitive on-call rota. This separation of consultant rotas also meant there were inconsistencies between sites; for example, the A&E handbook, much trumpeted at Conquest, was not used in Eastbourne.

- There was positive feedback from trainee doctors who had been on placement in the department. They said they had been made to feel part of the team and staff ensured that they were fully involved in all aspects of patient care and treatment.
- Staff within the department spoke positively about the care they provided for patients. Quality and patient experience were seen as everyone's responsibility.
- All the staff we spoke with said that they enjoyed the work they did. Most staff spoke with a sense of pride about their local team and department.
- The way staff felt about their involvement in recent changes and future plans for the department was variable; some said they had been consulted or told about changes, while others felt their opinion had not been sought for proposed changes to their areas of speciality within the department.
- Staff morale in the department was variable, but was generally better than at our last inspection in September 2014. Although a significant number of staff still felt marginalised and excluded from shaping the future of the service.
- The trust's quality and performance report for December 2014 showed high staff sickness levels amongst staff working in Urgent Care with 5.9% sickness for the month and 5.1% annually compared to trust wide sickness rates of 5.7% monthly and 4.8% annually.

Public and staff engagement

- The trust's integrated performance report in December 2014 showed the response rate from the NHS Friends and Family Test (FFT) in A&E met the trust's target of 20% for six out of the nine months between April and December 2014, with a range of between 13.6% and 35%.
- There was no evidence displayed in the department of changes made as a result of patient feedback such as 'You said we did', NHS Friends and Family Tests or patient-led assessments of the care environment (PLACE).
- A quality board was not displayed in the department to show staff how they were performing or to celebrate their achievements. These boards were available in other areas of the hospital. When we asked staff why they did not have a board, they suggested the ED had been overlooked.
- The engagement strategy was ineffective and local people remained angry at the lack of involvement afforded them by the trust in respect of the reconfigured services, including ED.

Innovation, improvement and sustainability

- Services at the trust were restructured between December 2013 and May 2014 so that general surgery, emergency and high-risk services, along with orthopaedic emergency and high-risk services were centralised at Conquest Hospital. The trust's inpatient paediatric ward is also at Conquest Hospital so ambulances conveying sick children are received at Conquest. A capital bid was secured by the trust development authority for expansion of the ED at Conquest Hospital. Phase 1 was completed with the creation of the CDU. Phase 2 and 3 were dependent on the approval of planning consent to extend the building of the ED into an existing car park.

Surgery

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

Information about the service

East Sussex Healthcare NHS Trust provides care to a population of 525,000 people and is one of the largest healthcare organisations in the country. The recent service reconfiguration saw some of the acute hospital services moved from the Eastbourne District General Hospital to the Conquest Hospital site in Hastings. We visited the surgical wards and theatre departments at the Eastbourne District Hospital site. The Care Quality Commission (CQC) undertook an unannounced inspection at the Eastbourne District Hospital on the 26th of March 2015. In order to carry out this inspection, CQC reviewed information from a wide range of sources to get a balanced and proportionate view of the surgical services. We also reviewed data supplied by the trust, external stakeholders and reviewed feedback from patients and members of the public who shared their experiences with CQC. We visited the surgical wards, discharge lounge, theatres, recovery areas, and observed care being delivered by staff. We reviewed online patient feedback from a range of sources and took the information we received from members of the public into consideration before, during and after the inspection process. The CQC held drop in sessions, where staff could talk to inspectors and share their experiences of working at the trust. For the purpose of this report the surgical department will be referred to as the surgical clinical unit which reflects the renaming of the service, post reconfiguration.

Summary of findings

We identified serious concerns that basic safety checks were not instilled into daily practice on the surgical and private wards we visited during the inspection. The emergency equipment logs we reviewed showed large gaps in the frequency of equipment checks, and the CD (Controlled Drug) registers demonstrated that daily checks were missed on several occasions every month. There was no evidence of pharmacy audit activity and one CD register even noted that drugs were “missing”; This had not increased the frequency of checks. Medication fridge temperature checks were also found to be incomplete.

Our inspection identified improvements in the theatre and recovery area which were compliant with key trust policy in relation to the checking of emergency equipment and CD medication. The hospital policies on emergency equipment and CD medication checks were found to reflect best practice but, were not being followed in practice. We identified incidents which had failed to be reported through the electronic incident reporting tool. The trends and themes identified across both hospital sites during the inspection were that staff neither had the time to complete forms nor felt that anything would change as a result. Data from the most recent staff survey suggests that staff did not feel secure in raising concerns. Safety thermometer boards were available in each ward area but we noted that they were either blank or displayed minimal and outdated information. Therefore, important safety information

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was not available for patients and their relatives to view. We have identified a significant concern that standards of cleanliness and hand hygiene were not being achieved or audited inline with the National Standards of Cleanliness. This meant that patients were not protected from the risk of acquiring a healthcare associated infection.

The trust continued with the struggle to meet referral to treatment times. We were aware that the trust board had an action plan in place and were receiving support from the Trust Development Authority (TDA) to reduce waiting times. However, we remain concerned about the sustainability of the progress currently being made. During the inspection we looked at how the prevention of postoperative Deep Vein Thrombosis (DVT) was being managed. Data for December 2014 to March 2015 indicated a significant number of patients did not have their Venous thromboembolism (VTE) risks assessed as indicated by national guidance. Staffing shortages continued to be a theme on the Eastbourne site. Staff told us that they were under continuous pressure to cope with the staffing shortfall. The trust was heavily reliant on agency and bank (temporary) staff to backfill posts. We found no evidence in clinical areas that these staff had received a formal induction to their clinical areas before commencing work. Theatre and recovery staff were being deployed to ward areas to bridge the staffing gaps on a regular basis. However, these staff were not provided with the necessary support to ensure they had the competency and skill set to work outside of the theatre environment.

We have continuing concerns regarding the culture and staff welfare. We found staff morale at this site to be very low. The recent NHS staff survey results were very negative and inspectors were aware that a significant number of the staff we talked with did not complete it as they felt it was a futile exercise. Staff continued to tell us that they felt unable to raise concerns for fear of retribution and felt disconnected from the senior and board level management. They continued to tell us they felt very overworked and undervalued in the organisation. The environment in the Urology ward was found to be unsuitable due to the volume of patients who attended this area. There was a general lack of

areas to assess patients in an environment where their dignity and confidentiality could be maintained. There was also a lack of suitable compliant storage for medical records.

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Are surgery services safe?

Inadequate



The last inspection at this site highlighted significant failings with emergency equipment and Controlled Drug (CD) checks. We continue to have the same level of concern in relation to safety checks in ward areas where we noted large gaps in the check logs. Staff told us that the low staffing levels impacted on their ability to carry out safety processes. The theatre and recovery departments demonstrated compliance with trust policy for undertaking safety checks.

A theme identified across the surgical clinical unit was the lack of pharmacy audit processes in relation to the safe handling, storage and administration of medicines. Staffing levels throughout the department were found to be insufficient to meet people's needs. This was also identified during the previous inspection. The trust has given assurances to CQC that it is actively recruiting to fill the vacancies, however, we were acutely aware that the crisis on the 'shop floor' has remained unchanged. The trust remained heavily reliant on agency and bank staff in the interim to ease the pressures. The urology ward appeared to be the worst affected by an insufficient number of nursing and admin staff.

We remain concerned that the department was not reporting all incidents that required reporting. We identified two incidents that should have been reported, if trust policy were being followed. We acknowledge that as part of the trust action plan, there was a commitment to strengthen the incident reporting process. Formal incident reporting had been introduced into the hospital induction for all new staff. However, there was little evidence that these measures had an impact in clinical areas. This meant that the organisation was unable to identify trends and themes in incidents or ensure it learned and improved the service. Staff were unable to give us examples of learning from incidents reported in their clinical areas and told us that learning was not freely disseminated. Staff told us that the staffing shortages had an impact on incident reporting as they needed to ensure that "clinical care was prioritised over form filling". Data received from the trust indicated a clinical incident where a swab was retained post operatively. The data from the patient safety drill down Jan

– Dec 2014 also indicated that an 'instrument was retained post operation'. However, neither incident had been reported as a never event. The environmental and hand hygiene audit data we received revealed that the National Standards for Cleanliness was not being achieved and the frequency of audit activity to monitor the standards was found to be inadequate in what was identified as a high risk area. Hand hygiene audits indicated that one ward only met the national standard score of 95% for two out of five months.

Our concern with the overall quality of the medical records held by the trust remains. Notes were found wrapped with rubber bands to ensure loose pages were not lost. Staff reported problems getting access to medical records and told us that temporary notes had to be frequently used. Some consultants refused to treat patients whose notes were unavailable. The trust were aware of our concerns regarding the availability and general quality of the medical records held by the trust. CQC have been assured that a robust action plan was in place to address this which included the roll out of Radio Frequency ID tags to improve note tracking and availability.

Incidents

- Our last inspection at the Eastbourne General site found evidence of incidents going unrecorded. Staff we spoke to were very open about the reporting practice in the department. They felt that continuously low levels of staff meant that paperwork did not always get completed and they told us that the clinical care and the safety of their patients was their first priority. A theme identified at inspection across sites was that staff felt that they were already working extended hours in order to catch up on essential paperwork and told us "they just couldn't do everything". Low staffing levels on this site were not routinely being reported. Staff told us that they were asked by senior managers not to report unsafe staffing as an incident.
- Staff were unable to give us examples of any learning or changes to practice that had occurred as a result of incidents being reported. Staff felt they did not receive relevant feedback or learning from incidents reported.
- The trust told CQC that steps to strengthen staff awareness of incident reporting had been incorporated into the hospital induction programme to ensure that new staff had been made aware of their duty to report

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incidents. However, we did not find that these steps had influenced or had an impact on clinical areas. We identified two incidents in one ward area, relating to a fall and a pressure ulcer, both of which had gone unreported. This meant that the trust was unable to appropriately measure or address the risks posed from the underreporting of incidents and improve the service as a result.

- It is worth noting that two out of the five key findings in the staff survey for which East Sussex Healthcare NHS Trust compared least favourably with other acute trusts in England relate to the percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice, and fairness and effectiveness of incident reporting procedures.
- Trust data indicated there had been no ‘never events’ over the last twelve months. A ‘never event’ can be defined as a serious, largely preventable patient safety incident which should not occur if the available preventative measures were implemented. However, data received from the trust indicated a clinical incident where a swab was retained after surgery. Data from the patient safety drill down Jan – Dec 2014 indicated that an ‘instrument was retained postoperation’. Neither incident had been reported as a never event.
- The previous inspection identified a concern with Mortality and Morbidity (M&M) meetings in general surgery. M&M meetings were established across the NHS to review deaths as part of professional learning and to provide the hospital board with the assurance that patients were not dying as a consequence of unsafe clinical practices. We received evidence that the trust continuously monitored mortality and morbidity across the clinical unit. The minutes of the general surgical M&M meeting dated September 2014 were reviewed and provided evidence that the M&M meeting activity in general surgery had been reinstated. However, we requested, but did not receive meeting minutes after the September 2014 meeting.
- We received comprehensive evidence of M&M and audit activity team learning from the urology and anaesthetic teams.
- We requested the Root Cause Analysis (RCA) data for eight SIRI’s relating to the surgical clinical unit reported between October 2014 to March 2015. Not all of the

investigations had been completed, however the RCA reports we viewed had documented organisational learning and had an action plan in place. We did not receive documentation that evidenced on going monitoring or progress of individual actions plans.

Safety thermometer

- Safety thermometer data was being collected by the clinical areas regularly.
- Each area had an information board available for the information to be displayed. However, we found most of the boards in the areas we visited were completely blank. This meant that patients did not have access to the safety data for the ward where they received care.

Cleanliness, infection control and hygiene

- Hand hygiene audits were undertaken by each clinical area. We reviewed the hand hygiene audit data from September 2014 to March 2015 and found that it depicted a varying and concerning trend. Surgical areas are considered to be high risk clinical areas and there is an expectation that hand hygiene scores should achieve a consistently high standard. The data presented to CQC was for a seven month period. One ward on the Eastbourne site reached the recommended hand hygiene score of 95% or above, for two out of the 5 months audited, between Sept 2014 and Feb 2015, this area had not been audited in March. Three other areas and had consistently maintained a score of 100% for the same seven month period. However, given the concerns identified with these audits at the Conquest hospital, it suggests inadequate management of infection control from a trust wide perspective.
- We saw that cleaning rotas were in place and curtains were changed and dated in line with trust policy. We requested the environmental hygiene audits for all areas in the surgical clinical unit in order to check the overall quality and standards being achieved. However, the data we reviewed raised a significant concern that high risk surgical areas were not meeting the national target of 95%. Data demonstrated that one ward area fell below the recommended standard for six consecutive months. Two areas that were appearing to maintain their standards were not subjected to an audit for two months. These areas saw their standards drop below the recommended scores when these areas were finally audited in March 2015. The data did not include

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environmental scores for Michelham ward which was being used as an elective orthopedic ward at the time of the inspection. The results of these audits month on month showed that the national standard was not being achieved across either sites. The data showed an inconsistent approach to audit monitoring of standards in surgery. It also demonstrates that where standards were identified as outside of the acceptable ranges, action was not taken to address and improve standards, to protect patients from the risk of acquiring a healthcare associated infection.

- Infection control data reported to the Centre for Disease Control and prevention (CDC) between April 2014 and April 2015 showed that the trust reported 3 cases of MRSA (Methicillin-Resistant Staphylococcus Aureus), 51 cases of C.Diff (Clostridium Difficile) and 20 cases of MSSA bacteremia (Methicillin-Susceptible Staphylococcus Aureus).
- We noted from the trust board minutes dated March 2015 that there was an increase in C.Diff cases identified over the preceding three months.
- We saw that an adequate supply of personal protective equipment was available and was being used by staff when delivering care.
- There were a number of side rooms available on each ward which were utilised appropriately for the purpose of barrier nursing and infection control purposes.
- The Surveillance of Surgical Site Infections in NHS Hospitals in England 2013/14 report showed that the trust's rate of inpatient surgical site infections for total hip replacements (0.15%) was within expected limits during 2013/14, and they recorded no surgical site infections for total knee replacements over the same time period.

Environment and Equipment

- We continued to find significant discrepancies with the checking of emergency resuscitation equipment on the surgical ward areas. We found checklists that demonstrated that these checks were not being carried out regularly and were not embedded into everyday practice. One ward we visited had omitted 50

emergency crash trolley checks between 26/12/2014 and 26/03/2015. Another ward we visited showed us that in a period of 26 days in March, only five checks had been completed.

- The theatre and recovery areas were able to demonstrate compliance with emergency checks and key trust policies.
- The environment in the Urology ward was found to be unsuitable for the number of patients who attended this area. There was a general lack of areas to assess patients in an environment where their dignity and confidentiality could be maintained.
- This area also had insufficient secure storage facilities for medical records and unsuitable storage for medical equipment. For example, large hoists (moving and handling equipment) stored in the small patient waiting area.
- We were aware that recovery was used as an overflow area when capacity had reached its maximum on this site. However, the area had no toilet, washing facilities or sluice.

Medicines

- We reviewed the controlled drugs (CD) registers in all the areas we visited and found that routine checks were not being carried out inline with trust or national policy. One ward we visited had failed to check their CD's on nineteen occasions in January, fifteen occasions in February and ten occasions in March (up until the 26/03/2015). It is worth noting that there was an entry in the CD book on the 12/02/2015 that a drug was "missing", and another entry dated 04/03/2015 had the following text recorded "checked and correct as Ketamine was not documented in CD book- dispensed 02/03/2015". These entries suggest that CD's are not being handled inline with trust policy or national guidance. We also noted that on some occasions entries clearly stated that drugs were not checked due to inadequate staffing levels.
- One of the registers identified a CD as missing but we noted the frequency of the checks afterwards continued to be sporadic rather than daily as per trust policy.
- There was a noticeable lack of pharmacy audit in all areas. If regular quality monitoring had been in place the risks found at inspection may have been identified and managed appropriately.

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- Theatre and recovery were able to demonstrate compliance with the frequency of controlled drugs checks.

Records

- The staff discussed the availability of records; One staff member told us “The note situation is a joke”. Another staff member gave us an example of starting work at five in the morning to drive to the Conquest to obtain notes needed at Eastbourne to ensure that patient care was not affected by a lack of availability. Whilst we highly commended staff’s dedication to ensuring patient care is unaffected by the current medical record crisis, this is an unacceptable practice that may pose a risk to the staff member and the organisation in terms of data protection and from a governance perspective. The emphasis is on the organisation to ensure that medical records are routinely available.
- We reviewed a selection of patient records and found that they contained the relevant risk assessments which demonstrated that patients were having the majority of their care needs risk assessed. However, our concerns regarding the overall quality of patients’ medical notes kept at East Sussex Healthcare NHS Trust still exists.
- The majority of clinical notes we reviewed were in very poor condition and wrapped in elastic bands to prevent pages being lost. This meant that there was a high risk that patient sensitive data and important clinical records could easily be lost or filed out of sequence, thereby affecting patient care.
- There were also problems with the availability of patients’ notes, and thus a frequent use of temporary notes being generated.
- If a patient had been seen and treated in the hospital previously, staff could access medical secretary letters which provided recent and relevant patient information. We were aware that some consultants refused to see patients without their notes due to the clinical risks it presented. This meant that patients’ treatment was delayed and valuable consultant time was being wasted.
- The trust acknowledged problems with the availability of notes and has an action plan for the implementation of an Radio Frequency Identification Device (RFID) tracking system. This system should reduce the incidence of lost notes and will aid note-traceability throughout the trust.
- We have concerns regarding the storage of clinical notes on the Urology ward. We found an unlocked office outside a waiting area which contained confidential medical records. This room was easily accessible by unauthorised personnel and, due to its position, was not in line of sight of the admin desk which meant that staff would be unaware if the room was accessed.
- We identified a very small but cluttered clinical storage room beside the admin desk on the urology ward that was also being used to store large volumes of medical notes. We were made aware that staff had been instructed to move the notes as a matter of priority as CQC were carrying out an inspection. Whilst we did not see the notes being stored in this room during the inspection we were aware of the steps taken to ensure we did not see the routine and inadequate way that medical records were being stored. This room was permanently unlocked and could be easily accessed by unauthorised personnel.
- We identified some room for improvement in the nursing documentation we viewed. For example, times, dates and staff designation was not always recorded.
- We also found examples of good practice in the records we viewed. This included staff recording that they had introduced themselves to the patients and made them aware that they were the designated person in charge of their care and there was evidence that consent was obtained before any care or intervention was carried out.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The medical records we viewed indicated that informed consent was usually obtained in line with national guidance. However, CQC have received two significant concerns relating to the consent process at East Sussex Healthcare Trust. The themes identified from these contacts related to consent being obtained for specific surgical procedures and another being carried out without discussion or further consent from the patient. This raised a significant concern regarding how informed consent was obtained and upheld.

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- A sample of medical records we reviewed demonstrated that formal consent was obtained, and that appropriate discussions had taken place with patients prior to surgery. Documents also evidenced that patients were made aware of the likelihood of surgical complications as a result of having a surgical procedure. The patients we talked with during the inspection told us they were given a suitable amount of information to be able to give informed consent for a surgical intervention. They also confirmed that they were given enough time to make their decision to proceed, and to ask any outstanding questions of their surgeons.
- Where a patient had been assessed as lacking mental capacity, we saw the appropriate assessments in place to ensure that best interest decisions could be made by the nursing and medical teams.
- Staff demonstrated an understanding of mental capacity and could verbalise the safeguarding escalation process.
- Staff had a lack of clarity regarding Deprivation of Liberty Safeguards (DoLS) and were unable to identify a DoLS and tell us about any action they would need to take.
- Staff were able to demonstrate what constituted a safeguarding concern and the process in place to report such issues.
- Continuous support was provided to the trust by the adult social care team from the local authority to investigate and learn from safeguarding incidents.
- The themes identified by CQC from referrals identified poorly planned discharges and pressure ulcers which were identified in the community once the patient had been discharged as well as medication concerns.
- Staff told us they did not always receive feedback or learning from alert investigations.

Mandatory training

- Clinical areas were able to demonstrate accurate training records.
- Staff told us that access to training was impacted by poor staffing levels.
- The trust had set a target of 85% completeness for mandatory training across the organisation. We were aware that it was not achieving this. Whilst most new staff had completed induction training, participation rates for other training did not meet the target of 85%. Theatres performed marginally better than the Surgical Clinical Unit, being below target in Manual Handling (82.9%) and Health and Safety Training (68.33%). The Surgical unit was below target in all subjects with completion rates varying between 60.09% for Health and Safety training to 82.26% for Fire Safety training.

Safeguarding

- CQC were aware of an overarching organisational safeguarding investigation which returned an outcome of substantiated financial abuse at Eastbourne District Hospital. This related to several thefts from vulnerable patients, predominantly in one clinical area. The investigation outcome found that the trust had failed to protect patients from the risk of financial abuse because it had not followed its own policies and procedures. This is a breach of Regulation 11 (1) (d). The trust has a detailed action plan in place to address its shortcomings and prevent reoccurrence. Our inspection found an improvement in the way patients valuables were handled, documented and stored. Patients were very clear that the trust policy had been explained to them upon admission. However, staff were unable to give inspectors the specific learning from the safeguarding investigations. This may suggest problematic communication in this ward area.
- The trust had a safeguarding policy in place which reflected national guidance.

Management of deteriorating patients

- VitalPAC (an electronic vital signs system) for monitoring deteriorating patients was in use.
- We were aware that the VitalPAC system had failed in January 2015 and that the trust had reverted to using paper documentation while the systems were being repaired. This incident was reported via the appropriate notification system to CQC.
- A concern across the two acute sites identified concerns with the timeliness of the VitalPAC hand terminals' synchronisation. Staff told us that this led to unnecessary delays and the need to undertake repetitive tasks.

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- The staff relied heavily on the use of agency staff. However, we noted that these staff did not have password access to the VitalPAC or blood monitoring technology. Permanent staff told us they got round this problem by allowing agency/bank staff to use their passwords to record observations. This practice was a breach of trust policy and of the Data Protection Act 1998 but staff felt they had no alternative but to allow temporary staff access to maintain patient care at a safe level. Staff also shared their passwords to allow agency staff to access blood glucose equipment.
- We noted that one ward matron on this site had admin access to the various systems and was able to provide agency staff on that ward with their own IDs. However, this was not common in any of the other areas we visited.
- Compliance with the World Health Organisation (WHO) safety checklist was audited regularly and the records demonstrated good compliance. However, we noted that the audit process could be improved. We found the final element of checklist of the records we viewed was not consistently completed which may have an effect on learning and safety in the department.
- When the National Early Warning Score (NEWS) indicated a concern about a patient's condition this was escalated and the patient was subject to a medical review.
- The surgical department used the NEWS system to help identify and monitor deteriorating patients.
- We noted that the skill mix in some areas was not ideal, as newly qualified nurses were relied upon to support services. Newly qualified staff at the Eastbourne site told us that they did not receive the level of support they needed due to the pressures on staffing numbers. One newly qualified member of staff gave us an example of being left in charge of a clinical area with a healthcare assistant and was told that experienced nurse support was provided from the next ward if she needed it. The trust had assured us that newly qualified staff get appropriate levels of support, however, we remain concerned that the support provided may be severely affected by the staffing crisis and skill mix and new staff may be working outside their competencies.
- The trust reported its agency usage at 7.9%, which is higher than that national average of 6.1%.
- The trust introduced a specific induction for the temporary workforce. However, we found ward areas had little or no oversight of their temporary workforce. There was no documentary evidence that staff received any induction or were familiarised with their work environments.
- Staff told us that they made every attempt to have a member of experienced permanent staff present at all times, but that this was not always achievable.
- CQC was also made aware that theatre staff were being requested to work on ward areas at busy periods. Staff raised concerns about their competency and ability to undertake this work as it was a very different skillset. We were unable to evidence the support mechanisms in place for these staff to work in new clinical areas or how core competencies were measured.
- The trust was in the process of using an acuity tool to measure and monitor staffing levels across the department for a month.

Nursing staffing

- The staffing levels across the surgical department continued to be insufficient to deliver individualised patient care. The urology ward reported having 5 WTE (Whole Time Equivalent) nurses short of the established staffing levels.
- Staff continued to tell CQC that they were continuously affected by staffing shortages and that “nothing had changed” since our last inspection.
- Our unannounced inspection again observed nursing staff delivering safe patient care, but it was at a cost to their own welfare by skipping breaks, working late, etc.
- Staff told us that missing breaks and working extended hours had become normal practice on wards.

Medical staffing

- Nursing staff on this site raised concerns regarding junior availability and the effect it had on ward discharges. This meant that patients were frequently waiting for an extended length of time for their discharge to be processed. It also meant that potential

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bed spaces were being blocked and impacting patients flow through the site. Quality Walk minutes identified these delays impacting 25% of the bed capacity in the urology ward.

- The trust reported its medical staffing skills mix as 222 WTE (whole time equivalents). This comprised of 38% consultants, 22% middle grade doctors, 29% registrars and 12% junior doctors.
- Consultant presence had increased during the week and at weekends.
- The trust continued to be heavily reliant on locum doctors to deliver its services. Locum use was running at 7.9%, which was above the national average of 6.9%.
- Middle and junior grade doctors were on duty 24 hours a day in the department. We did not identify any concerns with this cover during the inspection. However, a trend identified across both acute sites worth noting was that ward staff mentioned that doctor availability frequently had an effect on the timeliness of discharges.
- Telephone support was also available from the Conquest if required out of hours.

Major incident awareness and training

- The trust had an appropriate major incident policy in place.
- Major incident training had been provided to staff. The last training was delivered before the service reconfiguration in July 2013. With recent changes to work environments, medical specialities and mobility of staff, this posed a potential risk to the organisation.
- Staff we spoke to were aware of the policy to defer elective surgical activity in order to prioritise unscheduled emergency procedures during a major incident.

Are surgery services effective?

Requires improvement



CQC remain concerned about trust compliance with venous thromboembolism (VTE) in particular at this site. We reviewed data that demonstrated a total of 74 patients between mid December 2014 and mid March 2015 that did

not have their VTE care needs assessed during their admissions. The mortality and patient safety data showed the trust performance relating to post-operative pulmonary embolism prevention to be double the peer average, which suggested more action was needed for the prevention of post-operative pulmonary embolism at ESHT.

We found that Nil By Mouth (NBM) best practice was not always being followed which meant that patients were without food and drink for prolonged periods. We were told the urology team had introduced staggered admission times in a bid to address this and to improve patient flow on the ward. The trust compliance with RTT for non-admitted pathways showed poor compliance against targets agreed with the trust Development Authority and local commissioners. The ratings for February 2015 showed that General surgery, Trauma and Orthopaedics, Ophthalmology and Gastroenterology rated as red with waiting lists and backlogs significantly higher than agreed. The overall waiting list showed at total waiting list of 8,936 patients for the four specialties identified. (General surgery as 2378, Trauma and orthopaedics 2014, Ophthalmology 2450 and Gastroenterology as 2094). We noted that urology was meeting its targets. We were aware of actions being taken to improve treatment times, however we remain concerned with the sustainability of the current action plan. The current configuration and resourcing available to the pain team continued to be a significant concern, given that the service is expected to be delivered across two hospital sites. The team is currently staffed by two part time band six trained nurses and one locum anaesthetist.

Data for the urology service suggested a higher than average readmission rate for elective and non-elective admissions. We asked what action had been taken by the trust to address this, and found some confusion regarding the actions which were understood to have been taken to address the concern. The surgical unit shared an audit plan with us to demonstrate the activity within the department. We did not receive any completed audit reports for review. Audit activity within the department could be significantly improved upon, and expanded to incorporate more nurse led audit activity.

We noted an improvement with consultant cover at the trust. However, significant improvement was needed to ensure the delivery of robust and effective multidisciplinary care seven days a week. The records we viewed demonstrated that the trust adhered to best practice

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guidance, such as NICE CG50 (Acutely ill patients in hospital). We found records demonstrating co-morbidities were documented, there was an MDT approach to care and staff escalated concerns when NEWS scores triggered. An outreach service was also available in the department. We found suitable arrangements in place which reflect the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery.

Evidence-based care and treatment

- Our view of trust compliance with venous thromboembolism (VTE) guidelines and policy have remained unchanged. The trust had a VTE policy in place which reflected national guidance from the Royal College. However, we found that significant numbers of patients did not have their VTE risk assessed as per protocol. The trust may wish to address this as a matter of priority. We reviewed data that demonstrated a total of 74 patients between mid-December 2014 and mid-March 2015 that did not have their VTE care needs assessed during their admissions. CQUIN (framework enabling commissioners to reward excellence) compliance has been noted as being below the trust targets for VTE compliance.
- Data received from the trust labelled 'patient safety drill down' indicated that the trust had a higher number of DVT's and PE (pulmonary Embolism – clots in the lungs that can prevent breathing) than the peer average. This suggested that patients may not have received appropriate VTE prophylaxis and that national guidance was not being followed. This data was submitted in a spreadsheet as an image rather than tabulated values that would assist in data interpretation.
- We requested audit data from surgical VTE audits carried out to form part of the inspection review. We were provided with a document listing eight VTE audits, three of the eight related to the surgical unit and one of the relevant three was recorded as completed. The trust did not submit the completed audit report to CQC for review.
- However, we noted that minutes from a Quality Walk undertaken on the urology ward in January identified VTE and dementia assessments as below the trust targets. We also reviewed the action plan for this area, which we noted had not addressed the concerns identified with VTE and dementia assessments.

- The mortality and patient safety data showed the trust's rates of incidents relating to post-operative pulmonary embolism prevention to be double the peer average, which suggested more action was needed for the prevention of post-operative pulmonary embolism at ESHT.
- Data reviewed demonstrated that the trust was not meeting its referral to treatment targets for surgical patients. The trust had an action plan in place to address this and was working closely with the trust Development Authority (TDA) to make the necessary improvements. The ratings for February 2015 showed the following services (General surgery, Trauma and Orthopaedics, Ophthalmology, gastroenterology) rated as red with waiting lists and backlogs significantly higher than agreed. The overall waiting list showed at total waiting list of 8936 patients for the four specialties identified. (General surgery: 2378, Trauma and orthopaedics:2014, Ophthalmology:2450 and Gastroenterology:2094). We noted that urology was meeting its targets.
- VitalPAC electronic monitoring played an important role in monitoring patient conditions but we identified delays on occasion of up to four hours in data being synchronised between handheld and main terminals.
- The records we viewed demonstrated that the trust adhered to best practice guidance, such as NICE CG50 (Acutely ill patients in hospital). WE found records demonstrated comorbidities were documented, there was an MDT approach to care and staff escalated concerns when NEWS scores triggered. An outreach service was also available in the department. The care plans we reviewed demonstrated that patients had their care needs adequately identified and risk assessed during their admissions.

Pain relief

- The trust had a dedicated pain team which provided a service across both hospital sites. However, we continued to have concerns relating to current configuration, sustainability and quality of the service which can be provided given the staffing resources available.
- Pain services at East Sussex Healthcare trust continued to be delivered by two part time band 6 staff nurses and a locum anaesthetist. There was no clinical lead for the

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service. We are concerned that the service is unable to deliver a quality and robust cross site pain service to meet the needs of patients and provide support to nursing staff across two hospital sites, with minimal staffing resources. Patients we talked with during the inspection told us that their pain was well controlled and records we looked at were completed.

- However, the trust may wish to note that the CQC have identified a theme relating to inadequate pain control during hospital admissions from our contact with the general public.

Nutrition and hydration

- National guidance for patients who are required to be nil by mouth prior to surgery was not always followed. We found a blanket approach to keeping patients nil by mouth. This meant that patients were without food and fluids for unnecessary and extended periods of time, which did not reflect national guidance or demonstrate individualised patient care. However, staff informed us that the Urology team had started to embrace staggered admission times. This meant that patients were less likely to be kept without food or fluids for prolonged periods.
- The ten sets of notes we viewed demonstrated that patients had their nutrition and hydration needs risk assessed using the Malnutrition Universal Scoring Tool (MUST).
- Appropriate measures were put in place to monitor any identified risks, for example referral to a dietician, nutritional supplements, weight monitoring, food diaries and hydration charts.
- However, we found an inconsistent approach to the completeness of fluid monitoring charts, with some being nearly empty and some charts not totalled. This failed to provide an adequate assessment of patients' fluid intake over a 24 hour period. Inappropriate and inaccurate use of fluid balance charts generated additional work for staff and was of little benefit to patients.
- Patients reported being very satisfied with the quality and choice of food available.
- The trust provided a range of meal choices which meant that individual or religious needs could be met.

Patient outcomes

- The risk of readmission for elective Urology surgery was higher than the England average with a standardised score of 152 against the national benchmark of 100 (below 100 is better than average). We asked for an explanation for this and noted some confusion with the actions described to address the concern. The two people we asked implied that the other was reviewing the cause. However, neither had taken any action to identify the cause and address the high readmission rates.
- Readmission rates for other surgical disciplines were found to be within the England averages.
- The rates of death within thirty days of surgery had been reduced from .04% from .034% with the peer average currently at 0.025%.
- The most recent CQC Intelligence Monitoring report has not identified any concern with any surgical procedure.
- The surgery data obtained from the trust demonstrated a reduction in day surgery activity in the last six months of 2014 when compared to the same period in 2013.
- The data we viewed demonstrated the trust was meeting the national targets for unscheduled care.
- Where medical patients received medical care on surgical wards, due to a shortage of medical beds there was a 'buddy' system in place to ensure that they received the medical care needed. The nursing staff with whom we talked informed us that the system generally worked well, but expressed frustrations in recent weeks with its efficiency.
- The trust contributed to national audits such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- The average length of stay across the trust for elective procedures is slightly better than the England average and for Non-Elective it is slightly worse.
- As per our previous findings, there were appropriate arrangements in place which reflected the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. These included handover of information between medical teams and access to operating theatres and diagnostics. The trust also

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participated in a 'trauma network' with another hospital. This meant that patients admitted with various traumatic problems were managed with combined input and decisions by specialty consultants.

- We saw evidence of trust involvement in national audit programs. There was also evidence of a departmental audit activity to monitor compliance with national guidance, and some activity driven by clinical interest. Audit activity within the department could be significantly improved upon and expanded to incorporate more nurse-led audit. However, staff told us that the staffing shortages meant that meaningful engagement with audit was difficult.

Competent staff

- Junior doctors on the Eastbourne site were very complimentary about the support and quality of teaching provided by the consultant group. The quality of the training that junior doctors received was also evidenced in the recent deanery report.
- We viewed records which demonstrated that staff had an annual appraisal.
- Staff confirmed that they had received an annual appraisal and an appropriate level of training in order for them to be able to perform their roles. However, we noted that there was little training provided over and above what was stipulated as mandatory due to financial restraints and staffing pressures.
- Clinical supervision was not widely available in the surgical department. This meant that the organisation was missing an opportunity to assist staff to learn through reflection to improve their competency and confidence.
- Annual checks to Nursing and Midwifery Council PIN numbers were undertaken to ensure that staff held a valid registration.
- There was an annual re-validation process undertaken by the trust to monitor medical staff skills and learning objectives.
- Consultants' comparative outcomes were routinely published and available in the public domain on the NHS Choices website.

Facilities

- One ward we visited had notably inadequate storage for medical records, broken lockers behind the admin station that could not be locked, and a very loose shelving unit behind the nurses station that we considered to be a health and safety risk to staff.
- We found a chair in an office area that did not meet basic infection control standards. The lining of the chair seat was ripped and the lining contents were falling out.
- We also identified four cylinders of oxygen on a ward not being stored as per national guidance.

Multidisciplinary working

- There were no multidisciplinary team (MDT, is composed of members from different healthcare professions with specialised skills and expertise.) meetings on the urology ward. Considering the average age of the patients on this unit, a weekly MDT meeting would improve the quality and timeliness of planned discharges.
- There was evidence of a multidisciplinary team approach to care in the patient notes we reviewed. However, staff told us that communication between disciplines could be difficult at times.
- The pre-assessment team were able to demonstrate a very good working relationship with anaesthetic colleagues.
- There were arrangements in place for the transfer of patients between the Conquest Hospital, Eastbourne District General Hospital and the other community sites.
- The physiotherapists and occupational therapists told us they had recently recruited more staff which would improve multidisciplinary team working within the trust.

Seven-day services

- We found consultant cover available seven days a week at Eastbourne Hospital. This included consultants being onsite during normal working hours Monday to Friday and providing on-call services out of hours. There was also a consultant-led ward round for surgical patients at weekends.
- The availability of physiotherapist cover remained unchanged. Physiotherapy services were available five days a week with limited on-call cover provided at weekends.

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- There was no weekend or out-of-hours cover for other therapy services, such as occupational therapy, dietician or speech and language therapists (SALT) teams.
- There was limited access to a pharmacist out of hours and at weekends. Cover was provided by an on-call system.
- There was adequate provision of imaging services out of hours.

Are surgery services caring?

Good



We have judged the surgical services at Eastbourne District Hospital to be caring. Patients we talked with during our inspection were very complimentary about the staff in the surgical department. They told us that staff helped them understand the care, treatment and choices available to them and empowered them to be involved in the making of decision about their care. Patients felt confident that they could raise a concern and have their views and experiences taken into account during their hospital stay.

We observed staff delivering care that promoted dignity, respect and independence and we observed positive interactions in all the areas we visited during the inspection. Comments received during the inspection included “everyone is brilliant”, “the nurses are lovely, they always offer to help” and “staff are hard pressed but no one has missed out, everyone has been so kind and they make me feel safe”. However, patients also reflected on their perception of the staffing levels and felt that there was “enormous pressure on staff”. CQC received a number of contacts from the public praising the staff at Eastbourne District Hospital. However, we also continued to receive some concerns and complaints regarding staff attitude and poor communication. These complaints mirror the concerns raised at the Conquest site and appear to be a trust wide issue. The majority of the contact we received continued to raise concerns for staff in terms of wellbeing, staff shortages and the impact on the care delivered. Our observations on the Eastbourne site recognised that staff were dedicated to their patients and teams and delivering a good service despite the restraints placed on them in regards to staffing resources and an unsuitable ward environment. Regardless of the restraints, the staff on this

site were observed to be empathetic, kind and caring to their patients and their relatives. They also displayed a caring nature towards their work colleagues, which was refreshing and endearing to observe.

We saw several examples of staff going to extreme lengths to be able to meet the care needs of patients and the organisational demands, sometimes at a personal cost. Staff on this site also skipped breaks, regularly work late to complete essential documentation and work extra shifts in an attempt to ensure patients and their colleges were not affected by the poor staffing levels. The trust’s Friends and Family Test data demonstrated that surgery as a whole scored slightly higher than the England average.

Compassionate care

- We observed staff treating patients in a kind and compassionate way that promoted their dignity and respected their privacy.
- The staff we spoke with were noted as being resilient, hardworking and dedicated to delivering the best patient care they could.
- Curtains were drawn around beds when personal care was delivered.
- We observed staff introducing themselves to patients before any care or intervention was carried out.
- Each ward area had a board that displayed “you said we did” information. We noted that much of the feedback related to communication and noise levels. Wards were providing patients with ear plugs and staff told us they were much more aware of the noise levels at night and doing their best to minimise it. Other comments related to poor communication. Staff were aware of this concern and were able to tell CQC the steps put in place to address the concern from a multidisciplinary perspective.

Patient understanding and involvement

- During the inspection we spoke to patients who praised the staff highly and commended their hard work and dedication.
- The patients we spoke to felt that their care was respectful and promoted their dignity and independence.

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- As with our previous findings, there was a named nurse system in place, however, the patients we talked with were not aware of who their named individual was. Despite this, patients felt they would get the care they needed if they asked any member of staff for assistance.
- We noted that staff encouraged patients to complete the NHS Friends and Family Test feedback prior to discharge.
- The East Sussex Healthcare NHS Trust website also has a facility for patients to leave feedback.
- NHS Choices website also had a feedback facility for patients to leave feedback. The trust had a current satisfaction score of 3.5 out of 5 stars.
- The Friends and Family Test response rates for this trust overall were slightly higher than the England average.

Emotional support

- As with our previous findings, emotional support was predominantly provided by local nursing teams.
- The trust had a range of clinical nurse specialists employed to deliver specialist services to patients and provide specialist support for staff.
- We did not see evidence of support for patients who had anxiety or depression. We were told that staff would refer patients to the mental health team when necessary.
- We were not made aware of any specific counselling services available for patients. We were told that counselling was available via the clinical specialist nurses and the chaplaincy service for patients.
- The trust had a range of specialist nurses to support patients and staff for example, breast care, stoma, learning difficulties, cancer and McMillan specialists.
- During our inspection we observed a hospital volunteer providing support to patients on the ward. The patients enjoyed their interactions with the volunteer and the individual feedback we received about the volunteer visits was very positive.
- The Friends and Family Test results for surgical services at Eastbourne Hospital were mixed. Seaford 3, Seaford 4 and Hailsham 4 all scored in the mid 70's in the February 2015 report published on the trust website but Hailsham 3 only scored 45.

Are surgery services responsive?

Requires improvement



Referral to Treatment Times (RTT) had fallen below both the standard and the England average for surgical patients. Data shared in the trust Quality Account 2013/2014 showed the trust was meeting the RTT for 75% of admitted patients with a target of 90%. The trust compliance with RTT for non-admitted pathways showed poor compliance against targets agreed with the TDA and local commissioners. The ratings for February 2015 showed the following services (General surgery, Trauma and Orthopedics, Ophthalmology, gastroenterology) rated as red with waiting lists and backlogs significantly higher than agreed. Nurse led discharges were in operation at this site. CQC received a number of complaints regarding the quality of the discharges. There were no formal quality assurance measures in place to monitor the quality of the discharges. The CQC was aware that a number of complaints and safeguarding alerts had been raised as a result of poor discharge planning. We saw from the minutes of a quality round that discharges were noted as poor quality. However, we did not see any measures put in place to address the concerns.

There is continued concern that the surgical clinical unit is not learning, or improving quality, from complaints and comments made. Staff remained unaware of complaints which had influenced change, except from the ones made verbally to them in their clinical areas. Feedback was not formally monitored which could be seen as a missed opportunity to improve patient experience. Patient flow at this site was found to be a significant concern. The recovery area did not have enough capacity for the number of surgical patients. There was also a problem returning patients to their post-operative wards due to bed shortages and poor staffing levels. Patient safety in theatres was maintained by stopping operating lists as well as theatre and recovery staff frequently going to the ward areas to help with discharges and clean bed spaces. Occasionally patients were kept in recovery overnight until a bed on a ward become available. This is an inappropriate area for these patients as it does not have toilets, washing facilities, or a sluice. We also noted the excessive frequency of patient bed moves at unsocial hours on this site.

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During the inspection we identified one patient who had been moved five times during their eleven day admission. One of the five transfers occurred at ten pm. Another elderly patient was moved to a ward at eleven o'clock at night. Data provided by the trust indicated that multiple bed moves were a frequent occurrence at this site. The data we were provided did not give a date range or time period, but it did indicate that 3747 patients were subjected to one or more bed moves. There is continued concern that the surgical clinical unit is not learning or improving quality from complaints and comments made. Staff remained unaware of complaints which had influenced change, except from the ones made directly to them regarding noise, lights at night, or communication problems. CQC continued to have many contacts with members of the public who were engaged with the trust complaints process. Similarities identified from this contact revealed frustrations with the length of time taken to respond to complaints and the quality of the responses. People told us that the delays in responding had left them feeling ignored. The majority of the contacts we conversed with wanted to ensure that no other patient would experience the same failings. There was a sense that people just wanted the service to learn from these complaints and improve quality.

We were aware that clinicians raised concerns about the quality of the day surgery services and patients' experience provided at EDG post reconfiguration. The correspondence we viewed outlined best practice guidelines to ensure a quality, effective and safe service. We noted the response to the concerns was sent over three months after the original correspondence and failed to recognise the concerns raised. The CQC inspection has identified the same trends and themes which appear not to have been addressed by management. This does not reflect a responsive culture towards addressing staff concerns about safety and departmental performance.

Service planning and delivery to meet the needs of local people

- CQC received multiple concerns from patients who were not receiving outpatient appointments inline with treatment plans. There was also a pattern identified where an appointment was booked and then cancelled by the trust. This meant that patients were not reviewed for a prolonged length of time. Patients told us this was causing them additional stress and worry.

- East Sussex Healthcare NHS Trust continued to struggle to meet the referral to treatment times for surgery. RTT compliance had fallen below both the standard and the England average for surgical patients. The trust had an action plan in place to address this and was working closely with the Trust Development Authority (TDA) to make the necessary improvements. Data shared in the trust Quality Account 2013/2014 showed the trust was meeting the RTT for 75% of admitted patients against a target of 90%.
- The areas recognised by the trust with the biggest challenge in meeting RTT were general surgery, trauma & orthopaedics, ophthalmology and gastroenterology.
- Data provided by the trust indicated that between April 2013 and September 2014 only one operation was cancelled which led to a patient not being seen within 28 days.
- Nurse led discharges were in operation at this site. CQC received a number of complaints regarding the quality of the discharges. There were no formal quality assurance measures in place to monitor the quality for the discharges provided. The CQC was aware that a number of complaints and safeguarding alerts have been raised as a result of inadequate discharge planning. The trust had also identified concerns with the quality of planned discharges at this site. However, we were not aware of improvement measures in place to address the problem.
- Electronic discharge letters were sent out via post when patients left the hospital. CQC has received a number of contacts from patients who wished to raise a concern regarding the length of time taken for letters to reach their GP's.
- The CQC are also aware of a number of complaints and safeguarding alerts had been raised as a result of poor discharge planning.
- A trend identified on both sites related to the new system that centralised the booking process for patients who require surgery. The feedback received from staff at all grades relating to the recent changes was entirely negative. Theatre lists were only made available between two and three weeks in advance of the planned surgeries at Eastbourne site. trust policy stated that lists should be reviewed six weeks in advance.

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- Patient flow was raised as a concern at this site. The recovery area was too small to cope with the numbers of patients that went through the department. We saw data that demonstrated patients were spending extended periods in the recovery area after their operations due to the pressure on the beds in this location. For example, 50% of the patients who had surgery in January stayed for an extended length of stay in the recovery area. This figure fell to 39% in February. We found the recovery staff went to extreme lengths to ensure that the safety of patients in the clinical area was balanced with doing their utmost to keep theatre lists running. However, staff told us that operating lists were frequently stopped in an attempt to maintain a safe environment. Recovery staff worked and communicated very closely with ward staff and frequently went to the ward to help the staff prepare the bed spaces for a post-operative surgical admission due to staffing shortages.
- We were aware that clinicians raised concerns about the quality of the day surgery services and patient experience provided at EDG post reconfiguration. The correspondence indicated patient flow as a key concern from the department staff. Other concerns included: day surgery cases being amalgamated with elective cases, patients being admitted to the unit at 08:00hrs and not receiving surgery until much later in the day, patients being sent to inpatient wards post operatively, theatre utilisation, lack of a day surgery clinical lead, and the general quality of the day surgery pathway at EDH. The correspondence we viewed outlined best practice guidelines to ensure a high quality, effective and safe service. We noted that the response to the concerns was sent over three months after the original correspondence and failed to recognise the concerns raised. During our inspection we identified similar concerns relating to extended waits for surgery, extended periods of being NBM, bed blocking in the recovery area which had a knock on effect of the functionality of theatre lists and the pressure on inpatients bed availability.
- Patient flow was also a concern on the urology ward. The unit appeared to be unable to cope with the current service demand. Staff told us that the daily pressure on beds meant that patients who were having a trial without a catheter were frequently moved from their beds and into a waiting area. However, if they failed their

trial it then left staff with no appropriate area to re-catheterise and no area to readmit to, if needed. They also told us that patients had to be clerked in inappropriate places. We viewed these areas and found they did not promote patient dignity or confidentiality. We were told that staff felt it was nearly impossible to maintain dignity, privacy and confidentiality in this area.

- During the inspection we identified one patient who had been moved five times during their eleven day admission. One of the five transfers occurred at ten pm. Another elderly patient was moved to another ward at eleven o'clock at night. Data provided by the trust indicated that multiple bed moves were a frequent occurrence at this site. The data we were provided with did not indicate a date range or time period, but it did indicate that 3747 patients were subjected to between one or more bed moves.
- Average length of stay across the trust for elective procedures was slightly better than the England average, and slightly worse for non-elective procedures.

Meeting people's individual needs

- We identified occasions where the trust may not have been as responsive as it could have been in planning for consultant retirement. Examples included the replacement of a spinal surgeon, anaesthetist (pain lead) and pain service team post-surgical reconfiguration. These examples are not indicative of a responsive culture which promotes continuity of care for patients.
- Translation services were available in the department. We did not see this in use during the inspection process.
- There was a learning disabilities team who provided support to patients and staff. We received very positive feedback about the support the team provided to patients and staff during our inspection.
- Each patient had an information board above their beds with a space for their name, consultant and named nurse. The majority of the boards we viewed were fully completed on this site.
- We saw very positive and complimentary feedback about the enhanced recovery service at Eastbourne which demonstrated that staff were meeting patients' individual needs and receiving positive feedback as a result.

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- We found improvements had been made to the waiting lists for patients with complex health needs requiring oral and maxillofacial surgery.

Learning from complaints and concerns

- The unannounced inspection did not identify a noticeable difference in how complaints were handled or learned from following our September 2014 visit. The concerns we identified still remained.
- CQC became aware of two serious complaints from patients that raised serious concerns about the service. In a previous contact with the trust, we were assured that these types of complaint were followed up with the individuals at their annual appraisal. At the time of our initial contact the annual appraisals had not been undertaken. As our last inspection coincided with the end of year, we required evidence from the trust that complaints were addressed and learned from, as previously indicated. The trust submitted a list of consultants who had an annual appraisal and the appraisal date, however, this was insufficient to evidence the concerns being addressed. We then asked the trust to send anonymised appraisal records as evidence. The trust refused to submit the appraisal documents on confidentiality grounds. Therefore, the trust was unable to evidence that it addressed the concerns with the individuals. This may suggest that individual complaints raised against consultants were not being addressed in a manner that would facilitate learning, and improvements to patient care and experience. During the inspection one consultant said "I find the complaints process disturbing" and clearly felt the complaint process was a problem rather than a tool for driving service improvements.
- CQC has continued to receive complaints from members of the public regarding surgical services at ESHT. Patterns identified relating to surgery across the trust highlighted staffing shortages, particularly at night and weekends, poor patient experience, communication, RTT's and the trust's complaints process. A trend identified in both acute settings related to how the trust handles and learns from complaints.

- Staff were able to tell inspectors about complaints they received at point of contact. For example delayed discharges. These were not formally documented and therefore an opportunity to learn and improve the service was being missed.

Are surgery services well-led?

Inadequate



Our September inspection saw the surgical department rated as inadequate in the well-led domain. Our previous inspection highlighted a significant disconnect between board and floor and this inspection failed to identify improvements since our previous finding. We are very concerned about staff morale on the Eastbourne site, which appeared to be worryingly low. Staff told us "moral was in their boots".

The culture in the organisation was one of distrust and anxiety, and staff reported little confidence in management at senior or board level. Staff continued to tell us that they did not feel confident to raise concerns for fear of retribution. Staff expressed feeling disheartened by what was described as inconsistent and incoherent leadership. They also expressed feelings of being undervalued in the organisation, over worked and experiencing change fatigue. As with our previous findings, staff continued to tell us they did not feel confident to raise concerns. This was also identified in the recent staff survey report. CQC have been given assurances by the trust board regarding the steps it plans to take to address the concerns identified in our last report, to improve and support continuous meaningful consultation with staff and board to floor relationships. We are aware that the current situation will require an on-going commitment and robust approach to future engagement, and that any evident improvement may take a considerable length of time. However, the steps put in place have yet to have any impact on the staff in the surgical clinical unit. Staff expressed unfamiliarity with the vision and strategy for surgical services.

We found that the senior leadership of the service had not yet been firmly embedded and continued to be subject to continuous change. Staff reported feeling disillusioned about raising concerns. This was echoed in the recent staff survey. Staff told us that they continued to raise concerns and "no one listened". They also expressed feeling

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exhausted by what they perceived as “reactive not proactive” action in the trust. Contact with staff had also made CQC aware that one of the steps taken by management to address the ‘bullying culture’ identified across the organisation was to send an email to staff asking them to speak to their managers if they wished to address their concerns. CQC received many contacts from staff pointing out how ineffective this approach to communication was, but also highlighting in some cases it was the managers that were perceived as being responsible for the bullying. Staff felt that they were in a stagnant situation where they were unable to address their concerns. It is worth noting that CQC continued to receive correspondence and have contact with staff working at all levels, from a varied range of positions within the department raising concerns about the leadership of the service. Feedback from staff and the recent staff survey results identified low levels of staff satisfaction and high levels of stress and work overload. We remain concerned that staff feel they are not treated with respect, openness, or transparency when raising concerns. The culture in the organisation appears to be one of defensiveness, retribution and organisational deafness toward staff, patients and members of the public. We did not find any improvements to the way the trust engaged with members of the public since our last inspection. Feedback has shown that public trust in the leadership of this organisation has severely diminished and causes excessive local anxiety about services as a result.

The trust informed CQC of improvements made to the structure and functionality of the trust’s governance, risk and quality improvements board. However, staff continued to be unaware of the recent improvements and were unable to give any examples of how the boards worked or influenced changes, or drove improvements in the service. Important safety concerns identified in our last inspection appeared to have gone unaddressed.

Vision and strategy for this service

- The financial position of the trust and the service reconfiguration has impacted on the vision and strategy for the service.
- As with our previous findings, there was no evidence of a clear strategy for the delivery of surgical services that was known to staff working in the Surgical Clinical Unit or in theatres. We heard about the trust strategy during the meeting we attended with the TDA and trust

representatives prior to the inspection visit. We could not see this strategy had been devolved into a plan for the service that was known and understood by operational staff. Staff were unaware of how their roles supported the vision or values of the trust.

Governance, risk management and quality measurement

- The trust reported a strengthened governance, risk management and quality measurement processes. However the majority of the staff we talked with were unable to tell us about these processes.
- CQC outlined significant concerns in our previous report which we would expect to be managed under governance, risk management and quality measurement processes. However, there was little evidence that our concerns were being addressed. Some of the areas of concern related to basic safety checks within the department. Addressing these safety concerns had a sense of urgency, and would have had little or no cost attached to rectify the situation. However, with theatres as the exception, steps were not put in place to address the concerns across the clinical unit (including the private patients ward), which meant that patients were still exposed to an identified risk. This is not reflective of a fully functioning or effective governance, risk and quality measurement processes.
- There is much more work needed to improve staff awareness regarding the function, impact of, and clinical governance and risk management in the surgical clinical unit. It is worth noting that none of the staff we talked with, working on the shop floor, had ever attended or been invited to a governance meeting or received feedback from the regular meetings in the trust. This demonstrated that the governance function was neither effective nor an inclusive process.
- The trust had appropriate boards in place to monitor and improve care quality from serious incidents. These include the trust Serious Incident Review group and the Risk and Quality Management group. However, as with our previous findings the majority of staff we talked with were unfamiliar with the structure, function or learning from these groups.

Leadership of service

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- We asked several staff on the Eastbourne site what had changed since the last CQC inspection. The majority responded by telling us that “nothing has changed”, “we only see management when CQC are here” and “managers are just not listening to our concerns” and “morale is in our boots”. There was a prevailing opinion at this site that the senior and board leadership had an ineffective top down directive.
- More leadership re-organisation had taken place since our last inspection. This had left ward staff feeling frustrated as they felt that they were raising concerns which were not addressed because of the continuous movement of senior managers.
- The ward staff felt that there was inconsistent support from senior management because of this. Comments received from staff included, “If the managers stayed longer than three weeks we might start getting things resolved”.
- Staff continued to tell us that their immediate line managers and team members at clinical level were an invaluable source of support. However, we received feedback that senior/middle management was not as visible in clinical areas as staff felt they should be. One comment received was, “We haven’t seen them since your last inspection”.
- Staff continued to tell us that they were tired of the “reactive not proactive” management style. They also continued to tell us they had little faith in the current leadership at board level held little hope for change whilst the current leadership style of middle managers remained unchanged.
- Staff told us they have been trying to alert management at senior and board level about the continued staff shortages and the impact it was having on patient care and staff welfare long before our inspection in September 2014. In March 2015 we found the trust had started a staffing review to reassess staffing levels. The delay in conducting a review to address the staffing issue is very concerning. It does not promote trust in the leadership to address concerns that directly affect patients care or staff welfare in a timely manner.
- We were also told that staff were encouraged to fill out work stress assessments. One staff member told us that they completed the assessment which indicated they were subjected to work related pressures. The assessment submitted to a manager who said “I’m not sure what to do with this”. We also received examples from staff that had underlying medical conditions, who told us that they were not receiving the expected support needed from the human resources team. This may indicate that stress in the organisation is not being appropriately handled.
- There was evidence that change was still being carried out with little notice or opportunity for staff engagement. The latest changes affected the pre-assessment team who were given just one week’s notice that the department was relocating to a different area of the hospital. The distance patients had to walk to the new department had significantly increased and was having a real impact on the elderly, infirm and patients with mobility issues in particular.
- The staff survey measured the percentage of staff reporting good communication between senior management at their trusts. East Sussex Healthcare trust achieved just 18% for this question compared to the national average of 30%.
- Senior management had commenced quality walks in the trust in an effort to engage with staff and assess the quality of care. We reviewed minutes from a quality walk which highlighted some concerns regarding the process. It identified that no round undertaken had had a full complement of senior clinical leaders on the review and a recommendation was made for medical directors and associate medical directors to commit to attending a certain number of rounds. There was also a concern raised regarding the administration support provided for the rounds which had been affecting the timeliness of the reports. This indicated that the quality walk rounds required more resources and buy in from medical directors and associates.
- Evidence in theatres and recovery demonstrated that the most recent changes to the senior management team had had a positive impact on the department. For example, staff reported confidence in the nurse management, and there was ample documentary evidence that the department had taken steps to improve staff knowledge in regards to incident reporting, risk management, clinical governance activity and clinical unit meetings.

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- We identified occasions where the trust may not have been as responsive as it could have been in planning for consultant retirement. Examples included the replacement of a spinal surgeon, anaesthetist (pain lead), and pain service team post-surgical reconfiguration. These examples are not indicative of a responsive culture which promotes continuity of care for patients.

Culture within the service

- Our assessment of the culture within the surgical department at the unannounced inspection remained unchanged. It continues to appear dysfunctional and damaging to the quality and experience of patients care and the future of the organisation.
- Staff morale had been left in a poor state as a result of ineffective engagement and consultation processes when surgical services were reconfigured. Staff commented in particular about what they perceived as a destructive approach adopted by the trust's 'turn around team' to drive change.
- The latest staff survey results (published March 2014) revealed that staff satisfaction at East Sussex Healthcare trust was at an all-time low. Overall staff engagement, staff ability to contribute towards improvements at work, staff recommendation of the trust as a place to work, or receive treatment, and staff motivation at work results were rated as being in the lowest 20% in the country when compared to other trusts.
- We remained very concerned about the number of staff who felt unable to raise concerns.
- We continued to identify pockets of good clinical practice which was not shared across the departments or hospital sites.

Public and staff engagement

- Engagement with members of the public was found to be stagnant since our last inspection. There was no evidence that meaningful engagement with the public had been improved or even attempted in the six months after our first inspection. Feedback has shown that public trust in the leadership of this organisation has severely diminished and causes excessive local anxiety about services as a result.
- There was a perception amongst local people that communication with trust leadership was ineffective and their concerns about the quality of care or the perceived needs of the public continued to be ignored.
- Upon the publication of our last report, an open letter was provided with an information link to the trust website where patients and visitors could read the reports and review the trust Action Plan in place to address the concerns and demonstrate the progress made so far.
- The trust held an open meeting with staff on the day the CQC inspection report was published.

Innovation, improvement and sustainability

- The pre assessment team had a very clear vision and strategy for the development of the service which included training nursing staff to read ECGs and to introduce a health screening service for the elderly, which would maximise their health before surgery.
- A staff awards incentive was in place to reward staff and make them feel more valued within the organisation.
- LiA – listening in action group - continued to assist the organisation with learning from comments and complaints from patients.

Outpatients and diagnostic imaging

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

Information about the service

East Sussex Healthcare NHS Trust (ESHT) provides OPD services at its two Acute Hospital Sites Eastbourne District General Hospital (EDG) and The Conquest Hospital. It also provides OPD clinics at Bexhill Hospital, Uckfield Community Hospital, Victoria Hospital and Winchelsea and District Memorial Hospital.

In the year 2014/2015 ESHT treated 134,872 patients in Outpatients (OPD) with 298,720 clinic attendances. 69,900 of these patients were treated at Eastbourne District General Hospital with 146,242 clinic attendances during this period.

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

EDG ran clinics in the following specialities Breast Surgery, Cardiology, Clinical Oncology, Dermatology, Diabetic Medicine, Endocrinology, Ear Nose and Throat (ENT), Gastroenterology, General Surgery, Geriatric Medicine, Gynaecology, Haematology, Maxillo Facial Surgery, Neurology, Ophthalmology, Orthodontics, Paediatrics, Rheumatology, Thoracic Medicine, Trauma & Orthopaedics, Urology and Vascular Surgery.

East Sussex Healthcare Trust provides integrated Radiology imaging services across the hospitals in the acute and the community settings. The hospital offer Computerised Tomography (CT), Magnetic

Resonance Imaging (MRI), X-Ray, SPEC CT, Digital Mammography, Ultrasound, Interventional Radiography, dental radiography and Nuclear Medicine scanning.

We reviewed documents relating to the Radiology Department and observed the workings of the department provided by the multi professional healthcare professionals including care provided by medical and nursing staff, radiographic and administrative staff. We spoke to patients receiving radiology investigations and from people who contacted us separately to tell us about their experiences. We reviewed performance information held about the trust.

Outpatients and diagnostic imaging

Summary of findings

During our last inspection we found that the condition and availability of patient's health records was inadequate. At this inspection we found that no progress had been made and staff were still managing high levels of health records not being available for clinics, poor tracking of health records and health records which were oversized and in poor condition.

We also found that in some instances patient's confidential information was not stored securely.

When we met with trust executive representatives they told us about plans for improvements in the management of records across the organisation. The Private Trust Board Minutes dated November 2014 showed that the board had approved the business case for an Electronic Document Management/Clinical portal and medical record scanning system that required TDA approval due to the scale of the financial commitment involved. The trust was aware that there were current problems in the safe and effective management of records and felt that the proposed system would improve the situation significantly.

We found that the OPD was not being cleaned or audited in line with the National Specifications of Cleanliness and trust policy.

There was no clinical triage of the impact of cancellation of clinics. Cancellation was performed as an administrative task with no clinician making decisions about the impact of cancellation on the patients wellbeing.

The call centre was not fit for purpose with a shortage of skilled staff and operating systems that were not working to advantage patients. As a result of these issues patients and staff were often unable to contact the call centre when they needed to.

At our last inspection GP letters were not being sent consistently within the five days allocated for this task. This was because of a lack of staff, and issues with the quality of the letters being translated abroad. This had not improved since our last inspection and medical secretaries were still experiencing the same difficulties in performing their roles.

At our last inspection the trust was not able to evidence that they were meeting with RTT NHS standard operating procedures across all specialities for either 2 week or 18 week targets. At this inspection the trust was still not able to evidence that they were meeting with these targets consistently across all specialities.

The trust was not meeting the targets set to reduce the backlog of patients on the waiting list for both admitted and non admitted pathways.

The team responsible for informing patients when clinics were cancelled had a backlog of work and were struggling to meet with the demands of the role. Many patients were being informed at short notice when appointments were cancelled even when clinics were cancelled with the required six weeks' notice. Many patients had not been notified when their clinic appointments had been cancelled and were arriving at the department to be sent away.

We found that medicines management had improved since our last inspection.

We saw caring and compassionate care delivered by all grades and disciplines of staff working in OPD.

Radiology staff told us that across the trust there were several vacancies in magnetic resonance Imaging (MRI) computerised tomography (CT) and Ultrasound (US). We were told that CT and MRI vacancies were due to the trust introducing a seven day service with staff working excessive hours to meet this commitment; staff described the pressure they felt due to poor staffing levels.

There were four vacancies across the Consultant Radiologist workforce. Locum consultant Radiologists had been in post for over two years to support the service. Radiology registrars were part of the medical workforce. However there was a shortage of trainees, with the trust having only two registrars instead of five. The outcome of below establishment Consultant Radiologist posts and training registrar posts was that the trust's out of hours reporting service was outsourced and the capacity of the department was diminished resulting in extended reporting times which was identified on the Trust Risk Register.

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The trust was struggling to recruit to consultant posts in Ophthalmology, Rheumatology and in pathology. Ophthalmology had considered new ways of working to manage this situation. Rheumatology had used locum cover to clear waiting lists and pathology was also covering workloads using locums. The trust was unable to evidence that this cover would be sustainable in the long term.

At this inspection we found that patient's experiences upon entering the department had improved. Systems had been put in place to ensure that patients were directed to the correct areas, and IT systems now informed staff when patients had arrived in the hospital. This meant that if a patient did go to the wrong department staff would be aware of this. The queue at reception had reduced and the area was calm and ordered throughout our inspection. This was not the case in the radiology department where patients arriving in the department were not always supported through a booking in process due to a lack of staff. The departments waiting areas were not fit for purpose as they did not provide space and privacy for patients in gowns to maintain their dignity.

Nursing staff had made great improvements in service delivery since our last inspection. However, administration staff were still unsettled and unhappy about the changes that had been made to their department. They had experienced changes in management since our last inspection but felt that the service had not improved as a result.

Are outpatient and diagnostic imaging services safe?

Inadequate



Staff did not always report concerns, incidents or near misses. Staff were afraid of, or discouraged from, raising concerns and there was a culture of blame. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was little evidence of learning from events or action taken to improve safety.

We still found incidents that had been unreported; these included 42 administration incidents, and inadequate reporting mechanisms for health records that could not be obtained for clinics. Although at this inspection we found a raised awareness amongst nursing staff regarding incident reporting, we still found incidents that had been unreported and an inadequate reporting mechanism for health records that could not be obtained for clinics. Staff were amalgamating several incidents about missing records into one report on the electronic system so there was no real awareness of the scale of the problem. Whilst the staff kept a note of how many temporary notes were made up there was not monitoring of how many notes were unavailable.

Staff did not always assess, monitor or manage risks to people who used the services. Opportunities to prevent or minimise harm were missed. We found that the OPD was not being cleaned or audited in line with the National Specification for Cleanliness and Trust policy which meant the unit managers did not know whether the OPD was sufficiently clean. Staff had limited understanding of the specification and risk levels of their department. Audits were less frequent than was required and where audits had been carried out they showed cleanliness did not meet the required standard. We observed areas of the OPD that were visibly dirty.

The management of healthcare records was a persistent recognised risk. The trust had some plans in place to address this in the future but at the time of writing the report there was no mitigation of the risks associated with missing and temporary notes. During our last inspection we found that the condition and availability of patient's health records was inadequate. At this inspection we found

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that no progress had been made and staff were still managing high levels of health records not being available for clinics, poor tracking of health records and health records which were oversized and in poor condition. There was no system in place for reuniting the temporary notes with the original ones.

We also found that in some instances patient's confidential information was not stored securely.

Clinic cancellation was a frequent occurrence and affected many clinics across most specialities. There was no clinical review of the patients affected when a clinic was cancelled and there was potential for people who needed urgent appointments because of their condition to have delays that affected the timeliness of their condition being diagnosed or treated.

We found that medicines management had improved since our last inspection. However, we found some medicines that were being stored in the department had past their expiry date, and the keys to the medication cupboards was not stored securely. There was scope for improvement with the management and storage of medications.

The completion rates for mandatory training did not meet the trust target.

The trust did not provide any evidence that any staff had completed level 3 safeguarding children training.

There were inadequate plans in place to assess and manage risks associated with anticipated future events such as consultants in hard to recruit to specialities retiring. The trust was struggling to recruit to consultant posts in Ophthalmology, Rheumatology and in pathology. Ophthalmology had considered new ways of working to manage this situation. Rheumatology had used locum cover to clear waiting lists and pathology was also covering workloads using locums. The Trust was unable to evidence that this cover would be sustainable in the long term.

Radiology staff told us that across the trust there were several vacancies in magnetic resonance Imaging (MRI) computerised tomography (CT) and Ultrasound (US). Staff described the pressure they felt due to poor staffing levels.

There were four vacancies across the consultant radiologist workforce. Locum consultant Radiologists have been in post for over two years to support the service. Radiology registrars are part of the medical workforce. However there is a shortage of trainees, with the trust having only two

registrars instead of five. The outcome of below establishment consultant radiologist posts and training registrar posts was that the trust's out of hours reporting service was outsourced and the capacity of the department was diminished resulting in extended reporting times which was identified on the trust's risk register.

We found some equipment that had not been tested for safety annually in line with Trust policy.

We reviewed the quality assurance records of one of the main x-ray rooms and found that these had not been completed regularly and did not meet the requirements set out in the Trusts IR (ME) R 2000 Medical Exposures' Manual and Standard Operating Procedures.

Incidents

- The trust has had one recent SIRI (Serious Incident Requiring Investigation) in the Ophthalmology OPD at Eastbourne hospital. Staff we spoke with were aware of the investigations that followed these incidents. We were shown the root cause analysis (RCA) for the investigations into these SIRIs. Following learning from these incidents administrative staff with ophthalmology experience were redeployed back to the service.
- Trust policy stated that incidents should be reported through a commercial software system that enabled incident reports to be submitted from wards and departments. We asked for a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns.
- We were shown the trust data on incidents which detailed the incident and the action taken following the incident.
- Staff completed an incident form which once submitted went to their line manager who reviewed the incident and reported on the actions that they had taken to mitigate a reoccurrence of the incident.
- Nursing staff discussed incidents that had occurred in their departments and the investigations that followed them. They were able to demonstrate learning from these incidents by showing us the changes of care and processes that the department had instigated as a result.
- Incidents were discussed with all nursing staff at monthly meetings.
- We were shown a log of forms entitled, 'Central Outpatients problem/action forms'. These were an outline of problems encountered at reception at the

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Eastbourne site. The forms had been kept between 19 December 2014 to the date of our inspection with the last entry being on the 21 January 2015. During this time there were 42 incidents recorded on the form. Most were regarding patients who had attended clinics without being made aware that their appointment had been cancelled or patients whose clinic letter had sent them to the wrong hospital site. None of these incidents were reported through the incident reporting system.

- When we asked the manager why they were recording incidents in this format and not using the trust wide incident reporting system, they responded that this was what they had been told to do by senior staff.
- All of the radiology staff that we spoke with told us they were encouraged to report incidents using the electronic reporting system, this including both radiation and non-radiation related incidents. There was a service level agreement (SLA) with a third party to oversee any radiation related exposure incidents providing expert radiation protection support and advice.
- Radiation Protection Supervisors employed by the trust ensured compliance with the Ionising Radiation Regulations 1999 (IRR '99) and Ionising Radiation (Medical Exposure) Regulations 2000. The RPS's were the first point of reference in the investigation of all radiation related incidents. Every two months the Radiology risk meeting discussed all the significant incidents. Two risk radiographers (one from each site) attended the meeting. A template of the incident was published placed in the x-ray room control area, staff room and online. Staff contacted the risk radiographers or Radiology Service Manager (RSM) if they had any queries. We saw evidence of the templates in the X-ray rooms during the inspection.
- The trust provided data about incidents reported in the eight months before our inspection. Incidents were recorded by speciality so are not site specific. In 2014, eight radiation related incidents for exposures 'much greater than intended' were reported to the Care Quality Commission which was greater than the previous two years but this was measured against activity levels which had increased over this time.
- We reviewed the Radiation related incidents, the appropriate investigations were undertaken and from the outcomes new working practices had been put into clinical place to prevent similar incidents happening in the future. For example in the Computerised

Tomography (CT) department an authorisation code was allocated to CT 'out of hours' requests to highlight to staff performing the examination, that the scan had been authorised by a Consultant Radiologist.

- Staff in the Nuclear Medicine department told us that if an incident occurred, the radiographic staff followed the trusts procedures in reporting the incident as well as informing the patient of the incident immediately. This included giving a description of the incident, how it happened and what would happen next.
- Staff we spoke with at Eastbourne hospital had not received trust training on the statutory Duty of Candour (a legal duty to be open and honest with patients or their families when things go wrong that can cause harm) and were unable to describe the processes the Trust had in place.
- Feedback from incident reporting in radiology was managed through monthly radiology clinical governance meetings that covered both acute sites. All staff were invited to these meetings. Where staff were covering the clinical areas and unable to attend, the meeting minutes were on the shared drive for staff to access. During the meeting, incident reporting was discussed. In the first three months of 2015, we were told that two staff meetings had taken place.

Cleanliness, infection control and hygiene

- There were hand hygiene, 'Bare below the Elbow' audits undertaken which demonstrated staff were compliant with best practice guidance. These were done for each OPD area, and documented in the annual clinical governance report.
- The staff in the OPD were complying with the trust policies and guidance on the use of personal protective equipment (PPE) and were bare below the elbows. However, on 24 March 2015 at 16.00 in consulting room 27 and 14 two doctors who were not bare below the elbows were observed treating patients. One had their sleeves rolled up but had a wrist watch on, whilst the other did not have his sleeves rolled up above the elbow.
- We observed staff in the main OPD washing their hands in accordance with the guidance published in the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).

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- Each area displayed their hand hygiene results for the previous month on patient information boards. The results for each OPD area were 100% compliant with hand washing techniques.
- There was no alcohol gel in the dispenser immediately on the left as we entered the main OPD, we brought to the Matrons attention and the hand gel was removed. When we checked two days later the hand gel had not been replaced. This meant that patients and staff were unable to gel their hands on entering the department.
- The area was generally clean but attention to high dusting and detail appeared to be lacking. When the Head of Nursing and the Matron were asked they said that the area was low risk and was audited annually. The Head of Nursing told us that they were trying to get the area upgraded to the next level as there was some invasive treatments taking place in the OPD. Under the NSC OPDs are classified as significant risk areas unless invasive procedures are carried out when they are classified as very high risk areas. The senior nurse had not understood this and the OPD was incorrectly categorised and so not subject to sufficiently robust or frequent cleaning audits.
- The trust hotel services cleaning policy states that, 'All Trust cleaning is carried out to the NHS National Specification for Cleanliness in the NHS, taking into account those changes introduced under the Health Act 2008'.
- We looked at the cleaning audit report from Eastbourne OPD. None of the audits complied with the time frames within the National Specifications for Cleanliness in the NHS for the risk categories identified.
- OPD were audited monthly (the standard sets out this should be weekly) in December 2014, February 2015 and March 2015, with the exception of Pevensy Day Unit which was not audited in the March 2015 audit.
- In these areas in December 2014, using the overall figures sent by the trust, of the 4 areas audited, two passed and two failed to meet the required standard of cleanliness.
- In January 2015 no audits were recorded, in February 2015 of the 4 areas audited by the trust two passed and two failed. In March 2015 all three areas audited failed to meet with required standards of cleanliness.
- Of the 13 other areas which were classified as high risk or significant risk none were audited in December 2014, January or February 2015.
- Staff working in Radiology had a good understanding of their responsibilities in relation to cleaning and infection prevention and control. Departmental staff wore clean uniforms and observed the trust's 'bare below the elbow' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas. We reviewed the training records and saw that radiographic and nursing staff had attended Infection Control Training. In the Nuclear medicine department staff told us they were due an inspection from the Police and Environmental Agency of their waste management procedures for radioactive waste.
- In the main x-ray department, we spoke to a radiographer who was able to describe the infection control measures undertaken with a patient with a communicable disease. These included x-raying patients at the end of the day's list if possible or when the department was at its quietest. All staff would wear PPE and it was the radiographic staff responsibility to clean the equipment after use with 'Clinell' wipes. This was in line with Trust policy.
- Housekeeping staff were responsible for the general cleaning of the department. One staff member we spoke to was unaware of any auditing of the cleaning standards. During the inspection we observed there was evidence of compliance with the NSC in that we saw colour coded mops and a sign clearly displaying the recommended colour coding. We saw the cleaning checklist in the cupboard for week commencing 23rd March 2015 which was completed as expected with a signature denoting the area had been cleaned. Deep cleans had been undertaken according to the checklist.
- The department areas we visited were generally clean but attention to high dusting and detail appeared to be lacking. Particularly high dusting, under chairs and edges of flooring. In the first waiting area, high levels of dark coloured dust on cubicle curtain rails, four chairs were inspected two of these were torn making them not compliant with infection control guidelines and one had chewing gum underneath. Within the changing cubicles there was evidence of the floors not being cleaned to the NSC standard as there was black coloured build up around the edges and corners, dark coloured dust at high level, tops of the cubicle.
- In Reception area 2, 10 chairs were inspected 7 had chewing gum underneath and 7 were torn making them non-compliant from an infection control point of view.

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- There was no standard for waste management with a mixture of different coloured bins, containing different coloured waste bags, some with and some without signage.
- HTM 07 -01 Safe management of healthcare waste states, 'Segregation of waste at the point of production into suitable colour-coded packaging is vital to good waste management. Health and safety, carriage and waste regulations require that waste is handled, transported and disposed of in a safe and effective manner. Proper segregation of different types of waste is critical to safe management of healthcare waste and helps control management costs. The use of colour coded receptacles is key to good segregation practice.'
- Therefore, staff may be confused by the different colours of bag and bin with no signage available which could lead to the miss-segregation, miss consigning and classification of the waste. This could lead to the waste being transported to the wrong facilities for onward treatment.
- From observation in the OPD we saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment and that replacements were provided, when necessary.
- We saw that resuscitation trolleys were available within the Radiology department and were checked and maintained ready for use in an emergency.
- In the main x ray department staff were able to show us a copy of the most recent risk assessment undertaken (5/9/14). This was a comprehensive risk assessment that covered occupational safety as well as risks to people using the service and the public. This was carried out by the radiographic staff. The next risk assessment was due in 2016 if conditions remained constant.
- In the examination rooms we visited we observed the correct storage of PPE including lead coats, thyroid and gonad shields and radiation glasses. We observed that each item was labelled with the thickness of lead and we were told by the radiographer that visual examinations take place regularly and screening of the PPE took place annually to ascertain if any cracks or folds had appeared. This complied with Regulation 9 (3) of the Ionising Radiation Regulations 1999 (IRR'99).

Environment and equipment

- We looked at equipment risk assessments which included the preparation of equipment, and disposal of sharps such as scalpels.
- The OPD held a register of medical devices used in the department, which described their usage and any related issues.
- We noted that the three resuscitation equipment trollies in the OPD were checked regularly and equipment stored on the trolley was appropriate and within its expiry date.
- We inspected 5 pieces of medical equipment, only one of these were was in date with a 'next test date' of April 2015. The matron confirmed that equipment safety testing should be undertaken annually. The equipment out of date was Weighing scales opposite consulting room nine with a test date due November 2014, Weighing scales outside clean supply A with a test date due November 2014, Eye sight test machine mounted on wall in corridor area A with a test date due March 2001 (Matron told us that this machine is not used as the doctor that used it had retired), weighing scales curtained area outside consulting room eight test date due November 2014.
- Across the department we saw that a quality assurance (QA) programme was in place for all radiographic equipment requiring all checks to be performed at regular intervals on all equipment, as required by current legislation. We reviewed the quality assurance records of one of the main x-ray rooms and found that these had not been completed regularly and did not meet the requirements set out in the Trusts IR (ME) R 2000 Medical Exposures' Manual and Standard Operating Procedures.
- Records of all equipment faults were recorded and the actions taken to mend any faults that developed during the working day. We saw that the necessary quality assurance checks for specialist equipment had been completed following equipment repairs before use. We saw that the relevant documentation had been completed in line with legislation and was available in the examination rooms control areas and in the Radiology Service Manager's office.

Medicines

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- Medicines stored were in date and were stored securely. Keys for medicine cabinets were stored in a locked area or held by a named RGN. When doctors required access to medications this was managed through the trained nurses.
- Medication records were completed and medications prescribed were checked and signed for by two members of staff. We spoke to staff working in the Nuclear Medicine Department, who were able to describe in detail the safe transfer of radio pharmaceutical substances. This included the safe transfer of the substances to the hospital from their supplier to the transfer, handling, storage and administration of the substances in the clinical setting. This was compliant with 'the Medicines (administration of radioactive Substances Regulations 1978.(MARS)
- Contrast agents for CT scanning and Interventional Radiology were stored appropriately in the imaging rooms.
- A 'Patient Group Directive'(PGD) which is a written instruction for the supply and /or administration of a named licenced medicine for a defined clinical condition needs to be in place to support staff in the delivery of contrast agents which may be necessary during a radiological procedure. There was no PGD available for the use of contrast medium.
- A PGD was submitted to us by the trust for the delivery of Buscopan by radiographic staff.

Records

- Health records were stored in paper format with diagnostic and clinic letters being stored electronically alongside paper records. Relevant staff were given passwords to access electronic records and had been trained in the safe use of the system.
- We noted that in one consulting room notes health records were piled up unattended. The door to this room was open with access from a main corridor used by patients and visitors. Although staff arrived in the room shortly after our arrival patient confidential records had been left unattended.
- We found unlocked notes trolleys in the department some of which were behind curtains others stored in open corridors outside of clinic rooms. The department Matron acknowledged that this was not an effective way to maintain patient confidential data. The department had been approved funding for locked cabinets for patient health records. The matron told us that they would be placing the order for these over the next few days.
- Medical secretaries told us that they were concerned about the numbers of patient health records stored in cabinets in the ophthalmology OPD. On the last day of our inspection secretaries told us that two members of staff had been told to clear these health records into a room near to the ophthalmology secretaries. We were shown the room which we were told had approximately 300 records of which the secretaries had managed to clerk 100 we saw in excess of 150 records housed in the cupboard.
- Secretaries who were already struggling to manage their workloads told us that now that the notes had been muddled up their jobs had been made more difficult as a result of this action. The impact of this was that appointment letters were late or weren't sent and GP letters might not be sent.
- The secretaries told us that as these notes had not been tracked to the cupboard, if the notes were needed before being tracked back to the library these notes would not have been found and therefore unavailable for use.
- During our previous inspection we had found that the availability of patient's health records in clinics had been a problem and that staff were not consistently recording when health records were not available.
- At this inspection we were told that there had been no improvement on the numbers of health records available at clinics.
- We were told that staff had recently been directed to report through the Trust incident reporting system when notes were not available. As the numbers of incidents of this nature were so high staff were told to send one incident report a day but to say in the body of the form how many health records were missing in that day. This was a failure of proper governance as it resulted in skewed figures as one incident about health records would be recorded, and yet this could be relating to a number of separate incidents but this was not featuring in the incident reporting figures. Therefore this was not a robust way to record and report missing health records.

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- At our last inspection we raised concerns about the condition and availability of patient health records. At this inspection we found that the trust had not improved on these areas.
- The trust told us that they did not have any specific audits of unavailable patient notes but since February 2015 they had been collating the number of temporary notes that had been produced. This was now reported weekly as part of the clinical administration dashboard. We looked at the seven weeks' worth of this data (across both sites) which had been collected and saw that in this period 955 sets of temporary notes had been set up across the Trust. This was an average of 136 temporary records being set up each week in the Trust. The data was not broken down by site.
- There was no system in place to reunite the temporary notes with the original notes. The impact of temporary notes was that the staff did not always have all the necessary information on which to base decisions. Vital medical history information was not always available and this could lead to repetition of tests, a potential for missed diagnosis, wasted journey for the patient and additional costs for the trust.
- The board meeting minutes of February 2015 stated that the health records department had suffered from a lack of capital investment over the years making it difficult for the department to run an effective service. It was reported that a business case had been submitted to the TDA for funding extra storage space for paper records and investment in an electronic system going forward. We were told during our inspection that funding for these projects had now been secured.

Safeguarding

- The trust had a safeguarding policy. Staff working in the OPD had completed mandatory safeguarding training to level 2, and Child Protection training to level 2. Staff were able to talk to us about the insight and knowledge they had gained from this training. They were also able to show us the trust safeguarding policies on the intranet.
- The training record provided showed no staff had completed level 3 safeguarding children training at Eastbourne Hospital. The intercollegiate document Safeguarding Children and Young People: roles and

competencies for healthcare staff 2014 recommends that level 3 training should be completed by all clinical staff working with children, young people and their parents/carers.

- OPD staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the Trust Safeguarding Lead was and how to contact them.
- An OPD staff nurse was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- Staff we spoke with in radiology also demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. Staff we spoke to were able to describe the actions they would take if they believed a child or vulnerable adult appeared for an examination showed evidence of possible abuse.

Mandatory training

- Mandatory training was recorded electronically with a traffic light system which alerted managers when staff were close to or breaching mandatory training requirements.
- We were told that all nursing staff in the department were up to date with mandatory training requirements.
- Staff are given time to undertake mandatory training which was offered in a format of one days' worth of face-to-face training, augmented with e-learning.
- All of the staff we spoke with confirmed that they had received their mandatory training in line with the trust policy.
- The training record provided by the trust showed lower levels of completion of mandatory training. Whilst 93% of eligible staff had completed BLS training, the completion rates were lower for other areas such as equality and diversity training (77%), fires safety (79%) and information governance (86%).
- The records did not show that medical staff had completed mandatory training.
- We were able to review the training records of the multi professional radiology department and saw that the majority of the staff had completed their mandatory training in 2014/15.
- We were told that new staff would go through a trust and departmental Induction Programme and they must prove to be competent in the specialist imaging modalities before they can become a lone worker.

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- In the CT department we were shown the competency framework that new radiographic staff had to complete before they could become lone workers. This was a comprehensive competency framework and the modality lead signed off the staff member before they were able to work out of hours on their own. We were told by one staff member that Local Rules were incorporated into the departmental induction and training which is updated yearly.

Assessing and responding to patient risk

- Staff had received mandatory training in patient resuscitation and demonstrated a good knowledge in dealing with medical emergencies.
- The OPD had written protocols for staff when dealing with a patient taken unwell or collapsing in the department. The OPD did not use National Early Warning Score (NEWS). Staff that we spoke with were able to describe how they would deal with a medical emergency in the department.
- Where patients attended OPD for minor procedures the department used a Generic Minor Operation Local Anaesthetic Care Pathway. We were shown examples of use of the tool.
- There was no system in place for triaging patients who were due to attend cancelled clinics. The cancellation was managed from an administrative perspective but not from clinical one. There was no review of the degree of urgency of any of the cancelled appointments.
- The Rheumatology nurse led clinic used a biologics check list tool for patients attending clinic. This checklist allowed staff to assess patients risk using a number of assessment criteria which informed best treatment routes.
- We saw that systems were in place to ensure the right person, gets the right radiological scan at the right time. This included the justification of the request forms on receipt of the request by the modality Radiologist or radiographer who could re direct to another imaging modality if it was felt the requested examination was not appropriate.
- On arriving in the Computerised Tomography (CT) department, we observed patients completing a safety questionnaire followed by checks performed by the radiographer prior to the scan being performed. This ensured that the right person was receiving the right radiological scan. Across the department, several incidents had occurred around the identification of patients, we saw the department had responded to the incidents in a timely, appropriate manner and further processes had been introduced to prevent further similar incidents happening in the future.
- The World Health Organisation (WHO) Surgical Safety Checklist was required for use in any operating theatre environment. We were told by nursing staff that the Checklist was part of the process which included a 'team brief' before the list started and a 'team de-brief' at the end of the list. The Nursing staff we spoke to were able to describe the process and show how the WHO surgical safety checklist was being used within the interventional Radiology Suite.
- There were no WHO Checklist audits within interventional radiology.
- Staff we spoke to in the Nuclear medicine and the main X ray department told us that the Radiation Protection Advisors (RPA) and Medical Physics expert (MPE) were readily assessable for advice and support via the telephone, email and visitations to the department. Staff we spoke to told us that the RPA and MPE would give specialist advise on radiation related queries such as advice on isotope incidents and any exposures 'much greater than intended'.
- To comply with IRMER, departments have to establish the pregnancy status of a patient prior to any relevant medical exposure. We asked staff what systems were in place to prevent the irradiation of pregnant woman. We observed notices in the changing rooms and in the nuclear medicine waiting area.
- In the Nuclear Medicine and CT department, we observed patients completing safety questionnaires which included asking female patients if there was any chance they could be pregnant. This was re checked when the patient entered the examination room by the Radiographer.
- Departmental policy stated that all patients between the age of 12-60 years must be asked about their pregnancy status. We were told that if a patient was pregnant but it was felt that the examination needed to take place then lead protection will be used to protect the foetus. This needed to be signed off by a radiologist.
- We observed the systems were in place to prevent contrast induced nephropathy. The computerised tomography (CT) and Magnetic resonance imaging (MRI) scanning units had access to the 'e-searching system' which enabled radiographic staff to check blood results of patients before contrast injection to ensure that

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patients at risk of Acute Kidney Injury did not inappropriately receive contrast agent. Staff told us that trauma patients who may not have blood results would require a medical consultant authorisation if a contrast agent is required. This system significantly reduced patient risk.

- On the Radiology rooms we visited that perform radiographic examinations, we observed that all the necessary warning notices on the doors and illuminated boxes outside the rooms were in place. There were permanent signs, with pictorials, stuck onto each entry door stating 'Radiation Stop' & 'Do Not Enter' to prevent inadvertent entry to the room.
- We were able to enter an x-ray room whose doors were opened and the X ray machine was not switched off at the isolator. No staff were in the immediate area. This could result in a person's entering the room and cause damage to themselves or the equipment. On reviewing the risk register for the area we saw it stated that 'at the end of a shift and / or when there is no Radiology department staff in the immediate area the equipment is switched off at the isolator'.
- We did observe that not all room doors stated what piece of equipment was in the room, for example the control room in Nuclear Medicine stated it was the 'exercise room'.
- We were told by staff that for in patients the wards will be rung before the patient is requested down to the department to establish how poorly they are. Any patients with a high early warning score or infection risk will require a nurse escort.
- The Radiology Department have a radiology assistant that is able to support the porters with the transfer of patients from the wards to X-ray. The RSM told us that they are trained to provide basic life support. However very ill patients would require a nurse escort which we were told could be a challenge.

Nursing staffing, Allied Healthcare Professionals and other Staffing

- All of the nursing staff that we spoke with felt that staffing was not an issue in the outpatient department and felt that there were enough staff of a suitable skill mix to manage the workload.
- The OPD was managed by the Head of Nursing who reported to a general manager and clinical service

managers. OPD areas were managed by Matrons who were Band 7 nurses, the department then employed band 6 and band 5 staff nurses. HCAs were both band 2 and 3 nurses.

- The OPD was running on a 40% trained nurse to 60% Health Care assistant roles. The manager had recently attended a study programme on productivity and efficiency and following this had plans to alter the staff ratio to 30% trained nurse to 70% health care assistant. The matrons across both main OPD sites were working together to manage a shift in staffing ratios.
- Clinic templates were set up six weeks in advance and nursing rotas were constructed around clinic demands.
- The matron attempted to ensure that nurses worked within the speciality that they knew. Where clinics required it (e.g. clinics with invasive procedures) staff nurses were supplied.
- The OPD did not use agency nurses and only used regular bank nurses that they knew had obtained the relevant competencies to work in the department.
- Managers were able to describe how they were managing long term sickness; the department had a low turnover of staff.
- Radiology staff told us that across the trust there were several vacancies in magnetic resonance Imaging (MRI) computerised tomography (CT) and Ultrasound (US).
- In US we were told that the Lead Radiographer had left and had not been replaced which placed pressures on the operational staff. Attracting ultra-sonographer was a national problem, so the trust had introduced incentives to attract Ultra sonographers to the trust. However, we were told the equipment was old and there were poor career development for the staff which made recruitment difficult.
- The RSM told us that there was enough staff to support the Radiology service however when we spoke to staff we were told that staffing of clerical and radiographic staff was an issue. One member of staff told us that even although there was a large pool of staff, all areas had to be covered which meant that staff found it difficult to cover the scheduled shifts and the on call rota.
- Another member of staff told us that the Radiology reception area two was frequently unmanned. There was a need to increase the number of reception staff as the numbers had reduced since November 2014. This resulted in the radiographers and Radiology

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Department Assistants (RDA) having to perform reception duties which reduced the efficiency of the service provided by taking trained staff away from the work they were trained to perform.

- The department was a training centre for student radiographers; applicants for vacancies were received from the training student following graduation. The RSM told us that the feedback from students was good which helped in the trusts recruitment of staff.
- The radiology nursing workforce employed across the trust consisted of a matron, two clinical Nurse Specialists, two Nursing sisters, two Staff Nurses and one HCA. Five of the Nurses were available to cover on call in the interventional radiology service across both hospital sites. Two further nurses were in training and would be available on completion of their training to participate in the on call rota. A radiologist we spoke to told us that the Interventional on call is demanding and nursing staff had to cover both sites.
- The call centre for both sites was situated at the Conquest hospital. During our last inspection staff were raising concerns about the central location for the call centre as many staff did not want to relocate to the other hospital site. Since that inspection the call centre had relocated and the majority of staff had been redeployed on the Eastbourne site. This had meant that a low number of appropriately skilled staff had been moved to the new site. The staff that had had skills in place were upgraded and most had been redeployed to the clinic maintenance team which managed clinic cancellations.

Medical staffing

- Shortages of medical staff in some specialities resulted in many cancelled clinics and long waits for appointments. The problem was exacerbated by locum doctors being used to clear the backlog of first appointments and improve trust compliance with the referral to treatment time targets. These patients were then not always offered follow up appointments within a clinically acceptable timescale as the permanent consultants did not have capacity to see them .
- The ophthalmology OPD had plans in place to recruit to future consultant vacancies. They planned to redesign the service in order to replace consultants with optometrists and at the same time increase nurse led injections clinics and develop nursing competencies.
- The trust had struggled to fill the post of a rheumatology consultant who had retired. Despite several attempts to advertise the post the trust had been unable to recruit. As a result the referral to treatment times (RTT) in this area had been particularly poor.
- The trust had recently cleared rheumatology lists using outside consultant cover over four weekends. However, this was not a sustainable approach to dealing with the issue in the long term.
- We saw the impact of the shortage of rheumatologists on one young patient who was left untreated and in considerable pain for an unacceptable length of time and whose long wait to be seen was compounded by a lack of follow up and failure to initiate appropriate treatment to prevent further progression of their disease.
- The trust board report stated that trust had been unable to recruit as this was a national shortage area and they were having difficulty in obtaining locums to cover. The trust had known of the planned retirement but there was no evidence of a forward thinking approach to succession planning.
- Trust policy stated that medical staff must give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner. The unit audited compliance with this policy, although the trust did not audit the reasons why clinics were cancelled in less than six weeks.
- In the pathology department the trust had a total of 3.8 full time equivalent consultant posts not filled. This was a vacancy rate of 27.5%. In the February board meeting minutes it was reported that vacancies in histopathology had been resolved through the use of locums but a longer term solution was required to achieve a sustainable position.
- The trust had advertised its vacancies internationally but there had been no interest. Minutes of the Pathology Services Meeting in March 2015 reported that the fifth advertisement for consultant histopathologists had been unsuccessful. This had included advertising internationally.
- There was no clear strategy to improve recruitment in hard to fill posts and in specialities where there were national shortages.

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- The department was presently three consultants short, with another doctor due to retire. The minutes stated that they were managing cross-cover wherever possible but service was severely compromised, and even at risk when a consultant was off.
- There were four vacancies across the consultant radiologist workforce. Locum consultant radiologists had been in post for over two years to support the service.
- Radiology registrars were part of the medical workforce. However there was a shortage of trainees, with the trust having only two registrars instead of five.
- The outcome of below establishment consultant radiologist posts and training registrar posts is that the trust's out of hours reporting service was outsourced and the capacity of the department was diminished resulting in extended reporting times which was identified on the trust's risk register. The outsourcing only covered the reporting on emergency and urgent scans and x-rays leaving a backlog of routine work for fewer permanent staff.
- There were no audits of the quality of the service where the reporting was outsourced.
- The trust provided us with a copy of their induction policy which included the induction of locum staff. The policy included a generic local induction tool to guide staff as to what needed to be covered when a new member of agency staff started work for the first time.

Major incident awareness and training

- OPD was designated as an ambulatory care decant area for the emergency department during a major incident.
- Staff were aware of their role in a major incident and had prompt cards to remind them how to manage a major incident.
- One senior staff member told us they had completed major incident training and were able to describe the department's role in the event of a major incident. Regular exercises were carried out across the trust.
- The trust had major incident cascade systems in place.

Are outpatient and diagnostic imaging services effective?

Staff were able to demonstrate the use of NICE guidelines and best evidence practice in the planning and delivery of patient care.

Staff respond compassionately when people need help and support them to meet their basic personal needs as and when required. They anticipate people's needs. People's privacy and confidentiality is respected at all times.

Staff were able to evidence competence in their roles and in the delivery of care.

The OPD department did not routinely work over seven days but had on occasions ran clinics over weekends. One of the CT scanner operates 8am-8 pm Monday to Thursday and 8am-5pm on a Friday. The second CT scanner runs 9am-5pm Monday to Friday. A Saturday and Sunday list was undertaken on both scanners. An out of hour's service runs for emergency examinations.

Evidence-based care and treatment

- The Ionising Radiation (Medical Exposure) Regulation 2000 (IRMER), stipulate the basic measures that needed to be in place to provide radiation protection of persons undergoing a medical exposure. Across the imaging modalities we visited, we observed that the regulations were being actively implemented. We saw evidence of standard operating procedures, clinical protocols; local referral guidelines based on the Royal College of Radiologists guidelines, justification policy to ensure all medical exposures were justified prior to the exposure being made.
- We saw evidence that systems were in place for the trust to report 'much greater than intended' incidents involving radiation to the Care Quality Commission (CQC). This is a statutory requirement and the Trust actively engaged with the CQC.
- The Ionising Radiation Regulations 1999 (IRR '99) aimed to protect the public and the health of the staff who work with ionising radiation, by specifying the duties of the trust to ensure compliance to the regulations. We were able to observe compliance to the regulations within the department through the carrying out of risk assessments, Quality Assurance programmes, and the provision of PPE, the development of Local rules for each modality and the employment of a RPA. Radiation protection policies, including Local Rules, were available in the shared drive and also within clinical areas.
- National Diagnostic Reference Levels (DRL's) were available together with the local rules. In one of the x-ray rooms we visited the radiographer was able to show the levels set which enabled the patients dose to be

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calculated at the end of the medical exposure. These were derived from the DRLs and with input from the medical physics expert. Staff told us that the Medical Physics expert monitors the 'DRL' as part of the rooms Quality Assurance Programme which was scheduled regularly. The outcome of the exposure was recorded together with data to permit a patient dose to be measured. If the DRL is exceeded, a note was made of the reason and recorded in the radiology management system.

- The department had a variety of clinical protocols in place. We observed that guidance from the Royal College of Radiologists was used as a basis to develop local policy.
- We reviewed the Interventional Radiology guidance on conscious sedation. We saw that the 'Guidance for safe sedation practice' was developed in association with the 'Academy of Medical Royal Colleges –Implementing and ensuring safe sedation practice for healthcare'. This demonstrated the trust use of professional guidance to develop policy. However, compliance with safe sedation practice was not audited.
- In the CT department we were told by staff that the NICE pathways were in place around the care of Stroke and Head injured patients. This required Brain CT scans to be performed within a one hour window in certain situations. No audits of compliance with the pathway were provided.
- The Rheumatology OPD demonstrated how they were using NICE guidance 130 Adalimumab, etanercept and infliximab for the treatment of rheumatoid arthritis by using the DAS28 score which is a measure of disease activity in rheumatoid arthritis (RA).
- The Rheumatology OPD also demonstrated some degree of compliance with NICE guidelines CG79 Rheumatoid arthritis: The management of rheumatoid arthritis in adults with regard to the criteria for drug administration within this guidance. However, we were contacted by a patient where the timescales for treatment contained within the guidance were not met and who suffered disease progression as a result of this.
- Doctors in the Colorectal OPD demonstrated the ways in which they followed the Royal College of Surgeons of England guidelines for the management of colorectal cancer (2007).
- National Institute for Health and Care Excellence (NICE) guidance for Smoking cessation had been met within the department. The OPD assessed each patient who

accessed the service to establish whether they would benefit from a referral to the Smoking Cessation service. Staff would refer patients to the service where a need was established.

Nutrition and hydration

- On reviewing a patient information letter sent to patients attending for a CT scan, we saw that guidance was given to patients who may be diabetic to ensure the patient's health was not compromised prior to the examination.
- Retail outlets and cafes were available on site for people to purchase refreshments when they attended the OPD.

Pain relief

- In general, patients attending OPD did not need of analgesia being administered at the time of their appointment.
- Analgesia stored in OPD was for use with patients attending for gynaecological procedures.

Patient outcomes

- The trust was designing a pilot study to trial the use of Cancer Clinical Nurse Specialists running 'breaking bad news' clinics, to support the 62 day target and expedite the patient pathway. The target timescale for this was March 2015.
- There was a trust protocol for patients who had breached the 2 week target.
- The trust informed us that there were no audits of waiting times in clinics within the preceding 12 months.
- Overall the trust has an average Follow-up to New ratio when compared to other trusts.
- There were no audits of patient outcomes for outpatient care and treatment.
- The trust told us in an email that, "Any relevant audit issues to the department are discussed at Governance meetings". The governance meeting minutes did not detail very much about clinical effectiveness and audit.

Competent staff

- Health care assistants (HCA) in the department were working towards the protected care certificate. The trust employed a HCA development educator who was supporting staff with this.

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- Generic protocols were in place to ensure that staff understood the department's expectations in relation to tasks such as running clinics, booking patients into clinics, and uniforms.
- The OPD held information on training records which indicated which staff had obtained further competencies above mandatory training which enabled them to perform their role.
- Nursing staff working within speciality clinics had obtained competencies to deliver care in the areas that they were working. For example, in the gynaecology clinics nurses were able to demonstrate that they had received both theoretical and practical training in basic cervical sample taking.
- On starting work at the trust staff attended a corporate induction. Following this they worked in OPD supported by a named member of staff who supported them. Staff were expected to complete a competency training pack during their local induction programme. New staff in Ophthalmology completed two weeks supernumerary in order that they could learn specific skills and techniques.
- A Service Level Agreement (SLA) was in place to support the trust with access to a Radiation Protection Advisor (RPA) as required by IRR ('99) and a Medical physics expert (MPE) as required under IRMER. Both roles being undertaken by a registered physicist. The RPA's duties included producing Diagnostic Reference Levels, writing Local Rules in collaboration with Radiation Protection Supervisors (RPS's) and Radiology Services Manager, advising the RPS and attending the Radiation Protection Committee on matters of dose limit/ dose excesses/ incidents.
- RPS's with a 3 year validation schedule was employed by the Trust whose function was to secure compliance with the IRR (99) and whose main role is to oversee the Local Rules and ensure that they are implemented. One RPS we spoke to told us that an update in training was due and that the Trust would support the attendance at a three day course.
- All Radiographic staff were trained and held either a Diploma of the College of Radiographers (DCRR) or a BSc (Hons) in diagnostic imaging. We were unable to review the records that confirmed that all radiographic staff were registered on a two year basis with the Health and Care Professionals Council (HCPC). There are codes of Practise for both the SCOR and the HCPC which must be followed, any breaches will result in a radiographer being reported. The RSM told us no staff had been referred to the HCPC recently however one staff member had been referred in the past.
- We were told by a member of staff that all newly appointed Radiographers had a mentor allocated to them for at least the first 6 months post qualification. Student radiographers were classed as 'operators' by the trust. This allowed students to carry out a variety of functions which were clearly defined in the standard operating procedures of the modality they were being trained in. A modality lead told us that students are under direct supervision of a radiographer during their work experience in the department. This is in line with current legislation.
- Across the trust we were told that 5 radiographers had completed the post graduate training in clinical reporting. Radiographers supported appendicular and extremities plain film report and one was trained in CT head reporting.
- We reviewed the Consultant Radiologist certificates for the 'Administration of radioactive substances Advisory Committee (ARSAC). The certificates were up to date and set out the delivery criteria. This was in line with current legislation.
- The IT technical manager told us that all staff received Information Governance training as part of their mandatory training, which was supported with written procedures. We reviewed the training records and saw the majority of staff had received Information Governance training.

Multidisciplinary working

- The Colposcopy clinic held multidisciplinary team (MDT) meetings every three weeks. We were shown the minutes from these meetings which were attended by Clinical Nurse Specialists (CNS) Staff nurses, pathology and the Consultant. Other specialities held similar MDT meetings at varying intervals dependant on necessity. For example, urogynaecology held meetings once a month whereas Oncology held them weekly.
- One stop clinics were run where needed for gynaecology patients where colposcopy, biopsy, and bloods were collected during one clinic appointment.
- Staff were able to access dieticians and pharmacy support in clinics where needed.
- MDM video conferencing was available across both sites of the Trust.

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- Consultant Radiologists were core members at the Cancer MDT meetings; this allowed the MDT meetings to meet national standards. Non-cancer MDT's including cardiology; rheumatology and A/E also required radiological input. A consultant Radiologist told us a quarter of a radiologist time is spent preparing and attending the MDT.
- In the imaging departments IR (ME) R 2000 Medical Exposures' Manual & Standard Operating Procedures lists the non-medical staff able to make referrals for radiological examinations; these included for example Podiatrists, Chiropractors, Radiographers, Nurse Practitioners, and Physiotherapists. Non-medical referrers must have undertaken Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) training.

Seven-day services

- OPD were running clinics over five days. However, they had recently opened weekend clinics to clear a backlog in Rheumatology clinics.
- One of the CT scanner operates 8am-8 pm Monday to Thursday and 8am-5pm on a Friday. The second CT scanner runs 9am-5pm Monday to Friday. A Saturday and Sunday list was undertaken on both scanners. An out of hour's service runs for emergency examinations.

Access to information

- The Picture Archiving and Communication System (PACS) linked all the patients' examinations and reports together which meant the Radiologist could access all examinations and reports during the reporting process. The PAC's system linked in with other systems across the south coast which meant that if the patient has an X-ray examination at another hospital, this examination could be accessed and used in the reporting process. However we observed the inclusion of the PAC system on the trusts risk register. There was a risk that when the PACS tape library fails that the service was unable to retrieve historic images which meant that comparison reports could not be produced in a timely manner, causing a disruption to Radiology reporting service. The trust was monitoring this and had introduced systems to mitigate the risk.
- The Technical Support Manager told us that an Image exchange portal (IEP) which connected to other providers was in place to transfer images if patients require a specialist opinion or emergency transfer. The

- Radiology PACs was connected to the IEP at another hospital allowing the immediate access to information to healthcare professional across different providers to support improved patient outcomes.
- The Clinical Record Interactive Search System (CRIS) is a workflow management system that was integrated with the PAC system. All images and patients history can be accessed for comparison and consistency.
 - All access to the PACs is through the practitioner applying for access. The technical support manager told us that medical locums could be issued with an emergency account and log on book. Weekly checks were performed to chase up access forms to ensure the Trust Information Governance Policy is adhered to. The technical support manager was able to demonstrate this process in action to us during the inspection.
 - We were told that staff were not always aware of all the systems in place around the transfer of images. Training was said to be made available on a one to one basis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with a staff member who was the OPD link nurse for deprivation of liberties (DOLS), mental capacity act (MCA), and safeguarding. They had attended a six day study programme which covered DOLS, MCA, consent and the use of passports for patients with a learning disability. The staff member spoke enthusiastically about the course and the learning that they had gained from it.
- The training record provided by the trust showed very low levels of training completion in the Deprivation of Liberty Safeguards 2005. At Eastbourne Hospital 15% of staff had completed the training. The record showed the training was not applicable to the majority of staff, including nursing staff. There was no explanation for this.
- Radiographic staff had received training in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. One member of staff we spoke to was able to describe the processes in place to support a patient who lacked capacity and how this was implemented in the department.

Are outpatient and diagnostic imaging services caring?

Outpatients and diagnostic imaging

Good



We saw very caring and compassionate care delivered by all grades and disciplines of staff working in OPD. We observed good interaction between staff of all grades and the people using the department.

Staff offered assistance without waiting to be asked. Staff worked hard to ensure patients understood what their appointment and treatment involved.

Corridors were being used in some areas of OPD for patient height and weight checks and observations such as blood pressures. This afforded patients with little privacy and dignity.

Compassionate care

- Corridors were being used in some areas of OPD for patient height and weight checks and observations such as blood pressures. This afforded patients with little privacy and dignity. The OPD was looking at the OPD room layout to establish private areas for these examinations to take place.
 - One of the strengths of the service in the OPD was the quality of interaction between staff and patients.
 - We watched staff assisting people around the different OPD areas. Staff approached people rather than waiting for requests for assistance, asking people if they needed assistance and pointing people in the right direction.
 - We saw staff spending time with people, explaining care pathways and treatment plans. We noticed that staff squatted or sat so that they were at the same level as the person they were speaking to and maintained eye contact when conversing.
 - We observed staff interactions with patients as being friendly and welcoming. We saw staff stopped in clinics to greet patients that they knew and ask after their well-being. We observed that patients that attended clinic regularly had built relationships with the staff that worked there.
 - Staff were expected to keep patients informed of waiting times and the reasons for delays. We observed this happened in all areas of the OPD during our inspection.
- All of the patients we spoke with were complimentary about the way the staff had treated them. One patient said, "I would give the hospital a ten out of ten. I came yesterday and had a brace fitted, I had a problem and rang and they fitted me in today".
 - The OPD reception was in the entrance to OPD. The area was busy with patients arriving for appointments. There were signs and barriers to prevent people from crowding around the desks. Reception staff told us that when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk. The receptionist told us that as they checked patient's personal information they ensured that they could not be overheard. This showed that staff had considered ways to ensure that patient's personal information was protected.
 - We saw that staff always knocked and waited for permission before entering clinic rooms.
 - Radiology reception staff told us that when patients arrived for appointments their name, address, GP and area being examined were checked with the patient at the desk. The reception area at Eastbourne was an open window at the edge of the waiting area. There was no privacy for patients when reception staff were booking patients in. This meant that people's personal information could be overheard by people at the edge of the waiting room as well as anyone walking past the reception area. The reception was inadequate and did not protect people's personal information.
 - All of the patients we spoke with were complimentary about the way the staff had treated them. One patient we spoke to told us 'they had nothing but praise for the hospital'. In Radiology they are very efficient, I only sat down and they have called me. I have been called in early.' A second patient we spoke to told us that it was the first time they visited the department however they felt it was quicker and the staff were friendly'.
 - Friends and Family Test results were recorded in the monthly Nursing Quality Performance Review Group report. For the three months from January 2015 - March 2015 the results for OPD overall were 71.6%, 62.5% and 93.4%. Scores relating specifically to Eastbourne hospital were not recorded.
 - In February Friends and Family Tests for Maxillofacial OPD were 75%, Ophthalmology 80.7% and Trauma and Orthopaedics 92%.

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- Results of surveys and Friends and Family Testing were shared with staff and patients on display boards within the departments.

Understanding and involvement of patients and those close to them

- We spent time in the department observing interactions between staff and patients.
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account.
- We saw literature being explained to patients in clinic. We saw patients being handed detailed information which was explained to them by nurses who checked their understanding. Nurses also ensured that patients had a contact number to call if they had further questions or concerns when they returned to their homes.
- We also observed the doctors behaving in a friendly and respectful manner towards the patients in their care.
- We spent time in the radiology department observing interactions between staff and patients. All of the patients we spoke with told us that the examination that they were attending for was discussed with them, and in a manner that they were able to understand. Patients told us that they felt included and that their preferences were taken into account.
- In the nuclear medicine department we were shown a form which patients are given after they had received their nuclear medicine injection. This acts as a reminder for the patients to return to the department at a specified time to receive their scan.

Emotional support

- The OPD was a calm and well-ordered environment. We saw nurses constantly updating patients on clinic waiting times and checking that patients were comfortable and happy.
- We saw an example of staff supporting a frail elderly patient with compassion and dignity. One relative said, "We had a bad experience somewhere else. She likes to come here; staff are much more friendly and capable".
- The OPD had a comfortably decorated room set aside to offer to patients and their relatives to have quiet time to reflect and speak with staff after being given bad news.

- We heard an interaction over the telephone in the main OPD where a staff nurse was answering a patient enquiry. We heard the nurse reassuring the patient whilst explaining very clearly the procedure that the patient was booked into clinic for.
- Macmillan teams were on site to offer patients support when they had been given difficult news.
- The department had quiet rooms which were comfortably decorated to use for patients requiring privacy to digest difficult news and to ask staff further questions.

Are outpatient and diagnostic imaging services responsive?

Inadequate



People were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment. People experienced unacceptable waits for some services. At our last inspection the trust was not able to evidence that they were meeting with RTT NHS standard operating procedures across all specialities for either 2 week or 18 week targets. At this inspection the Trust was still not able to evidence that they were meeting with these targets consistently across all specialities. There were backlogs of patients on the waiting list in most specialities.

In Q4 (January 2015- March 2015) the trust performed worse than the England average for all three cancer targets. The performance against the 2 week target for urgent referral by a GP to the first consultation showed 92.4% compliance against a national average of 94.7%.

The call centre had been relocated to the Conquest Hospital site since our last inspection. The facilities such as the call centre did not meet people's needs. The move had resulted in the organisation having to staff the call centre with new inexperienced staff and this had caused problems which were still on-going at the time of our inspection. The call centre was not fit for purpose with a shortage of skilled staff and operating systems that were not working to advantage patients. The call centre was not working efficiently. As a result of these issues patients and staff were often unable to contact the call centre when they needed to.

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At our last inspection GP letters were not being sent consistently within the five days allocated for this task. This was because of a lack of staff, and issues with the quality of the letters being translated abroad. This had not improved since our last inspection and medical secretaries were still experiencing the same difficulties in performing their roles.

People were unable to access the care they needed. The team responsible for informing patients when clinics were cancelled had a backlog of work and were struggling to meet with the demands of the role. Many patients were being informed at short notice when appointments were cancelled even when clinics were cancelled with the required six weeks' notice. Many patients had not been notified when their clinic appointments had been cancelled and were arriving at the department to be sent away.

Clinic preparation staff were still under a great deal of pressure and felt that the problems that they reported to us at the last inspection had not improved. They were preparing clinic health records at short notice due to staffing levels. They were wasting time preparing clinic health records due to the poor tracking of patient records across OPD. Many records were still unavailable for clinics and the preparation of temporary health records was regular practice at every clinic, these were also set up by clinic preparation staff.

With increasing demand, the complexity of the procedures and workforce issues pressure was being placed on the effective workings of the radiology department.

Reporting on MRI, CT and plain films was not being managed within required timescales.

At our last inspection we found that the patient journey through the department on arrival was poor with patients experiencing long queues, being sent to the wrong departments by the central reception, and nurses in clinic having inadequate IT systems to allow them to know when a patient had arrived in clinic.

At this inspection we found that patient's experiences upon entering the department had improved. Systems had been put in place to ensure that patients were directed to the correct areas, and IT systems now informed staff when patients had arrived in the hospital. This meant that if a patient did go to the wrong department staff would be aware of this. The queue at reception had reduced and the area was calm and ordered throughout our inspection.

This was not the case in the radiology department where patients arriving in the department were not always supported through a booking in process due to a lack of staff. The departments waiting areas were not fit for purpose as they did not provide space and privacy for patients in gowns to maintain their dignity.

Service planning and delivery to meet the needs of local people

- On entering the hospital the main reception desks were directly in front of patients. Signage told patients where to queue and queues moved fast and without any issues throughout our inspection.
- The main OPD matron had worked on systems to ensure that patients understood which clinic areas they should go to and what to do when they got there. This was an improvement on our last inspection when we found patients were joining long queues and getting lost often presenting in the wrong areas of OPD.
- Computer systems had also been improved since our last inspections and staff in clinics were able to tell when a patient had checked in at the front reception desk. Therefore on the rare occasions that patients now got lost staff were able to track them down and help them to the correct area of OPD. Staff all acknowledged that the checking in system had been improved since our last inspection.
- Each area had patient information boards these contained a variety of information including staff photos, infection control and hand hygiene audit results and patient survey results.
- The OPD had bariatric chairs available in most areas. There was scope for further work on seating particularly with different height chairs to meet with the requirements of patients who required this.
- The Trust had a 'pay on foot' car park for visitor use. Parking was charged based on the amount of time people were parked for. We saw that where clinics over-ran staff could assist patients with partial refunds on their parking costs.
- Patients attending for outpatients and other visitors had access to a coffee shop and restaurant area.
- In the radiology department the main reception desk did not provide any privacy for patients booking into radiology. The area was an open window which allowed patients conversations with staff to be overheard.

Outpatients and diagnostic imaging

Reception staff were undertaking other duties at the reception desk. This contained patient identifiable material which could be seen by the persons booking into reception.

- We found that the main radiology waiting areas were basic. Staff told us that the shutters to the reception window are closed until the reception opens at 8.30 am or remained closed if there was a shortage of staff. Radiological Examinations took place from 8am. This meant that patients were arriving without support and having to sit and wait until a member of the radiological staff appeared to collect them for the examination.
- We observed that mammography patients had a separate changing and waiting area with soft lighting and an area to sit while waiting for their examination. However patients waiting for other radiological procedures had to sit after getting changed with other patients and members of the public in their gowns. One patient we spoke to told us that she "Did not like sitting next to a man in a gown and would prefer a ladies only area if we have to sit with our gowns on". Staff told us that new gowns had been available since the beginning of the year and these provided patients with more dignity than the previous gowns.
- We visited the mini waiting area for one of the CT scanners. We found that beds and patients in wheelchairs could be placed in this area. Curtains could be drawn round to provide privacy for the patient. However one staff member told us that the two cubicle wheelchair changing facilities had only one hand rail and folding doors could be a hazard.
- Staff told us that the changing facilities provided no privacy and there was a need for changing rooms that opened into a private area before patients were taken into the examination room. Patient's dignity and was not being met prior to patients receiving radiological examinations.

Access and flow

- At our last inspection the trust was not able to evidence that they were meeting with RTT NHS standard operating procedures across all specialities. At this inspection the trust was still not able to evidence that they were meeting with these targets across all specialities.
- The non-admitted RTTs were very variable with a trust wide data showing an average of all specialities meeting the 18 week target in 92.8% of cases but with much

worse performance in specific specialities. Notably gastroenterology showed a 61.7% achievement, 88% in general medicine and 89.6% in General Surgery. There were specialities that showed a significantly better performance with Geriatric Medicine showing as achieving the target 100% of the time.

- The trust had performed worse than the England average for all three measures of cancer waiting times by Quarter 2 - 2014/2015.
- The trust did not see or treat the required number of patients against two week wait standard, breast symptom two week wait and 62 day standard. The two week wait standard average for the Trust was 91.23% which sat below their target of 93%. The two Week Breast standard sat at 89.64% for the Trust which was below the standard of 93%.
- In Q4 (January 2015- March 2015) the trust performed worse than the England average for all three cancer targets. The performance against the 2 week target for urgent referral by a GP to the first consultation showed 92.4% compliance against a national average of 94.7%.
- In Q4 the 31 day target for the time between deciding to treat and the first treatment for this period was achieved for 94.2% of patients against a national average of 97.5%. In the same period the 62 day target for the time from initial referral to the first treatment was achieved 77.7% of the time against a national average of 82.3%.
- The most recent board meeting minutes stated that in relation to the cancer targets the trust had not achieved the 2 week wait standards due to patients being unable to attend urgent appointments within fourteen days and that the trust had engaged with the CCGs and stakeholders to improve this. It was reported that an audit had been carried out between May and September 2014 of the referrals by GPs into the two week wait categories and those patients who had breached because they were unable to attend.
- The trust had written to 12 GP practices asking them to ensure that patients were aware of the potential seriousness of their position and had provided them with a script and leaflet to use. As a result two practices had responded asking for more information; and a further audit had conducted in one practice with the main rationale for non-attendance being that patients had been elderly and confused.
- RTT times for non-admitted patients have been consistently below the England average and below the national standard since Nov 2013. The Trust used the

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following protocol for managing compliance with the 18 week RTT times. Daily Monitoring of RTT Outpatient waits were recorded through an electronic booking tool which appointed patients to their relevant pathway and its targets. Daily or weekly meetings with individual specialties. Weekly meetings managing patients who had exceeded 18 week patient pathway performance targets. A weekly NHS Trust Development Authority (TDA) call; and monthly meetings with Clinical Commissioning Groups (CCG).

- The trust provided us with details of their performance in January and February 2015 against the performance targets. In general surgery the target waiting list was 2279; the trust had increased the actual waiting list from 2290 to 2378 over this period.
- The target total waiting list target for non admitted pathways was set at 19840. The trust had increased the actual waiting list from 19842 to 20530 during this time.
- In order to manage the long waiting lists in Rheumatology which the most recent NHS England statistics (January 2015) showed were at 30.2% (for non-admitted pathways) where the national standard is 95%; The trust had run weekend clinics for four weekends running which cleared the long waiting lists. In order to manage this the trust had bought in consultants from other areas of the country to work these clinics. The week that we inspected the Trust had bought the RTT for Rheumatology up to 86.1% which although a significant improvement still left the division sitting below the expected operating standard for the NHS.
- The trust was not meeting the planned trajectory for improvement in the waiting lists and backlog for the admitted 18 week target. The trust supplied up with details of their performance against the RTT performance trajectory agreed with TDA and local commissioners. It showed that the trust performance was red RAG rated for most specialities in respect of the 18 week admitted pathway. In some specialities the waiting list had increased over the two month period the trust had supplied us with data for.
- For trauma and orthopaedics the waiting list target was 801. In January 2015 the actual waiting list was 1468 and in February 2015 it was 1427. In ENT the waiting list had risen from 284 in January to 332 in February 2015 against a target of 249. In gynaecology the waiting list had increased from 271 to 285 over the same period against a target of 218.
- Staff told us that although they saw the benefit of clearing the waiting list for new patients which helped the trust to manage its 18 week pathways for new patients they were concerned that this had left the trust with a backlog of around 150 patients who needed to be seen in clinic for follow up appointments. The trust was able to manage 15-20 Rheumatology clinics at its two acute sites per week ordinarily which were staffed by two consultants and two nurses.
- Paper referrals from General Practitioners (GPs), consultants and ED were managed by a team at the Eastbourne site. Once received, referrals were opened date stamped and sorted into specialities. Clerks then booked the patient onto the partial booking system before sending the referral to the relevant consultant for triage. The protocol stated that this should be completed within 48 hours and staff were managing the process at the time of our inspection within 24 hours.
- Once triaged the referral would be rated for urgency and then forwarded to the central booking team at the Conquest site to make the appointment. Due to the limitation of the IT system the urgency of an appointment did not translate to booking staff so the team at the Eastbourne site needed to send a separate email instructing the booking team about which referrals were urgent, soon, or routine.
- Urgent appointments were to be made within two weeks, soon within four weeks and routine within six weeks.
- Central booking staff then booked appointments using the urgency scale along with guidelines for each speciality.
- Speciality guidelines informed staff of the timescales for booking appointments. If staff were unable to book appointments within this timescale they would use the escalation policy to escalate this to divisional leads. For example, at the time of our inspection general surgery was booking at no more than nine weeks whereas ophthalmology was 13 weeks, with gynaecology being 10 weeks at The Conquest Site and 17 weeks at the Eastbourne site.
- Where booking staff had escalated patients who they were unable to book within the timescales required divisional managers would steer staff on how to manage these bookings. We were told that this would be addressed by providing extra clinics, converting follow up appointment slots into new appointments, double booking clinic spots or by agreeing breaches in the RTT.

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- One issue raised by both staff and patients was the cancellation of clinics. Clinic cancellations were managed by a team at the Conquest site. Trust protocol dictated that clinics should be cancelled with at least six weeks' notice. Staff told us that this was not always adhered to and they were regularly receiving cancelled clinics within six weeks for reasons such as study leave.
- On the Eastbourne site, between September 2014 and March 2015, 91 clinics had been cancelled at short notice (less than 6 weeks), with 3632 clinics cancelled during this period with more than six weeks' notice.
- The team managing clinic cancellations had a backlog of work. This meant that they were cancelling clinics within one to two weeks of the clinic. This meant that even where clinics were cancelled with more than six weeks' notice patients may not receive this information until a week before their appointment.
- Staff told us that patients did turn up in the department unaware that their clinic appointment had been cancelled. Staff responsible for telling patients about cancellations confirmed that this did sometimes happen. They told us that this was usually because they did not have the patient's most up to date information on their records, and were unable to track the patient down.
- On the Eastbourne site between 15th September 2014 to 30th March, the Patient Advice and Liaison service (PALS) had received 129 complaints from patients who had arrived for clinic appointments that were cancelled without being notified.
- We spoke with seven patients from both sites about clinic cancellations. Of the seven patients we spoke with five had had clinics cancelled. One had not been notified and arrived for their appointment to be turned away. They told us that they had been informed of their new appointment the day before by letter. They said, "I didn't complain because the staff were so nice and apologised". Another patient said, "I arrived for an appointment to be told that it had been cancelled the week before and a letter had been sent to me telling me. I hadn't received it and there were a lot of people that day being sent away. I got another appointment but it wasn't until March which meant my appointment was six months overdue".
- This meant that the central booking team were a new team with most of their staff employed over the Christmas period. The team had no experience and were trained with support for a short while from a member of the clinic maintenance team. The clinic maintenance team were located in a temporary building ten minutes walk away from the booking staff base. Plans were in place to move this team back to the main booking office although there were no dates for this at the time of our inspection.
- Medical secretaries told us that the lack of experienced staff in clinic bookings meant that they were often distracted from their own work by staff from clinic booking requiring assistance. The booking department manager told us that inexperienced staff who needed support was their main challenge along with attempting to retain a disgruntled staff group.
- At the time of our inspection staff and patients told us that contacting the call centre was extremely difficult. Medical secretaries told us that they were constantly fielding calls from patients who were unable to contact the call centre. Medical secretaries told us that they also could not get their calls answered by the call centre so they emailed requests to them rather than call.
- It was established during our inspection that there was a fault on the line between the Eastbourne site and the call centre. Staff did not know how long the fault had been in place.
- Some patients still had previous letter heads directing them to call the Eastbourne number. Their call should have been redirected through to the conquest booking centre but this had not been happening.
- Another issue was the 'Round Robin' telephone system in operation in the call centre. This meant that calls would ring on each phone in sequence until someone answered the call. The Round Robin system had been set up to use 12 telephone lines however the call centre used five to six operators. Therefore the system still rang through to twelve phone sockets which increased the time that people were left waiting for calls to be answered. When the calls got to the end of the line of twelve terminals the caller was thrown out of the system, with no option to leave a message.
- It had been discovered that when staff were busy on other tasks they were unplugging their telephones at the socket, the operating system was unable to detect that phones had been unplugged and this also increased the time that people were waiting on the line.
- We were told the solution would be a new call centre, the funding for this has been secured and the telecoms department were meeting with a company on the 26th March 2015 to discuss the options available to them.

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- Since our last inspection staff told us that it had been recognised that follow up appointment bookings needed to be addressed and the trust had placed a team at the Conquest site to manage follow ups.
- At our last inspection clinic preparation staff were under a great deal of pressure and were struggling to manage workloads. At this inspection they told us that although they had seen a change in management the situation had not improved.
- Clinic preparation staff printed off a list of patients attending clinics around a week before the clinics and their job was to locate and prepare patient health records for the clinics. The team were assisted by two runners who collected notes that were tracked to the library.
- As in our last inspection the biggest challenge for staff was locating notes that had not been correctly tracked and were waiting in other areas of the hospital. The job of tracking health records from clinics had still not been allocated. This meant that from the point in clinic until medical secretaries tracked notes which they had collected in clinic back to the library no one knew where health records were.
- Clinic preparation staff needed to travel around the hospital sites attempting to locate and collect the health records that they required. They told us that they still needed to set up a large number of temporary note folders which was both time consuming and unsafe in some clinics.
- They told us that four consultants refused to see patients without health records whereas other consultants would take a view on whether it was safe to see a patient without their full health records. A temporary set of health records contained patient identification labels, the most recent clinic letter and recent test results. We did not observe this during our inspection visit but have subsequently been contacted by people to whom this had happened and a senior nurse confirmed to us, by telephone, that this was the case.
- Clinic preparation staff were meant to prepare notes three days in advance of clinics. However they told us that they usually prepped clinics for the next day. Records we looked at confirmed this. This meant that where health records were not available consultants may be cancelling patients for clinic for the following day.
- The Trusts policy required GP letters to be sent following clinic appointments within five days. Medical secretaries we spoke with across both sites told us that this policy was not being adhered to consistently. They said that the reason for this was that dictated letters were sent abroad for typing. They said that the typing of these letters was not always correct and that secretaries had to listen to the dictation and check them against the letters that they received back. They also told us that they did not have enough staff in some areas (for example Ophthalmology) to meet with the demands of the service. We asked for the data collected on this but the trust did not provide us with it.
- DNA rates for all Outpatient clinics have generally been higher (worse) than the England average over the last year. We asked but were not told of any plans that the trust had to address this issue.
- We were told that on the whole the radiology department was meeting the 6 week diagnostic target with a 1% tolerance. This means that in February 2015, 10 patients were outside this target. Trust data confirmed this.
- Demand for CT scans had increased by 7% in the last year. The complexity of scans now required more time spent on reporting the images to ensure all the necessary information was retrieved from the examinations. With increasing demand, the complexity of the procedures and workforce issues extreme pressure was being placed on the effective workings of the radiology department. However the department was managing to stay within the 6 week target.
- Staff we spoke to told us that this was happening to the detriment of patient wellbeing and care as many staff felt they could not give patients the time they required. Areas of highest activity included MRI, CT and US at Eastbourne District General Hospital.
- Plans are in place to bid for a second MRI scanner however we were told that the hospital had lost the 'Musculoskeletal contract and the effect this will have on the demands placed on the service is unknown. This is likely to reduce the workload and remove the pressures being placed across the service.
- The GM told us that a cancer tracking meeting took place weekly. This closely monitored the time cancer patients wait for examinations. All patients that were close to breaching were discussed and processes put in

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place to prevent this happening. For example if a MRI scan had not been reported and the MDM is due, the GM will expedite this to ensure the report is available to discuss at the MDT.

- Inpatient examination aimed to be performed within 24 hours. We were told they were not achieving this in all cases. Requests could be escalated if there is a clinical concern. We were told that examinations were brought forward if escalated by the clinical teams. The RSM audits the time taken from when the examination is performed to the time the report is reported.
- We were told by the RSM that routine MRI scans were taking up to 30 days for a report to be released. Urgent CT scans are reported on the day however at least two hundred routine CT scans were waiting for three weeks to be reported. The decision had been made to outsource any CT scan that was not reported within a month.
- On the day of the inspection (25/03/15) at Eastbourne District Hospital 312 routine CT scans were awaiting reporting and 176 MRI'S. We were told that the oldest scans were three weeks old which was outside the two week target. Scan reports are escalated if a patient is due a clinic appointment. In Nuclear Medicine we were told that the SPECT CT images take a lot longer to report and therefore they are not meeting the 5 day reporting target.
- We observed that on the trust risk register 'examinations required' surpassed the reporting capacity of images and therefore images are not reported in a timely manner. Capacity paper already highlighted workforce deficiency in numbers. High number of non-urgent MRI and CT scans unreported at present.'
- To mitigate this situation, solutions had been sought including ad-hoc and extra hours of the Radiologists, outsourcing reports to the independent company and prioritising cases. We spoke to a reporting Radiographer who told us that a SLA was in place for extra plain films to be reported each month. The Radiographer would come in the evening and weekend to report.
- The RSM told us that all the high risk examinations including chest and abdominal films had all been reported. We spoke to a reporting Radiographer who told us that a SLA was in place for extra plain films to be reported each month. The Radiographer would come in the evening and weekend to report

- Staff told us that the removal of the X-ray porter had reduced the effectiveness of the service provided. We were given examples where in- patients could be X-rayed however staff are unable to get the patients down from the wards resulting in staff and equipment available to perform an examination but no patients.
- In CT we were told they lost the CT porter which had resulted in a reduction in the flexibility of the service they provide. Staff were auditing the process but no results were yet available. We saw that on the 20th March the time taken to get an in-patient down from the ward ranged from 25-60 minutes.

Meeting people's individual needs

- The OPD was able to access telephone translation services for patients. This could be arranged without notice when patients who required the service presented themselves in clinic. We saw examples of this happening during our inspection.
- The OPD had a link nurse with a special interest in learning disabilities. The OPD had folders for staff which included information for assisting patients with a learning disability. The information included a variety of communication tools, along with information and spare copies of hospital passport. Hospital passports were completed at home and brought into hospital to give staff information on the best ways to care for the patient's individual needs.
- The OPD had a link nurse for dementia who ensured that they were informed of new initiatives and best practice and shared this with the rest of the team. OPD staff highlighted patients with dementia during hourly intentional rounding. The OPD had a resource box for staff including information on dementia and tools such as memory photos to assist people with dementia within the department.
- Staff told us that where ladies required a female doctor to examine them due to cultural or religious preference, that this request would always be respected.
- Information leaflets were available in different languages upon request. The department was also able to access information leaflets in easy read formats.
- There were patient leaflets in each waiting area of the OPD which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We

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saw patients reading this information. When asked, they all said that the information was in a format that they understood. There were no leaflets in the waiting area of the radiology department.

- The Service provided chaperones where required for patients. We were told that staff were always available for this.
- We observed that the CT department has an active on call service. Reviewing the on call diary we saw that all examinations were performed in an emergency situation including abdomen and pelvises, chest and abdomens, brain, cervical spine and aortic scans. On one Saturday, in March 2015 we observed the member of staff was in from 17.50- 02.40 am performing a variety of emergency examinations. This demonstrated that the department is meeting the needs of the local population.
- Staff we spoke to told us that they provide a 24 hours and weekend service however the appointment system does not reflect this. Staff felt they needed to improve the structure on how appointments are offered to have minimum disruption to peoples life's and use the system effectively to meet patient's needs.
- An on call Interventional Radiology service is provided which undertakes a variety examinations to ensure patients' needs are met outside the normal working hours.
- The OPD used these boards to display a 'you said we did' section – these told patients about things that they had said and what the department was doing to improve this for them.
- There were no patient leaflets in waiting areas. Patients told us that they had been sent information letter explaining the examination they were having prior to their appointments.
- There were no information displays explaining to people how they could complain. The waiting areas were poorly signposted. They lacked information such as patient relevant information.

Learning from complaints and concerns

- The trust provided us with information about complaints received regarding complaints in OPD, across the trust. This showed a total of 79 complaints had been received between September 2014 and March 2015, 27 had been regarding Patient Pathway, 17 around Communication, 16 regarding the provision of services, 14 the standard of care, three about the attitude of staff,

one about the environment, and one regarding infection control. There was no breakdown by site provided. The figure differs significantly from that provided by the PALS service where 129 complaints were recorded about cancelled and delayed appointments on the Eastbourne site alone.

- The trust held a log of complaints and the learning points established from each complaints investigation.
- In the Board Report Feb 2015 Patient Advice and Liaison service (PALS) summary noted that there had been a spike in contacts during the latter part of July and August and this related to the changes in the outpatient booking-in system.
- Of the 251 OPD contacts made with PALS from 15th September 2014 to 30th March 2015 on the Eastbourne site 42% (141 complaints) were regarding the appointment telephone line, 38% (129 complaints) were about Cancelled appointments with no letter received, 8% (26 complaints) about the Queuing and booking system, and 6% (21 complaints) about Incorrect information being within appointment letters. The remaining 7% were about specific, individual concerns.
- Staff told us that they mainly dealt with verbal complaints which were mainly around appointment issues and long delays in clinics.
- In each OPD area matrons held regular meetings with staff where complaints were discussed as an agenda item. The Head of Nursing held monthly clinical unit meetings where complaints and risks were discussed. Each matron compiles a monthly quality report which was discussed at these meetings. This included positive and negative comments from their department which were discussed as a group.

Are outpatient and diagnostic imaging services well-led?

Inadequate 

We found that nursing staff were well led. They had moved forward under the supportive leadership of the Head of Nursing and had made great improvements in service delivery since our last inspection.

Nursing staff had improved governance structures and were meeting regularly to monitor and improve the service using learning from quality data, complaints and incidents.

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Nursing staff were engaged with their managers and were all working towards building the best service they could for patients.

Administration staff were still unsettled and unhappy about the changes that had been made to their department. They had experienced changes in management since our last inspection but felt that the service had not improved as a result.

Just prior to this inspection a new interim manager had been employed to improve the administration service. They were aware of the issues that had occurred due to the poor implementation of the restructuring of administration services last year. They were able to discuss with us the learning from this.

Although it was early days the interim manager had started to implement positive changes to the governance surrounding administration and was able to demonstrate that they had a plan to improve some of the areas that had caused concern. It was too early during this inspection to make a judgement on the effectiveness or sustainability of these changes.

Vision and strategy for this service

- Nurse management was working towards building skill sets across nursing teams. This would work towards further nurse led services.
- Ophthalmology were involved in a new design for clinics. All staff had been involved in the consultation process.
- Nursing staff told us that the trust wide administration review had caused problems in clinics which had not been resolved. Clinic staffs main concerns around administration were relating to health records management, DNA's and clinic cancellations.
- Staff working in administrative roles told us that they did not feel that the department had improved since our last inspection. Some staff we spoke with were distressed when they spoke about their management and felt the future was very uncertain. One didn't know who their manager was and told us that nobody ever asked how they were or what their workload was like.
- Some call centre staff were inexperienced and were not able to work at capacity due to staff shortages and a lack of support. They had experienced a recent change

in management. Although we spoke with this manager they were very recently in post and unable to provide us with evidence of strategic improvements and reassurance that the department would improve.

- There was a recognition from these managers that the OPD had gone through a difficult period due to the redesign of the administration of OPD.
- They discussed with us the learning that they had taken from the way in which these changes had been made. They said as a result any further improvements made to the service would be planned with gateway reviews preventing them from progressing until each action had been completed.
- They also recognised that the department had lost staff with historical knowledge about the department and its workings.
- The strategy going forward at the time of our inspection was to improve administration by recruiting bank and agency staff to fill roles whilst recruitment of five further booking staff and three further reception staff took place. To create standard operating procedures (SOPs) for clinic cancellations, escalating cancellations, and escalating and reporting RTT breaches; And to create a buddy system allowing staff to have specific competencies in the speciality they are working in along with a buddy sharing this knowledge when they are not at work.
- They felt that their biggest challenge was ophthalmology due to the high demand for the service and complex pathways. They had created a five step action plan. We requested this document but the trust did not provide us with it.
- Managers had also devised a clinical administration dashboard which would be reported on monthly. This dashboard covered activities such as partial booking, cashing up and RTTs. It had only been in operation for two weeks at the time of our inspection. We requested this document but the trust did not provide us with it.
- We were told by the General Manager (GM) for radiology that the first 5 year strategy for the radiology service had been developed. The strategy was due to be presented to the board in April 2015 for sign off. We were told that the strategy links in with the trust's vision and covers areas including workforce, equipment and capacity and demand planning. We did not see the strategy during the inspection.

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- Development of the strategy was through a Radiology Working Group, whose membership included the trust Chairman, Director of Assurance, Lead Radiologist, General Manager and the Radiology Service Manager.

Governance, risk management and quality measurement

- Minutes from the Specialist Medicine Risk and Incident Meeting for clinical matrons showed minimal ownership and local involvement in addressing key service delivery issues on the department risk register. In response to the waiting list backlogs entered on the risk register, the comments following discussion showed simply that there was, "A recovery plan which will address this". The data provided by the trust did not provide assurance that the recovery plan will address the risk.
- We were provided with minutes from meetings that showed local consideration of specific issues of concern and local monitoring of issues but we did not see evidence of wider organisational learning.
- The Trusts Quality Improvement Targets for 2014/2015 were for 95% of non-admitted pathways to be completed within 18 weeks, and 99% of patients waiting less than 6 weeks for diagnostic tests. The trust was not meeting these in all areas but had improved compliance with RTT for dermatology and rheumatology.
- The OPD collected data monthly for the Trust Clinical Governance Report. There was a governance board in operation at the trust. The OPD matrons attended a regular trust wide quality meeting where governance data was discussed and analysed.
- The Head of Nursing chaired a monthly quality review meeting and clinical unit meeting for matrons. In addition to this each matron compiled a monthly quality report which was discussed at these meetings.
- Minutes from the Specialist Medicine Risk and Incident Meeting for clinical matrons said, in respect of the report from our September 2014 inspection, "The report is currently available to selected staff in the organisation for verification checking. There are areas of concern highlighted in the report, which will be shared within the Organisation once it is released." There was no evidence from our visit or from any on the evidence provided by the trust that the nature of concerns were shared prior to publication of the report. Whilst the full report could not be shared, the main concerns could have been disseminated and improvements begun rather than waiting for publication.
- In the radiology medical imaging department we saw evidence of systematic audit both clinical and safety which was used to inform practice this included auditing the out of hours reporting service to ensure standards were maintained. Presently out of hour scans were re reported the following morning however we were told that this practise was being reviewed.
- Radiology was not a regular board agenda item. However the GM told us that radiology representation is present at the Clinical Management Executive Meeting which is attended by the Chief Executive, all executive's, GM's and clinical leads. The GM told us that at the meeting topics such as the risk register are discussed every two months, where high scoring and new risks are discussed. This forum gives the management teams the opportunity to learn about risks in other directorates and the effect they may have in delivering an effective service.
- The trust have a Radiation Protection Committee (RPC) which met every 6 months and was chaired by a senior member of the Radiology Directorate management team. The IR(ME)R Subgroup (individual RPSs) of the RPC considered and acted upon those issues relevant to this legislation. This and other specialist subgroups of the Committee may be empowered to undertake specific tasks on behalf of the Committee and the employer, though the responsibility for all actions remained with the employer under this legislation.
- The Head of Radiology is the IR(ME)R Practitioner responsible for defining Practitioner Guidelines, IR(ME)R 2000 and subsequent amendments policies, procedures and the implementation.
- The Radiology Service Manager attended divisional bi monthly clinical governance meetings where areas such as incidents, complaints and business cases were discussed across the directorate. This allowed other parts of the directorate to learn about challenges and service improvement plans that may affect them.
- Once a month a PACs meeting took place to discuss IT issues. Attendance at the meeting included the PAC system manager, Radiologist, RSM, modality leads and the outside contractor. This allowed any issues that

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arise with the system to be discussed and systems put in place to mitigate any risk as well as a forum to inform staff of possible problems with the system and solutions.

- Attendance at the Quality Committee, which is chaired by the Head of Nursing, allowed the GM to learn about serious incident updates and complaints. Business cases were discussed which allowed other GMs to learn about developments and the effect it may have on their service. When a Radiology Business case is discussed the lead modality Radiologist was present during the discussions. Feedback from the meeting was given to the Radiology Service Manager who kept staff up to date with developments across the trust.
- Following the investigation in to a serious incident a 'communicator' was introduced into the trust IT system which was linked to the Radiology Information system. (RIS) All referring clinicians have to accept and confirm they have received the radiological report. This provided assurance to the radiology department that referrers had received the report and actions would be undertaken by the referrer if necessary to improve patient outcomes.
- The radiologists had quarterly 'discrepancy meeting' which were educational meeting whereby Consultant radiologists discuss radiological reports. Reporting Radiographers were invited to these meetings. Any discrepancies found would be anonymised and discussed at the radiology risk meeting.
- The member of staff who reported the examination would receive feedback via email. If it is thought that the patients management has been compromised an electronic reporting system alert would be raised. Discrepancy Meetings are good clinical practice and provide on-going education for radiologists in a lessons learned continuous cycle of improvement which will benefit future patient outcomes and enhance reporting skills. It is a form of continuous professional development and service improvement.

Leadership of service

- We received very positive feedback about the impact of the Head of Nursing on the service. At our last inspection the Head of Nursing had only been in post for two weeks. Since that time it was evident that they had made an impact on the nursing side of the service with patients having a far better experience once arriving in the department. Nursing processes were slicker with

protocols in place to assist staff to perform their roles. There was a sense of calm and purpose in the department which was not evident at our previous inspection.

- At our last inspection staff had not had a clinical leadership meeting for more than 18 months. There were now regular leadership and governance meetings leaving staff better informed and feeling empowered to make positive improvements within their own areas.
- Feedback on the executive team was varied. A few staff told us that they had seen the executive team during walkabouts. However, the majority of staff told us that the executive team did not visit OPD.
- Administration staff were not positive about the leadership of the service. They told us that managers had been moved and replaced but that they had not seen positive changes to their systems of working as a result of this.
- An interim manager was in post to make improvements to the administration side of OPD. They demonstrated a good understanding of the challenges in the department, which had been brought about by the poor implementation of the restructuring and relocation of central booking and reception areas, along with a long term lack of investment by the trust in the storage, tracking and condition of health records. We did not see any written evidence of the plans. We did not see the department risk register but have subsequently been told by the trust that it contained entries relating to the poor quality of medical records and the failure of staff to update the notes tracker.
- Staff told us that each morning the team leads in radiology had a 5-10 minute meeting with staff to update the staff on any information of importance. We were shown that a communications book was in place for the general x-ray rooms. However we were told large staff meetings were scheduled but did not always take place.
- Radiology staff that we spoke with told us that they felt communications across the department was poor. One member of staff we spoke told us that they felt let down by management. Staff told us that they did not always feel supported.

Culture within the service

- Nursing staff we spoke with demonstrated that they were engaged with the senior team and received regular briefings regarding their departments.

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- Administration staff did not feel supported and some staff were unsure of who was managing them. They demonstrated a lack of interest in improvements to the service because they felt that their department had deteriorated through the redesign of the service and felt that nothing had been done to improve this. One member of staff told us that since our last inspection, “The good news is that the people who made this big mess up have been moved, but the bad news is – it is still the same”.
- We were contacted by several staff from administration who felt changes were made without any input from people doing the job. Some were angry and felt dismissed by senior staff. In one focus group administrative staff told senior staff, including associate directors, that it felt like they worked in a different hospital to the one being described by the senior staff.
- Other staff contacted us during and after the inspection visit to say they felt bullied and that when they had raised concerns they had been made to suffer. We saw emails from executive directors that were dismissive of concerns.
- Quality data was displayed in each area for patients and staff to view. The data displayed showed cleanliness scores, hand hygiene scores, friends and family test scores, staffing levels number of patient attendances in that area.
- Whilst there was still much work to do, all of the nursing and medical staff we spoke with placed a high importance to patient experience. They were able to describe to us how they had made improvements to patient journeys through the department, and how they received feedback when patient’s experiences did not meet with the vision and values of their department.

Innovation, improvement and sustainability

- The skill mix review for nursing staff aimed to provide staff with additional skills.
- The plans put in place to reduce the backlog of the waiting list and improve compliance with RTT times was reliant on staff working additional hours and overtime. Weekend clinics had been put in place and more clinics set up without additional funding. This was not sustainable.

Public and staff engagement

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Make sure the privacy and dignity of patients is upheld by avoiding same-sex breaches in the clinical decision unit (CDU) and other areas of the trust. Breaches of same-sex accommodation must be reported accurately.
- Review the arrangements for protecting the privacy and dignity of patients attending the radiology department and the OPD.
- Improve the management of medicines in the ED to promote patient safety.
- Review occupational health and human resources support and resources in place for staff who are on long-term sick leave or who need support, to ensure the trust can meet its duty of care to its workforce.
- Conduct a trust-wide review of staffing levels to ensure that patient acuity and turnover is taken into consideration.
- Give serious consideration to how it is going to rebuild effective relationships with its staff, the public and other key stakeholders. This was a requirement following our inspection on September 2014 but we are not yet assured from the action plan and speaking with the lead executive officer that this has been addressed.
- Create an organisational culture which is grounded in openness, where people feeling able to speak out without fear of reprisal. This was a requirement following our inspection on September 2014 but we are not yet assured that staff feel able to speak out without suffering detriment.
- Undertake a root and branch review across the organisation to address the perceptions of a bullying culture, as required in our previous inspection report.
- Review and improve the trust's pharmacy service and management of medicines.
- Review the reconfiguration of outpatients' services to ensure that it meets the needs of those patients using the service.
- Review the length of waiting time for outpatients' appointments such that they meet the governments RTT waiting times.

- Ensure that health records are available and that patient and staff data is confidentially managed.
- Give full consideration to whether there have been any breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5 (3)(d) Fit and proper persons: directors

Action the hospital SHOULD take to improve

- Ensure that staff fully and accurately complete documentation.
- Ensure that fridges used for the storage of medicines are kept locked and are not accessible to people and that medicines are secured in lockable units. This is something that is required as part of Regulation 13 in relation to the management of medicines but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the Regulation overall at the location.
- Develop sustainable systems for the review and monitor compliance with national guidance on VTE risk assessments.
- Develop sustainable systems for ensuring that emergency equipment is checked in accordance with trust policy and national guidance.
- The trust should ensure that the room in the ED designated for the interview of patients presenting with mental health needs has a suitable design and layout to minimise the risk of avoidable harm and promote the safety of people using it.
- The trust should review the number and skill mix of nurses on duty in the ED department to reflect NICE guidelines to ensure patients' welfare and safety are promoted and their individual needs are met.
- The trust should review the number of consultant EM doctors in the ED and how they are deployed to reflect the College of Emergency Medicine (CEM) recommendations.
- The trust should improve the uptake of mandatory training amongst staff working in Urgent Care.
- The trust should make sure there are enough competent staff working in Urgent Care to respond to a major incident.
- The trust should review the arrangements for monitoring pain experienced by patients in the ED to make sure people have effective pain relief.

Outstanding practice and areas for improvement

- The trust should review their arrangements for assessing and recording the mental capacity of patients in the ED to demonstrate that care and treatment is delivered in patients' best interests.
- The trust should make arrangements to ensure contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- The trust should review some areas of the environment in the ED with regard to the lack of visibility of patients in the children's waiting area; the arrangements for supporting people's privacy at the reception and triage bay and the suitability of the relatives' room
- The trust should review the provision of written information to other languages and formats so that it is accessible to people with language or other communication difficulties.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 5 HSCA 2008 (Regulated Activities) Regulation 2010 Requirement where the service provider is a body other than a partnership</p> <p>Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states: Records 20. (1) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of— (a)an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and. (b)such other records as are appropriate in relation to— (i)persons employed for the purposes of carrying on the regulated activity, and. (ii)the management of the regulated activity.. (2) The registered person must ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are— (a)kept securely and can be located promptly when required;. (b)retained for an appropriate period of time; and. (c)securely destroyed when it is appropriate to do so.</p> <p>How the regulation was not being met:</p> <p>The outpatient department was not protecting patient's confidential data. Patient records were left in public accessible areas without staff present and failing to comply with the Data Protection Act 1998.</p> <p>The outpatient department were not tracking patient health records because this job had not been considered during the redesigning of the service. The location of medical records were often unknown and resulted in delays or temporary notes being used. Trusts have a responsibility to track all patients' health records (Records Management - NHS Code of Practice Part 2 January 2009).</p>

This section is primarily information for the provider

Compliance actions

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

Regulation

Regulation 5 HSCA 2008 (Regulated Activities) Regulation 2010 Requirement where the service provider is a body other than a partnership

Cleanliness and infection control

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

To support our judgement about compliance with Regulation 12(2)(a), we have had regard to Criterion 1 of the Code which states that a compliant registered provider will need to demonstrate:

Cleanliness and infection control

12. (1) The registered person must, so far as reasonably practicable, ensure that —

(a) service users;

(b) persons employed for the purpose of the carrying on of the regulated activity; and

(c) others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2).

(2) The means referred to in paragraph (1) are —

(a) the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection;

(c) the maintenance of appropriate standards of cleanliness and hygiene in relation to—

(i) premises occupied for the purpose of carrying on the regulated activity,

(ii) equipment and reusable medical devices used for the purpose of carrying on the regulated activity, and

This section is primarily information for the provider

Compliance actions

(iii) materials to be used in the treatment of service users where such materials are at risk of being contaminated with a health care associated infection.

How the regulation was not being met:

The auditing across the hospital did not meet with required timeframes or required levels of cleaning set out in National Specifications Of Cleanliness in the NHS.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

17. (1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure—

(a) the dignity, privacy and independence of service users; and

(b) that service users are enabled to make, or participate in making, decisions relating to their care or treatment..

(2) For the purposes of paragraph (1), the registered person must—

(a) treat service users with consideration and respect;

(b) provide service users with appropriate information and support in relation to their care or treatment;

(c) encourage service users, or those acting on their behalf, to—

(i) understand the care or treatment choices available to the service user, and discuss with an appropriate health care professional, or other appropriate person, the balance of risks and benefits involved in any particular course of care or treatment, and

(ii) express their views as to what is important to them in relation to the care or treatment;

This section is primarily information for the provider

Compliance actions

(d) where necessary, assist service users, or those acting on their behalf, to express the views referred to in sub-paragraph (c)(ii) and, so far as appropriate and reasonably practicable, accommodate those views;

(e) where appropriate, provide opportunities for service users to manage their own care or treatment;

(f) where appropriate, involve service users in decisions relating to the way in which the regulated activity is carried on in so far as it relates to their care or treatment;

(g) provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement; and.

(h) take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have.

Why you are failing to comply with this regulation:

The privacy and dignity of patients is not being upheld. There are some sex breaches within the Clinical Decision Unit (CDU).

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations
2010 Management of medicines

Management of medicines

13. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

This section is primarily information for the provider

Compliance actions

Why you are failing to comply with this regulation:

The management of medicines within the ED, including storage and recording of temperatures, was not being carried out in accordance with national guidelines

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.