HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 1 OCTOBER 2015

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP - East Sussex County Council Members
Councillors Michael Ensor (Chair), Ruth O'Keeffe (Vice Chair), Frank Carstairs, Angharad Davies, Alan Shuttleworth, Michael Wincott and John Ungar

District and Borough Council Members
Councillors Sam Adeniji (Lewes District Council), Sue Beaney (Hastings Borough Council), Pam Doodes (Wealden District Council), Bridget George (Rother District Council), John Ungar (Eastbourne Borough Council)

Voluntary Sector Representatives
Julie Eason, (SpeakUp), Jennifer Twist, (SpeakUp)

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AGENDA

1. **Apologies for absence**

2. **Disclosures of interests**

   Disclosures by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.

3. **Minutes of the meetings held on 22 May and 16 June 2015** *(Pages 5 - 32)*

4. **Urgent items**

   Notification of items which the Chair considers to be urgent and proposes to take at the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgent.

5. **East Sussex Healthcare NHS Trust (ESHT): Care Quality Commission (CQC) Follow-up Inspection Report** *(Pages 33 - 70)*

6. **Sussex Partnership Foundation NHS Trust (SPFT): Care Quality Commission (CQC) Inspection Report** *(Pages 71 - 82)*

7. **High Weald Lewes Havens (HWLH CCG): Procurement of Community Services** *(Pages 83 - 90)*

8. **HOSC future work programme** *(Pages 91 - 96)*

9. **Any other items previously notified under agenda item 4**

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Crescent
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23 September 2015

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Future HOSC meetings: 10am, Thursday, 3 December 2015, County Hall, Lewes

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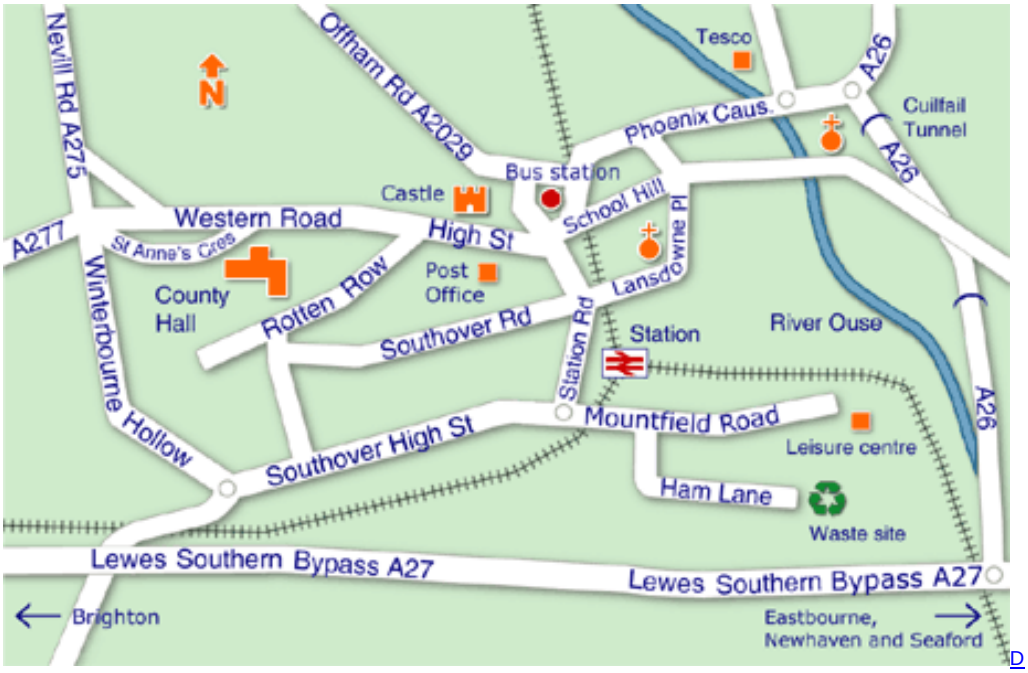

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Commonly Used Acronyms Glossary

A&E	Accident and Emergency department
ASC	Adult Social Care
BSUH	Brighton and Sussex University Hospitals NHS Trust
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DGH	District General Hospital
DH	Department of Health
EHS	Eastbourne, Hailsham and Seaford
ESCC	East Sussex County Council
ESHT	East Sussex Healthcare NHS Trust
FT	Foundation Trust
GP	General Practitioner
H&R	Hastings and Rother
HCAI	Healthcare Associated Infection
HOSC	Health Overview and Scrutiny Committee
HW	Healthwatch
HWB	Health and Wellbeing Board
HWLH	High Weald, Lewes, Havens
LTC	Long Term Condition
MIU	Minor Injury Unit
MLU	Midwife-led Unit
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NSF	National Service Framework
OPMH	Older People's Mental Health
PALS	Patient Advice and Liaison Services
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
SECAmb	South East Coast Ambulance Service NHS Foundation Trust
SPT/SPFT	Sussex Partnership NHS Foundation Trust
TDA	(NHS) Trust Development Authority
WIC	Walk in Centre

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 22 May 2015

PRESENT:

East Sussex County Council Members
Councillors Michael Ensor (Chair), Ruth O'Keeffe (Vice-Chair), Frank Carstairs, Peter Pragnell, Alan Shuttleworth, Bob Standley and Michael Wincott

District and Borough Council Members
Councillors John Ungar (Eastbourne Borough Council), Sue Beaney (Hastings Borough Council), Bridget George (Rother District Council), and Sam Adeniji (Lewes District Council)

Voluntary Sector Representatives
Julie Eason (SpeakUp)
Jennifer Twist (SpeakUp)

ALSO PRESENT:

Care Quality Commission
Tim Cooper, Head of Hospital Inspections
Terri Salt, Inspection Manager
Alan Thorne, Head of Hospital Inspection, South East

East Sussex Healthcare NHS Trust
Darren Grayson, Chief Executive
Stuart Welling, Chair
Dr Amanda Harrison, Director of Strategic Development and Assurance
Alice Webster, Director of Nursing
Dr Andy Slater, Medical Director
Jenny Crowe, Head of Midwifery
Imelda Donnellan, General Surgery Consultant and Clinical Lead for the Surgical Clinical Unit
Nicky Roberts, Consultant

Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Dr Martin Writer, Chair
Jessica Britton, Associate Director of Strategy and Governance
Allison Cannon, Chief Nurse

High Weald Lewes Havens CCG
Wendy Carberry, Chief Officer
Dr David Roche, Area Chair

Trust Development Authority
Julie Blumgart, Clinical Quality Director
Suzanne Cliffe, Portfolio Director (Acting)
David Robertson, Business Director

Healthwatch
Julie Fitzgerald, Director

Senior Democratic Services Advisor (ESCC)
Giles Rossington

1. APOLOGIES FOR ABSENCE

1.1. Apologies for absence were received from Councillor Angharad Davies (substitute Councillor Peter Pragnell).

1.2. **Councillor Michael Ensor:** there have been several changes to the Committee's membership following the annual council meetings of East Sussex County Council (ESCC) and the district and borough councils, although so far only two of the five district and borough councils have held their annual council meetings and so confirmed their HOSC representative.

1.3. We warmly welcomes the following new members:

- Councillor Angharad Davies as an ESCC member (replacing Councillor Peter Pragnell);
- Councillor Sam Adeniji as the Lewes District Council representative (replacing Councillor Jackie Harrison-Hicks);
- Councillor Bridget George as the Rother District Council representative designate until formal confirmation at the 27 May 2015 Rother Annual Council meeting (replacing Councillor Angharad Davies);
- The yet to be confirmed Wealden District Council member, who will be confirmed after 27 May 2015 Wealden Annual Council meeting.

1.4. We warmly welcome the continued membership of:

- Councillor Sue Beaney as the Hastings Borough Council representative;
- Councillor John Ungar as the representative designate of Eastbourne Borough Council until formal confirmation at the 27 May 2015 Annual Council meeting.

1.5. We warmly welcome the new HOSC support officer, Giles Rossington.

2. DISCLOSURES OF INTERESTS

2.1. There were none.

3. EAST SUSSEX HEALTHCARE NHS TRUST (ESHT): CARE QUALITY COMMISSION (CQC) QUALITY REPORT

3.1. The Committee considered a report of the Assistant Chief Executive that recommended it consider and comment on the Care Quality Commission (CQC) Quality Report on services provided by East Sussex Healthcare NHS Trust (ESHT).

3.2. **Councillor Michael Ensor:** The CQC report was published on 27 March but – because of the pre-election period – this is the earliest opportunity HOSC has had to meet to discuss and consider the report and its implications.

3.3. The CQC has carried out a follow up inspection of ESHT, but the report has not yet been published and so cannot be discussed at this meeting.

Evidence from the Care Quality Commission (CQC)

3.4. **Tim Cooper:** The Care Quality Commission (CQC) has made a pledge to inspect every acute trust by the end of the 2015/16 financial year. We inspected ESHT (in September 2014) as the inspection regime prioritises high risk trusts, and the Trust was setting off some of our risk triggers.

3.5. We had a team of 52 people for the inspection of ESHT. The Chair of the inspection was a senior doctor from a high profile London hospital who had been their Medical Director for many years and had a high international standing.

3.6. The CQC admits that it got the timing of the inspection process wrong. Due to unforeseen circumstances within the inspection team, and some of our internal processes, the sending of our draft report to ESHT (for checking and factual accuracy) was delayed significantly.

3.7. We met ESHT after it had added comments into the draft report regarding its factual accuracy. The meeting involved senior CQC inspectors and the Trust's Board and was convened to help understand some of the positions we might have misrepresented.

3.8. Some people are concerned that we did not hold a Quality Summit. We took this difficult decision at the very highest level of the organisation because – due to the delay in the submission of the draft report to ESHT – we had decided to carry out an unannounced inspection to update our position on the Trust. This meant that holding a Quality Summit the day before returning to inspect the Trust would not have been helpful.

3.9. Instead of a Quality Summit, The CQC held a meeting with ESHT on 23 March 2015 to discuss their action plan and then began a two-day follow up inspection the next day. The CQC report on the September 2014 inspection was published on the 27 March.

3.10. The CQC recognises that the publication of the report came at the very beginning of purdah, but we felt that the risk of publishing it then was outweighed by the risk of not publishing, for 8-10 weeks, a completed report that contained important information. Nevertheless, the CQC extends its apologies to those who were inconvenienced by the timing of the release of the report.

3.11. There are a number of headlines that can be extracted from the CQC report under each of the five key domains on which the CQC reports: safe, effective, caring, responsive, and well led.

3.12. **Are services safe? –** The CQC saw:

- Significant challenges in incident reporting in surgery due to insufficient staff; staff shortages had resulted in staff prioritising caring for patients over incident reporting.
- Challenges with incident reporting in outpatients and maternity.
- Agency staff – which ESHT relied on in a number of areas – did not have as much access to the incident reporting system as substantive staff. This meant that low or zero harm incidents –which help the Trust develop a learning culture – did not get reported.

- Challenges in maternity and surgery in infection prevention control, particularly around hand washing. Some staff were not following the Trust's policies, including fairly senior members of staff who should have been role models for behaviour.

- Mandatory training was below target, meaning that staff were not maintaining their competencies and skills in key and important areas.

- The condition of patients' medical records was poor and access to them was difficult as they were stored off site. This meant that we saw clinics where patients had only temporary notes that did not contain a patient's full medical record. As this happened so often, it had become normalised and accepted as standard practice in the Trust.

- Poor storage of confidential information that could have made it accessible to members of the public.

3.13. **Are services effective?** – the CQC saw:

- The Trust's own audit showed that 239 policies were out of date, demonstrating that ESHT was not on top of the process of keeping its policies up to date.

- The Summary Hospital Mortality Indicator (SHMI) – the measure of the number of people who die against those who should – was high before we visited and was one of the indicators that triggered our inspection.

- There was a large back log of patients waiting to be seen in a number of services, particularly ophthalmology, meaning that patients did not get treatment on time.

- Vulnerable patients requiring specific considerations under the Mental Capacity Act and Deprivation of Liberty Safeguards were identified by the Trust and well cared for.

3.14. **Are services caring?** – the CQC saw:

- Staff were caring for patients both collectively and individually, and patients reported to us that they were being involved in their care.

3.15. **Are services responsive?** – the CQC saw:

- Challenges around the outpatient redesign, which had been reconfigured in the weeks leading up to our visit. The outpatient reconfiguration had been really badly undertaken and significant tasks that should have been completed in the outpatient redesign had been missed. This resulted in long queues at the outpatient desk; patients getting lost for several hours in the building and being unsure where they were meant to be going; and clinicians unaware that patients were trying to find them.

- There was a higher than expected amount of anxiety from the public and members of staff about sharing their experiences of ESHT. We always have a number of people who want to come and tell us their story and we listen intently to them and take necessary action. During this inspection, many more people wanted to tell us their stories anonymously than we would usually expect. The lengths with which people went to protect their identity before talking to us caused us a significant amount of concern.

- There was a higher than average number of complaints, although the rate of complaints is now falling.

- ESHT's internal audit team described the reconfiguration of services as a sound and robust process and recommended it as good practice. We were concerned about the

anxiety the public expressed towards the reconfiguration and its potential impact on the services that they used.

3.16. **Are services well led?** – the CQC saw:

- A very poor relationship between the Trust Board and staff in the organisation. There was a significant amount of distrust and staff were concerned about their voice being heard.

- A poor understanding of governance and the governance processes from some staff, such as the process by which lessons are learned from incidents.

- Limited assurance of the effectiveness of some quality, risk and governance committees and whether that was impacting on improving care.

- A poor culture across the organisation. When we say "understanding the vision of the organisation", we don't expect all staff to be able to chant the Trust's mantra or recite its policies, but we do expect to staff to see and believe in their individual role in making the Trust a stronger and better place; we felt that this was missing in this organisation.

- A higher than expected number of whistleblowers.

3.17. When we met with the Trust management before our unannounced visit they spoke about making significant progress in some of the areas that I have talked about.

3.18. **Councillor Michael Ensor:** The report highlights areas that are rated 'good'. A week ago I attended the staff award ceremony where a number of key staff had citations of excellence. Therefore, I would wish to continue recognising that staff are working incredibly hard and providing a caring service to the public.

3.19. **Councillor Bob Standley:** It is unfortunate that the report took so long, but you have explained why that was. At the moment we have a damning first CQC report, but how and when will the second CQC inspection in March be reported?

3.20. **Tim Cooper:** The CQC report for the March visit has been written. The report will go through the National Quality Assurance Group (NQAG) process from 4 June. NQAG's role is to ensure that the CQC is consistent in its inspection process across the country. Following the NQAG process, we expect to send the report to ESHT a week later and provide the Trust with 10 days to check its factual accuracy. Our expectation is that a Quality Summit will be held in early July and the report will be published around 3-4 days later. Quality Summits are widely attended by all stakeholders and their purpose is to provide the collective health economy with the opportunity to consider how it will tackle the challenges in the report.

3.21. **Councillor Bob Standley:** When you say that ESHT is facing "challenges", are they not just caused by poor management, particularly from the top? Is poor management something you often find when you do inspections or is ESHT's management worse than normal?

3.22. **Tim Cooper:** An overall rating of 'inadequate' is amongst the lowest ratings that we can give. We rated ESHT 'inadequate' overall and for the 'safe' and 'well-led' domains; this demonstrates the level of concern that we have for the Trust. However, the CQC's role is to provide an accurate diagnosis of the challenges a trust faces. It is for the Trust Development Authority (TDA) to decide whether these challenges are fixable. This is in part because the CQC has to return to the organisations it inspects to see if they have

progressed; if the CQC was involved in helping to deliver the solutions it would highly compromise its ability to evaluate whether the organisation had improved.

3.23. **Julie Eason:** HOSC was told by the CQC two years ago – following its last inspection of ESHT – that the Trust faced systemic problems and was failing in all domains against which it had been rated. It is good to know that the Trust is now rated as 'good' against the 'caring' domain, and this is a testament to the staff working in the Trust. However, the Trust is still failing in most domains, despite action plans put in place following the last inspection. Given that the leadership was rated 'inadequate' and it appears that the issues the Trust faces are systemic, do you feel that there is the capacity in the organisation to turn things round?

3.24. **Tim Cooper:** The CQC as an organisation compared to two years ago is different, having completely revised its model for inspection. That is not to say that there are not parallels between the two inspections, but I would caution against making direct comparisons, because under the previous inspection methodology the CQC either passed or failed an organisation against each domain. Our inspections are now more in-depth and comprehensive and, I think, get to the bottom of some of the real issues.

3.25. The CQC has made comments in the report about management capacity and the Trust's organisational capacity to achieve improvement. Whether you, or the TDA, feel there is sufficient capacity is not for the CQC to say, but we have certainly recognised the gap in what needs to be done and the capacity in the Trust to achieve it.

3.26. **Councillor Ruth O'Keeffe:** Given the amount of concerns that staff appear to have had about coming forward to the CQC, do you think that there are other members of staff who did not come forward?

3.27. **Tim Cooper:** It would be very difficult for me to say that all members of staff who had concerns raised them with us, but there will be some members of staff with concerns who did not come forward – particularly given the desire that those staff who did come forward had to protect their identity. However, the CQC has a sufficient sample size of staff necessary to form a clear picture of the breadth of issues and to reflect the overall feelings of staff.

3.28. The CQC did everything it could to ensure that staff came forward. We gave staff significant opportunities to meet with us; we agreed to meet staff privately offsite if they were nervous about coming forward on hospital grounds; and we also asked the Trust – as we do all for all our inspections – to send out an email to all staff containing a confidential number that they could call us on.

3.29. **Councillor Alan Shuttleworth:** In light of what we have seen and read about the inadequacies at the senior level of leadership (the Chief Executive and the Chairman) including, the lack of vision; the loss of trust between the Board and staff; all the concerns about alleged bullying and other allegations; is it conceivable that the current leadership could turn around the situation?

3.30. **Tim Cooper:** I do not think it is fair for me to comment on whether the leadership is capable of making the necessary changes. The CQC has been accurate in what it has included in the report; it is for others to decide whether the leadership of the organisation is able to take the necessary steps or not. The CQC is absolutely clear that its only role after completing its report is to recommend to the TDA whether or not it thinks that special measures are appropriate. The Chief Inspector of Hospitals, who will make recommendations to the TDA, is waiting for the outcome of the second report before doing so.

3.31. **Julie Eason:** HOSC's role is to challenge and scrutinise the health service and hold it to account. The response from ESHT's senior management to HOSC during previous committee meetings has left me feeling bullied, despite the Committee having the authority to challenge; I can only imagine how staff must feel working for the Trust. Could you give us examples of some of the things that came to light relating to the culture of bullying?

3.32. **Tim Cooper:** I cannot relate any examples off the top of my head, but they are included in the report, and I think that there are a number of people who felt pressured not to raise concerns. We are committed to retaining the anonymity of the whistleblowers who came forward, so it would not be appropriate to refer to individual cases.

3.33. **Councillor John Ungar:** I, like many others, have read this report with horror and shock, but not surprise. This is because, as a HOSC member, I have been concerned about the issues the CQC has raised for a number of years. Thank you for bringing them to light with an evidence base.

3.34. Information is essential for clinical staff to make informed decisions. Did you come across any evidence that poorly maintained medical records were making it difficult for clinicians to diagnose and treat patients?

3.35. **Tim Cooper:** It is fair to say that there was a culture of acceptance in the Trust of the state of the temporary medical records. It is very difficult to make a parallel to individual cases, but the assumption that many of the clinicians working for the CQC made was that if you do not have all of the information on a patient in front of you, it has the potential to impact on the decision that you make.

3.36. I know that the Trust has given some thought and taken some actions regarding what they will do about the way they handle medical records, but at the time of our inspection in September 2014 it was both the quality of the medical records (many were bursting at the seams) and the ease of getting them to the site that was the issue. These problems can be solved, indeed we brought them to the attention of the Trust and within 48 hours some action had been taken. Equally it is fair to say that when you normalise a process that people know is not right, they are put in a difficult position when they try to correct the problem.

3.37. **Councillor Sam Adeniji:** What are the criteria for putting a trust into special measures? If ESHT has made some improvements by the time of the second report and moved from 'inadequate' to 'requires improvement' will the Trust no longer fall into special measures?

3.38. **Tim Cooper:** It is not the role of the CQC to put a trust into special measures, although we may recommend to the TDA that they are. The main trigger for special measures is an 'inadequate' rating in the 'well-led' domain, but the decision is also based on the reasons why a trust's leadership was rated 'inadequate'; the capacity of the trust to move out of special measures quickly; and the challenges that the trust faces.

3.39. Special measures are often viewed by trusts as a badge of shame, but it is a process that is designed to be supportive of trusts that are trying, and struggling, to move out of difficulties. The package of support behind the special measures is designed to help trusts get beyond their current problems and move forwards.

3.40. When the July report is released, the Chief Inspector of Hospitals will make a recommendation to the TDA, but the TDA will take the decision about whether or not to go ahead with special measures.

3.41. **Councillor Frank Carstairs:** The CQC said in its report that the reconfiguration of maternity and paediatric services "has led some of the public to lose confidence that this

service reconfiguration meets their needs. A much higher than expected attended the listening event and contacted us with their concern". In your opinion, were their concerns justified or were they missing the benefits of the reconfiguration?

3.42. **Tim Cooper:** The CQC's role is not to comment on a reconfiguration; that is a democratic decision taken by commissioners in consultation with the local HOSC. The CQC's role is to comment on the services as we see them, we would not comment on whether the reconfiguration was the right decision or not.

3.43. What we do comment on is how services meet the publics' individual needs. Therefore, we would comment on the impact of, rather than the reasons for, the reconfiguration. For example, whether the reasons for a reconfiguration have been widely understood by the public, and whether the way that the reconfiguration has been enacted has left people feeling vulnerable, uncertain, or disengaged form the process.

3.44. The CQC is not commenting on whether the reconfiguration is to the benefit of members of the public, it is commenting on the member of the public's concerns that their questions were not answered and they did not feel engaged during the decision to carry out the reconfiguration. The CQC's concern is that people feel disengaged from the reconfiguration, not that the NHS is embarking on a reconfiguration.

3.45. **Councillor Peter Pragnell:** The CQC report notes that patients' records were not securely stored. Did anything that the CQC saw lead you to believe that the provisions of the Data Protection Act 1998 had been breached?

3.46. **Tim Cooper:** We are absolutely clear of the need to keep medical records confidential. There is a difference between medical records being left out in the open where anyone can see them and medical records being left in a room that is unlocked and unsecured that people could access. The litmus test for whether the Data Protection Act has been breached is whether unauthorised people can access the records easily or not. Certainly, in terms of forming our judgement on our enforcement action – which we are working through at the moment – we are taking due account of all of those issues. I am not sure until we have finished this process, but it is possible that the Data Protection Act was breached.

3.47. **Jennifer Twist:** In my experience working in the voluntary sector, because of the culture at ESHT, patients and carers have had difficulties raising complaints as they are fearful of the impact on the quality of care that they would experience afterwards. Do you feel that this might have had an influence on how many patients came forward to speak with you?

3.48. **Tim Cooper:** This is not the first health economy that has had a reconfiguration that has caused significant anxiety in the community, and is not the first where we have come across community interest groups and save hospital groups that are interested in a particular area. However, the strength of feeling in the community and influence of those interest groups is greater than we expected. This may well be because the population is well organised, has a very clear voice and wants to use it.

3.49. **Councillor Michael Ensor:** We are the health overview and scrutiny committee of the NHS and our role is to observe and scrutinise the NHS from arm's length. We have called for enquiries into a number of aspects of the health service in East Sussex, including acute and community healthcare. We are grateful that the CQC has carried out this "deep dive" into the healthcare system that we have not been able to do due to the nature of our role. Should we have known about these issues before hand, and if not us, who in the NHS should have known?

3.50. **Tim Cooper:** Our new comprehensive inspection process means that we uncover challenges other people have not uncovered. My view is that without repeating the exercise we have done, you would not have achieved this level of detail. However, judging by the views of some HOSC members and looking at the situation retrospectively, the Committee had misgivings about ESHT; so there may have been processes that could have brought those misgivings to light.

3.51. **Councillor Michael Ensor:** HOSC will reflect on its own internal processes and how it conducts its scrutiny role in light of this report. Whatever the outcome, HOSC will be more challenging in its scrutiny of the NHS going forward.

3.52. HOSC is thankful for the CQC report and is looking forward to hearing details about the date of the Quality Summit.

Evidence from East Sussex Healthcare NHS Trust (ESHT)

3.53. **Darren Grayson:** I would like to thank Tim Cooper and his colleagues, particularly for his explanation of the process for the first inspection and the reasons for the delay in providing a draft report to ESHT.

3.54. The number of staff in the room today reflects the strength of feeling in the organisation – not just at leadership level but at all levels – about the process that we have been through, and continue to go through, with the CQC.

3.55. The inspection process began with a presentation to the CQC inspection team by me and the entire executive team. The presentation mentioned the vast majority of issues recorded by the CQC, including those around the perception of bullying and medical record keeping. The one area we were not well prepared on was around medicine management (pharmacy services). The presentation also included what the ESHT leadership team throughout the organisation was doing to address those issues.

3.56. This organisation has a track record of facing up to its issues – whether it was maternity, surgery, orthopaedics, or stroke services – and tackling them.

3.57. The inspection that the CQC did of the Trust in 2010/11 – the most recent inspection prior to September 2014 – resulted in the serving of several enforcement notices and warning notices. The Trust then went through a process of improving the quality of the services it provided that was to the CQC's satisfaction, and more importantly, to the Trust itself. ESHT was inspected eleven times between 2011 and the inspection in September 2014, none of which identified any issues of concern.

3.58. The Trust has a reputation of being honest about its issues, including the perception of a bullying culture – which it has acknowledged and is tackling. The Trust has discussed the perception of bullying at Board level and – most likely – at HOSC more than once, and it is highlighted in the annual staff survey.

3.59. We acknowledge that there is a long way to go, but these are not new issues faced by ESHT. The Trust has faced these issues for many years and some may even date back to previous organisations.

3.60. The CQC raised with us the issue that whistleblowers had come forward during the inspection. They were investigated and their allegations found to be unfounded to the CQC's satisfaction during the inspection.

3.61. Our Quality Improvement Plan (QIP) is led by the doctors, nurses, midwives and others who deliver the services on a day-to-day basis. It would be fair to say that there is a considerable amount of disappointment, anguish, disbelief and anger about the reports,

but we are very clear that our job is to face up to the issues in the report – most of which the Trust already knew about and was working on – and develop plans to tackle the issues and move the Trust on.

3.62. It is perhaps inevitable that there is a focus on the leadership of the Trust, which is fair and to be expected. The Chairman and I, and the rest of the Board, would not want to resile from our accountabilities for the performance of the Trust as a whole. We are absolutely clear that we are on a journey of improvement and have made considerable progress, but there is still a long way to go.

3.63. We have always been honest about these issues and the journey that we are on, both to HOSC and in other forums. We believe that we are taking the right steps; clearly there is a need to focus on making sure that staff, in particular, feel more a part of that journey.

3.64. **Dr Andy Slater:** As a doctor and executive of ESHT, I want to work in an outstanding organisation. ESHT has started a journey to achieve outstanding status, and having now made significant clinical and management changes, I would like to think that the Trust can achieve it.

3.65. A few years ago, the East Sussex Hospitals NHS Trust merged with the community trust to form ESHT; this strategic change was unprecedented for East Sussex. It was initially meant to be a management merger rather than a clinical merger, so since then there have been substantial difficulties creating a coherent service.

3.66. We had, in the past, services that we knew would not meet the demands of a modernising health service, for example, the demands of seven day working and the five year forward plan. The services that we have now are immeasurably more capable of meeting these demands and we are able to see how these services are improving healthcare to our population.

3.67. We underwent a management restructure because we recognised that our existing management structure was not meeting the needs of either our organisation or the population of East Sussex. The restructure took place just prior to the CQC visit – we could have delayed it but we felt that it would have been disingenuous to have done so.

3.68. As an organisation, we recognised that there were areas where we were not performing well. We developed QIPs for these issues that we shared with the CQC prior to their visit.

3.69. We are very grateful to the CQC for highlighting other issues which we were not sighted on, such as pharmacy services (medicine management), and we took steps to remedy these issues during the CQC inspection. When we received the full report, we were able to put together a more coherent plan for remedying these issues that was added to our QIP.

3.70. We have an incredibly dedicated and talented workforce who deliver care, so it would be a shame if the areas rated ‘good’ in the CQC report were not recognised today. I think that it is an incredible tribute to our staff that the care that they deliver was rated ‘good’ and that, within the ‘well led’ domain, it is incredibly heartening that the CQC recognised that management “in the front line” at the ward level works extremely well. We are extending working practices in areas where the management was rated as ‘good’ by the CQC throughout the rest of the organisation.

3.71. It must be recognised that the users of our services are overwhelmingly satisfied with the service that they receive. We have the challenge of communicating actual experiences of patients to the public.

3.72. Our clinical administration review was carried out to ensure that our clinical administration was fit for purpose. However, we made a mistake translating the recommendations of that review to the outpatient service. While it was necessary to implement the recommendations, the way in which it was done was not appropriate; we have taken immediate action to address the issues that the reconfiguration caused.

3.73. We knew that medical record storage was a problem. Many trusts have an electronic solution for patient records, but due to the national failure of the NHS ICT system, we were unable to be in a position where we had electronic records.

3.74. The ability of staff to raise concerns, as highlighted by the CQC, is troubling to me personally and the organisation as a whole. We have very clear policies and procedures about how to raise concerns. As I and other senior officers walk around the organisation we see no difficulty with members of staff raising concerns with us. Where it is possible we will remedy those concerns, and where it is not we will explain why.

3.75. Immediate measures were taken at the time of the CQC inspection to resolve the problems highlighted in pharmacy services.

Councillor Michael Ensor paused the presentation to allow questions from Members.

3.76. **Julie Eason:** HOSC received a report at its last meeting on 26 March (the day before the CQC report) in which we were told everything was improving in maternity and paediatric services and none of the issues in the report were mentioned. Who is responsible for this?

3.77. **Darren Grayson:** Every fact in the report seen by HOSC on 26 March was true and accurate.

3.78. **Julie Eason:** Why was some data for the report to HOSC on 26 March – which was included in earlier reports, and would otherwise have indicated that things were not improving – deliberately not included?

3.79. **Darren Grayson:** I have not seen this information. If it was to be shared with us, we would be glad to compare it to the information that we have been providing. I think that the information we provided last time was accurate and relevant – and the presentation today covering maternity and paediatric services will reflect that.

3.80. **Councillor Ruth O'Keeffe:** Our role as HOSC is to scrutinise the issues and not just commend the achievements of an organisation. You said that you are already working on solutions to the issues highlighted in the CQC report; that the problems were already ingrained over a number of years; and that some of the concerns raised by staff to the CQC were unfounded. Are you comfortable with what seem to be very large problems with the Trust?

3.81. **Darren Grayson:** To clarify, I said that during the inspection some staff raised concerns through the whistleblowing procedure with the CQC. These were investigated by the Trust and found to be unfounded to the CQC's satisfaction. Is that not the case?

3.82. **Tim Cooper (CQC):** A number – but not all – of the whistleblowers who contacted us had made claims that could not be substantiated.

3.83. **Councillor Ruth O'Keeffe:** I am concerned with the sense of ease at which it came across that you knew about the problems identified by the CQC beforehand. I am also concerned that you are saying people had no difficulty raising concerns with senior management, yet many people appear to have been very concerned about raising issues with the CQC. Is it fair to say that ESHT is complacent over the issues it currently faces?

3.84. **Dr Andy Slater:** We absolutely are not complacent about the issues and are enormously concerned that the CQC has identified a group of people within the organisation who feel that they cannot raise concerns. Staff seem happy to raise concerns with senior officers when they are present on the ward as – in my experience – they know it is an avenue for raising concerns. Therefore, we need to ensure that people understand the opportunities and avenues for raising concerns, so that if they do not feel comfortable raising concerns with their line manager, they can raise concerns at a more senior level. We have an independent non-executive director who concerned staff can talk to, as well as other avenues outside of the organisation.

3.85. It is not true that we do not accept the problems facing the Trust. We do have problems, we have recognised that we have those problems, and we have been working towards solutions for them. Solutions to big problems inevitably are more complex and take longer to resolve, for example, medical records. The number of medical records we deal with is enormous and we accept that the necessary investment had not previously been put in place, either in staff to maintain records or facilities in which to keep them. We are now addressing this by securing money for new storage areas and implementing a barcode and radio frequency tag system that will allow us to locate particular notes in a hospital. However, with the millions of notes that we deal with, it takes time to implement these changes.

3.86. **Councillor Michael Wincott:** Staff morale must be incredibly low at the moment. The CQC Report shows that there is good, compassionate care and staff are performing well despite the inadequate staffing levels in some areas. The Director of Nursing is regarded by the CQC very positively, which is good to know.

3.87. Clearly, nursing staff are not the problem; has the Trust Board told the nursing staff that the Trust's 'inadequate' rating it is not their fault? If it is not their fault, whose fault is it? I have been a nurse and I would want the Chief Executive to apologise for the management's failings. The biggest morale boost that Darren Grayson could offer staff is to say "sorry" and offer his resignation.

3.88. **Councillor Sam Adeniji:** The report talks about out-of-date policies, a culture of bullying, ill-conceived or poorly implemented changes, and a lack of clear vision for the organisation. This is not a problem of systems failure but of the management of the organisation – why are the Chief Executive and Chairman not resigning?

3.89. Clearly, there is an issue about staff trusting senior management. To achieve cultural change and to address bullying requires the building of trust, and senior management talking directly to staff is not enough. How do you intend to address bullying without changing management culture?

3.90. What are you doing to improve your relationship with the population that you serve?

3.91. **Councillor Alan Shuttleworth:** There is anger and concern amongst my colleagues, residents and staff. Staff are the lifeblood of the organisation and were rated 'good' by the CQC for the care that they provide. However, the CQC report contains a catalogue of issues around staff relationship with management. What we have seen today is a sense of denial and complacency towards the seriousness of the CQC report and the Trust's endemic problems. I think that the staff are looking to HOSC to address the main issue with the Trust – which I believe is the leadership. The culture of an organisation comes from the leadership, so a successful organisation has to encourage openness and integrity. I echo what my colleagues have already said: if I had seen the report as the leader of ESHT, I would have resigned, and I am surprised you have not done so already.

3.92. **Julie Eason:** It is good to see that Alice Webster is recognised as having the trust of her staff. However, the Chief Executive and Chairman no longer have the trust of this Committee – if they knew the problems were there, they did not tell us. They have not proactively put the issues on the table – the first time I have heard them talk about the bullying culture is this morning. Have the Chief Executive and Chairman tendered their resignations and if not, why not? If they have, why have they not been accepted?

3.93. **Stuart Welling:** The ESHT Board takes the CQC report very seriously – the Board has spent the majority of its time recently considering the CQC report and related issues. The Board is also deeply concerned about the Staff Survey and about any disconnect between the Board and staff. Darren Grayson and I have been trying to address this problem ever since we have been in post. We do not intend to resign. We are determined to continue the job of delivering change at ESHT. Many of the issues identified in the CQC report are operational. However, we do recognise that we need to address the bullying issue and the issue of communications.

3.94. **Darren Grayson:** In response to Julie Eason's point, ESHT brings to HOSC what HOSC asks it to bring: HOSC sets its own work programme and ESHT responds to it – and does so assiduously. Had HOSC asked for the staff survey and how it links to organisational development and bullying/harassment policies, we would have been pleased to bring those to you. If you want us to bring any issue we will bring it – we have never refused to bring an issue.

3.95. We are not in denial – we have tackled issues around maternity, orthopaedics, emergency medicine, stroke, surgery etc. – we have tackled these problems, although much more needs to be done. There have been problems with clinical administration particularly as it relates to outpatients, and we recognise that changes should have been made differently. We are not in denial about this. However we have expertly implemented many massive service changes – this has been recognised by the CQC and independent auditors. I am angry, particularly about the impact of the CQC report on staff who do not recognise their service in what the CQC describes. Clearly, to some extent the CQC is holding up a mirror to the organisation, but I do feel for staff who are upset at the public portrayal of very dedicated workers. In terms of ESHT's 'vision', we were clear with CQC about the financial challenges we face, and about the challenges articulated by the East Sussex Better Together programme, which make the future health landscape very unclear. We are about to set a major deficit budget, along with the majority of acute trusts across England. We have no coherent 5 year vision aligned with that of commissioners – that is plain fact.

3.96. **Councillor Bob Standley:** I am appalled by what I've just heard. ESHT should be coming to HOSC with what the HOSC needs to know, not just providing the HOSC with what it has specifically asked for – the relationship is meant to be that of critical friend

3.97. **Darren Grayson:** That is clearly what I didn't say.

3.98. **Councillor Bob Standley:** That is what I heard and what other members heard.

3.99. **Darren Grayson:** HOSC sets its work programme and ESHT is responsive to that. We provide vast amounts of information in routine reporting – board papers, external reviews etc. But we have taken the HOSC lead in terms of things that the HOSC wishes to look at.

3.100. **Councillor Michael Ensor:** I see where you're heading here. However, your earlier comments succeeded in riling the whole of the HOSC. I can confirm that in the past ESHT has answered questions we have asked, and provided data when we have requested it; but the committee is reacting to your contention that we as lay-people

should always be asking the right questions, and that your duty does not include supporting us to understand issues fully.

3.101. **Councillor Peter Pragnell:** Mr Grayson has said that he's happy to answer any questions, and that the Trust puts lots of information in the public domain; but if HOSC doesn't know about an issue how can we ask about it? Isn't ESHT obliged to tell us about important issues?

3.102. **Councillor Michael Ensor:** We are going round in circles now, and need to progress with the presentation.

Councillor Ensor asked ESHT to resume their presentation.

3.103. **Alice Webster:** ESHT has a comprehensive Quality Improvement Plan (QIP). Part of this is intended to counter any disconnect between 'board and ward' – for example we have executive directors leading key work-streams and these streams are linked in to existing work groups. A key area is incident reporting –for example, temporary workers unable to access systems to raise incidents. We have looked at this and at the data protection issues which impact upon it – part of this work has been completed, including a good deal of staff engagement. We are running a series of open staff forums in May and June for clinical staff and for administrators and support services. We will develop actions following on from this.

3.104. Another key area is around managing the feedback loop – this has come across in a number of different forums and we have been looking at how we feed back to staff when they report incidents – we are now following this up (using IT solutions). We have also looked at our incident-reporting policy and have significantly strengthened training – we have made it clear that if a staff member feels that an incident is important then they need to report it.

3.105. We have also focused on organisational development and communications – there's a work-stream about how we ensure that we know we're responding to incidents rather than assuming that someone else is dealing with them There is also a piece of work around how the organisation communicates, not just vertically but horizontally also – and how we communicate externally. Clearly we haven't been good enough to date and we will change this. We are also developing an ESHT organisational development strategy – this will not sit on a shelf! The strategy will be led from the top, with executive leads for all work-streams.

3.106. In addition, the Trust has a good track record around working with Healthwatch and will continue work to improve our learning from informal as well as formal complaints.

3.107. **Jenny Crowe:** Staff morale dipped after publication of the CQC report, but we are not in the same place now as we were in September when the CQC inspected. In September, the service had only recently completed its reconfiguration and was very much focused on managing this process. The service is very caring and we are determined to improve – and have made some changes already, reflecting on staff and user feedback – e.g. allowing partners to stay overnight when women being induced etc. We have also developed a range of services to support quality e.g. new-born hearing screening. Also, more maternity staff can now provide new born physical examinations enabling timely discharge even when paediatricians are not available. Communication is an issue – we now communicate monthly with all staff and walk the floor along with other senior managers. We are developing our maternity vision: ESHT intends to be both the provider and employer of choice, and we are already seeing staff returning to ESHT – this is a positive sign. In terms of midwifery we are fortunate to have two Midwife-led Units and a good home-birth service – we are working to ensure that women can easily access

information on these services and we intend to host user feedback on our services (via our new Facebook page). We work very closely with the Maternity Liaison Service.

3.108. There have been challenges – we have had vacancies to recruit to, and some issues with long term sick and maternity absences. We are looking at different ways of managing recruitment and staffing – NICE doesn't currently have a toolkit to allow trusts to use its latest guidance for staff planning. We are looking to flexibly recruit over our establishment staffing level to ease temporary sickness/maternity leave issues and will interview a number of staff next week. We have also launched a 'return to practice programme' for returning midwives to encourage back staff who previously worked at the trust.

3.109. **Nicky Roberts:** Since the reconfiguration we have 72 hours of consultant cover on the maternity ward per week. This is a significant advance on the previous position (40 hours). We also currently have a full complement of junior and middle-grade doctors and will shortly recruit to new consultant post. We are well-staffed and providing a safe level of obstetrics.

3.110. In response to Julie Eason's point on HIE: in terms of Serious Incidents (SIs), in the year prior to reconfiguration (Year to May 13) 22 SI; in the year following reconfiguration (May 13-April 14) 10 SI; and 7 in the subsequent year (May 14-April 15). There have been 2 SI since Jan 15, one of which was HIE. The HIE rate will never be 0%, but we have seen a significant reduction in HIE cases since reconfiguration, which is a measure of improved safety.

3.111. **Darren Grayson:** I want to keep on this point because Julie Eason earlier accused me of lying.

3.112. **Julie Eason:** (reads out from an anonymous letter sent to HOSC which describes an ESHT internal meeting post the CQC report: senior managers stated to staff that they believed the CQC report to be procedurally flawed and to give an inaccurate picture of services. However, staff disagreed, arguing that the report was largely accurate.) Is this what happened at the meeting?

3.113. **Jenny Crowe:** We've had a number of staff meetings about the CQC report – not sure which meeting is referred to here. Managers did raise concerns about the way CQC carried out inspections and did raise concerns about findings where we thought that the challenge was not of our recognition. This isn't necessarily to say that the CQC were incorrect, but that we didn't recognise the situation they described.

3.114. **Councillor Michael Ensor**: I want to halt this line of questioning for the moment.

3.115. **Julie Eason:** I'm happy to circulate the anonymous letter and have ESHT come back and respond later.

3.116. **Councillor Ruth O'Keefe:** I want to quote from the CQC report: "the Trust must review the impact of the maternity reconfiguration"; and "the NHS staff survey showed three areas where the Trust was rated worse than expected: one of these was staff who thought that the incident reporting procedure was fair and effective". Also, "staff in maternity were not using the appropriate processes for recording incidents and not appropriately escalating actions." It is on record that I have previously questioned the improvement of maternity services because I haven't seen a significant improvement in the data, particularly given that there have been fewer people using services post-reconfiguration so the rates might actually have been said to have gone up rather than down. I now find the CQC are saying this needs to be reviewed. I now have no confidence in the previous assurances to the HOSC.

3.117. **Jenny Crowe:** The difficulty here is talking about incidents rather than serious incidents – incidents include near misses etc. – events which ought to be reported, but which haven't necessarily impact upon care. A serious incident has very clear guidance about reporting. We do report incidents, but can always improve this and work with staff is ongoing here, particularly in terms of using IT solutions and improving the staff feedback loop. We can do better: we're not perfect, and the general level of incident report does need to be raised, but I can say with confidence that our serious incident reporting is functioning well.

3.118. **Councillor Ruth O'Keefe:** I remain very concerned – the Trust must review the impact of its maternity reconfiguration. I am sceptical about the data used to justify improvement in maternity services.

3.119. **Councillor Michael Ensor:** this meeting is not focused on maternity reconfiguration – we do need to return to this and potentially ask different questions and consider new metrics. Let's re-focus on the CQC report.

3.120. **Cllr Alan Shuttleworth**: I want to focus on the issue of trust – my recollection of maternity reconfiguration scrutiny was that we spoke a lot about incidents and raised just the kind of issues highlighted by the CQC. Given that the CQC has found poor levels of incident-reporting and the potential for this to mean that the trust is not learning from mistakes, I feel that we were given selective information by ESHT – we need to review the impact of maternity reconfiguration.

3.121. **Councillor Michael Ensor**: I now want to move on through the presentation and then bring the Clinical Commissioning Groups (CCGs) and the Trust Development Authority (TDA) in.

3.122. **Imelda Donnellan**: The CQC critiques surgery not just in terms surgical specialities but also in terms of theatre staff, anaesthetic staff, room environments and so on: the entirety of the service across all sites that deliver surgery. We were assessed shortly after the reconfiguration of services: this needs to be born in mind. When inspected we hadn't regained equilibrium following the reconfiguration – some staff were unsettled and some line-management arrangements had not bedded-in.

3.123. The rationale for reconfiguration was to provide a seven day consultant-delivered service and increased consultant anaesthetist presence. CQC didn't mention this major achievement. However a CQC inspection is the ultimate peer review – we do take it really seriously, even though the process was disappointing and demoralising for staff. Clinical leaders have got to pick staff up and work on morale – we have held a number of meetings to try and address this issue.

3.124. How safe are we? We have to look at objective criteria. I am pleased that the CQC acknowledges the time gap between inspection and the publication of the report: it's difficult for staff when there isn't early feedback from the inspection, although we have nonetheless continued to develop services. I won't talk about incident reporting because others have done so and planning is very robust here. The key for me is feeding-back to staff on incident-reporting – this did need bolstering and is now picked up in clinical governance meetings alongside infection control reporting, safeguarding, mental capacity etc. We are looking to introduce a Vital pack system to help pick up the deterioration of patients also. The CQC report highlighted mortality and morbidity reporting – it is important to note that ESHT was aware of this and had a plan already. I hope that this will be referred to in the forthcoming CQC report; it wasn't mentioned in the initial report. Surgery is now well on track in regard to these measures. We also consider and review deaths in low-risk groups, look at quality performance (returns to theatre, complications, complaints etc.) and are up to date with NICE guidance.

3.125. In terms of staffing, we had budgeted for a full establishment of staff, but lacked staff with specialist skills to fill vacant posts, despite an active recruitment programme. Our recruitment drive is now working, particularly in terms of looking outside the South East region. This is a nationwide problem, with no easy solution - going out to Europe or further afield poses its own problems.

3.126. Have changes improved things? The seven day consultant presence has had an impact. Performing operations Out of Hours is typically an indicator of problems (sepsis, haemorrhaging etc.) and should be minimised. I am pleased to say that Out of Hours operations have reduced by 40% following reconfiguration. This means that operations are happening when they should do. When Out of Hours working is required there is now much higher consultant presence. We now have a year's data for high-risk operations: for 229 patients operated on there were 14 predicted deaths due to high risk, but only 4 in fact died. This makes the trust an outlier for good performance – at odds with the CQC findings.

Evidence from the Clinical Commissioning Groups (CCGs), Trust Development Authority (TDA) and Healthwatch East Sussex

3.127. **Councillor Michael Ensor:** we're all very aware of the trust action plan and I don't want to explore it in detail now. I would like to ask the CCGs to comment now. My first question is whether the CQC report findings were news to the CCGs, and secondly what the role of the CCGs is in monitoring the action plan?

3.128. **Jessica Britton:** Just a comment on maternity: it is clear from the reports that the evidence from the CQC inspection further underlines our decision regarding the risks around recruitment and retention of key staff groups. We were always absolutely clear and transparent in our engagement and consultation, and no stone was left unturned in finding the best solution we could for the safest services. HOSC scrutinised this fully throughout the process and since, the data post reconfiguration, particularly in relation to Serious Incidents does indicate that the new configuration is safer.

3.129. CCGs are very much part of one NHS and all parts of the NHS look to commissioning and providing the best and safest services for our population. We know it's vitally important that our local population has confidence in our local services. Our job as CCGs is to commission services that best meet the needs of our population. We do this through Service Level Agreements. We commission activity, and quality, access and safety standards, it is then the provider organisation's job to determine how they organise the daily operational delivery of these services, and this is what the CQC inspected. We were disappointed with the timing of the CQC report publication and the lack of a Quality Summit and therefore welcome the suggestion that CCGs might co-chair, or certainly have greater involvement in, the Quality Summit for the next report when it takes place. Our focus going forward will be on working with all relevant stakeholders to ensure the necessary improvements are made, to monitor the action plan and provide the necessary assurance.

Dr David Roche: CCGs look at a good deal of ESHT data, but not at the CQC's level of detail – we will be able to use the CQC's data to inform future monitoring.

3.130. **Councillor Michael Ensor:** Thank you for this – we will need to revisit whole issue of monitoring. Now for the TDA: what is your role, particularly in terms of monitoring?

3.131. **Judy Blumgardt:** The TDA supports NHS trusts to deliver improvement. We help trusts prepare for the CQC inspection and ensure that staff are supported throughout the inspection process. We also support trusts to understand and respond to their CQC

report via an Quality Improvement Plan (QIP). We have an oversight model in place – we will meet regularly with ESHT to ensure it meets QIP demands and provide additional support as and when needed. Lots of additional support has already been provided. It is clearly important that the QIP actually addresses the CQC report findings. The TDA looks at the performance and delivery of QIP, and also looks at quality. The TDA will ensure that all stakeholders are part of process of monitoring the QIP. We have already held a board to board meeting with ESHT, where the TDA board scrutinised ESHT's capacity to deliver change. We can put additional support in place if required – we are awaiting the findings of the 2nd CQC report for this, and this support offer will be discussed at the Quality Summit.

3.132. **Councillor Michael Ensor:** Healthwatch is an important player here – what is their perspective?

3.133. **Julie Fitzgerald:** We had strong public engagement prior to the inspection, but then entered a longer than anticipated period post-inspection where we couldn't feedback to the public about the inspection process. Adding to the problems, the Quality Summit did not take place, and then the report was published on the eve of election purdah. Again this meant it was not possible to engage properly with the public and Healthwatch regrets it was unable to discharge its responsibilities fully. The CQC is aware of and recognises our concerns here.

3.134. We have recently met with ESHT Chief Executive and Director of Nursing to discuss how to improve ESHT public engagement and communication, particularly around capturing intelligence below formal complaint level. New Healthwatch systems will also capture valuable intelligence. We will also engage with internal ESHT meetings and feedback to the public – we have been doing this over past 18 months, although things haven't hasn't been as much in public as we have liked.

3.135. It is important that there is engagement with the Voluntary & Community sector, with the sector viewed as an asset in terms of engagement. We would also like to see regular discussions between senior ESHT managers and the public.

3.136. **Councillor Michael Ensor:** There is now an opportunity for more questions and to plan how HOSC will monitor this issue going forward. In the first place I propose that we have a special HOSC following the Quality Summit.

3.137. **Councillor John Ungar:** The CCGs commission services and monitor outcomes. Did you pick up high mortality/morbidity rates? And if so did you address this issue? Are you happy with the QIP?

3.138. **Jessica Britton:** CCGs do review, measure and report on mortality and morbidity – this has never been a major outlier (and does vary over time: snapshots don't give the full picture).

3.139. **Alison Cannon:** The CCG has a well-established and robust quality assurance **process**. The CCG meets monthly with the Trust to seek assurance on quality measures and scrutinises all aspects of data from a wide variety of sources for example, data the Trust provides, CQC intelligent monitoring data, staff and patient feedback and surveys, this information is formally reported to our governing bodies. The CCG uses this data to effectively triangulate areas of concern and seeks assurance from the Trust as to how this is being addressed to ensure patient safety and quality. Moving forward the CCG will be strengthening this process by reviewing quality in daily operations. This will be achieved by visiting areas of the Trust using observation, gathering patient and staff feedback to further enhance our existing knowledge of the quality of services provided to patients.

3.140. **Wendy Carberry:** The QIP does focus on the right priorities. We are currently discussing CCG involvement in monitoring this with both the CQC and the TDA.

3.141. **Alice Webster:** It should be noted that QIP formula was agreed at the outset with CCGs and the TDA. It is not something that ESHT has undertaken without consultation.

3.142. **Councillor Bob Standley:** I would like to propose a motion: " that East Sussex HOSC expresses great concern at the findings of the CQC inspection, has limited confidence in the Chair and Chief Executive of the Trust, calls on ESHT to implement the improvement plan as a matter of urgency, and expects ESHT to give regular updates to ensure HOSC members are fully informed of the progress of that improvement plan."

3.143. **Cllr Frank Carstairs:** I second the motion.

3.144. **Julie Eason:** I propose we substitute the word "limited" for "no".

3.145. There was general agreement to this.

3.146. **Councillor Michael Wincott:** I had a similar motion and would like to state that I have absolutely no confidence in the Chair or CE of ESHT.

3.147. **Councillor Peter Pragnell:** I was shocked when I read the CQC report. I would expect the people at the top of an organisation to carry the can for this level of performance. It is unfortunate that the ESHT Chair has left the meeting – because I fail to understand why he and the Chief Executive have not already resigned. I remain convinced at the case of reconfiguration, but I am appalled by this report and am stunned that the leadership has not already resigned.

3.148. **Councillor John Ungar:** HOSC should also acknowledge the good work of hospital staff.

3.149. **Councillor Ruth O'Keefe:** I suggest that we add to Cllr Standley's motion: "whilst recognising the caring qualities of the staff."

3.150. **Councillor Bob Standley:** My motion now reads: "whilst recognising the caring qualities of the staff, that East Sussex HOSC expresses great concern at the findings of the CQC inspection, has no confidence in the Chair and Chief Executive of the Trust, calls on ESHT to implement the improvement plan as a matter of urgency, and expects ESHT to give regular updates to ensure HOSC members are fully informed of the progress of that improvement plan."

3.151. **Councillor Sam Adeniji:** to the CCGs – what happens if a SLA with ESHT isn't met?

3.152. **Wendy Carberry:** There are levers within the contract and we would negotiate to get back on track (e.g. for 18 week performance target).

3.153. **Councillor Ruth O'Keefe:** I wanted a recorded vote, but not all District Council representatives have yet been appointed so I've been advised not to ask for this.

RESOLVED – that the motion be unanimously agreed.

3.154. **Councillor Michael Ensor:** In conclusion, I would like to have a sub-committee to look at the QIP and identify where we want to deep-dive – will then report this back to the16 June HOSC meeting. We will also add a special meeting at end of July. I would like to thank all the NHS organisations who have attended and also members of the public.

The Chairman declared the meeting closed at 1.22 pm

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 16 June 2015.

PRESENT Councillors Michael Ensor (Chair), Ruth O'Keeffe (Vice Chair), Frank Carstairs, Angharad Davies, Alan Shuttleworth, Michael Wincott, Sam Adeniji (District & Borough Councillor), Pam Doodes (District & Borough Councillor), Bridget George (District & Borough Councillor), John Ungar (District & Borough Councillor), Julie Eason, Jennifer Twist and Peter Pragnell

ALSO PRESENT:

Amanda Philpott, Chief Officer, Hastings & Rother CCG
Ashley Scarf, Director of Strategy, High Weald, Lewes & Havens CCG
Wendy Carberry, Accountable Officer, High Weald, Lewes & Havens CCG
Neil Waterhouse, Service Director East Sussex, Sussex Partnership NHS Foundation Trust

4. MINUTES OF THE MEETING HELD ON 26 MARCH 2015

4.1 The minutes of the meeting of the meeting of 26 March 2015 were agreed as an accurate record.

5. APOLOGIES FOR ABSENCE

5.1 Cllr Peter Pragnell substituted for Cllr Bob Standley, and Cllr Kim Forward substituted for Cllr Sue Beaney.

6. DISCLOSURES OF INTERESTS

6.1 There were none.

7. URGENT ITEMS

7.1 There were none.

8. EAST SUSSEX HOSPITAL TRUST (ESHT) CARE QUALITY COMMISSION (CQC) REPORT: REPORT BACK FROM WORKING GROUP

8.1 Members considered a report from a HOSC working group which recommended the establishment of a Scrutiny Review Board to scrutinise the East Sussex Healthcare Trust (ESHT) CQC reports and the trust's subsequent implementation of its Quality Improvement Plan.

8.2 The Chair told members that he had purposely not invited ESHT to this meeting as there was no new news of the CQC process; and the item being considered, although relating to the scrutiny of ESHT, did not require ESHT's active participation at this point.

8.3 The Chair informed the committee that the CQC was anticipating holding a Quality Summit in the week commencing July 13. The second inspection report would be published shortly after the Quality Summit. The Chair proposed reserving July 23 for a special meeting to consider the second CQC report, should the report be published on time. Cllr Ensor also stressed his eagerness that future scrutiny of this issue is undertaken in co-operation with Healthwatch and with East Sussex CCGs, suggesting that HOSC members might consider signing-up as Healthwatch members.

8.4 Julie Eason commented that she was frustrated that the Chair and Chief Executive of ESHT remained in post and that it was not possible for local stakeholders, including the HOSC, the county council, or district and borough councils, to influence this situation. She wanted it recorded that there was consensus amongst HOSC members that the ESHT Chief Executive and Chair should stand down, but that HOSC had no powers to enforce this.

8.5 The Chair responded that, in his view, it was a better for the HOSC to wait until the publication of the second CQC report before making further comments on the management of ESHT. The intention was that the ESHT Chair and Chief Executive would be invited to attend the special HOSC meeting on 23 July, should this meeting go ahead as planned.

8.6 Cllr John Ungar noted that he was concerned that the faults identified by the CQC may have had an adverse impact upon the care and safety of ESHT patients, and called for the Secretary of State to be asked to investigate ESHT mortality and morbidity data to see if care had in fact been adversely affected. Amanda Philpott noted that, whilst the CQC report provided very useful information on quality at ESHT, it was only one part of a suite of indicators. Looking at the full range of data, there is no strong case for escalating the matter to the Secretary of State. East Sussex CCGs are happy to work with the proposed Scrutiny Review Board to help members better understand how commissioners use the full range of quality data. The Chief Nurse has offered to lead on this.

8.7 Amanda Philpott noted that it was disappointing that the initial Quality Summit had not taken place, and there had consequently not been the opportunity for stakeholders to come together to explore the implications of the inspection report prior to its publication. It was to be hoped that there would be a more effective dialogue process for the second report. East Sussex CCGs also hope to be fully involved in conversations about quality between ESHT and the Trust Development Authority (TDA) going forward.

8.8 In response to a question about the value of the Better Beginnings Implementation Board in light of the continuing quality issues in ESHT maternity services highlighted by the CQC report, Amanda Philpott told members that the Board had been valuable in terms of providing assurance, although in future it was clear that a more robust assurance process was required – for example focusing more on daily operational data to determine the degree to which changes had in fact been implemented. It was also important to bear in mind that some of the failure to fully implement Better Beginnings actions has been due to a lack of anticipated external investment in services. There is a lesson to be learned here in terms of ensuring that, when an action is required of an NHS trust, all parts of that action are within the trust's gift.

8.9 Amanda Philpott informed the committee that unfortunately CCG Chief Officers and Chairs would be unable to attend a meeting on July 23 as they had to attend a regional NHS event.

8.10 **RESOLVED –** that a Scrutiny Review Board be established to scrutinise the CQC inspection of ESHT and ESHT's quality improvement actions in response. The Board will

set its own detailed terms of reference, but will include the themes outlined in the relevant report (To June 16 HOSC).

9. SUSSEX PARTNERSHIP FOUNDATION NHS TRUST (SPFT): CARE QUALITY COMMISSION (CQC) INSPECTION REPORT

9.1 Neil Waterhouse, Sussex Partnership NHS Foundation Trust (SPFT) Service Director for East Sussex, attended for this item.

9.2 The committee discussed how best to scrutinise the recent Care Quality Commission (CQC) inspection report of SPFT services and SPFT's Quality Improvement Plan in response to the report. It was agreed that the initial work in this respect should be undertaken via the informal joint committee of Sussex HOSCS. Cllrs Ensor and Wincott are the East Sussex HOSC representatives on this committee.

9.3 Committee members were invited to suggest areas of concern for the joint committee to focus on. Areas suggested were:

- Standards of ward-based care
- Bed availability - for both adult mental health and Children & Adolescent Mental Health Services (CAMHS)
- Services for people with Learning Disabilities (LD)
- Data on in-patient admissions, length of stay, discharge and re-admission rates (concerns that financial pressures mean that it is too hard to access in-patient beds, that patients are discharged too early, and that re-admission rates may be higher than they should be)
- Suicide prevention (both in terms of strategic planning for the population of Sussex and in terms of managing in-patient risk at SPFT units)
- Access to CAMHS

9.4 Mr Waterhouse told the committee that it is crucial that mental health receives the same parity of esteem as physical health, and that there have been positive recent developments towards this goal. In terms of the CQC report, the inspectors identified many areas of good practice across the trust, but also some areas of concern. It was particularly disappointing that aspects of services for the most vulnerable people were found to be unsafe.

9.5 Recent changes to the management of SPFT mean that services are increasingly delivered on a 'locality' basis. However, the CQC did not report separately on services in East Sussex, West Sussex and Brighton & Hove and it is difficult to use the report information to determine how each locality is performing, although it is evident that performance across Sussex is variable. For example, the use of out of area beds has been a problem for the trust in some localities, but not a significant issue in terms of East Sussex.

9.6 Mr Waterhouse noted that there had been a good deal of recent work to enhance CAMHS provision. For example partners have focused on improving services for young people detained for assessment by the police (under section 136 of the Mental Health Act), so that there is no inappropriate use of policy custody suites. This is in line with the recently agreed Crisis Care Concordat.

9.7 Mr Waterhouse told members that SPFT would be happy to talk about trend data, noting that East Sussex services performed well in terms of re-admission rates.

9.8 With regard to suicide prevention, the HOSC Chair, Cllr Ensor, wished to record his thanks to all agencies involved in this work, particularly the Beachy Head chaplaincy

service, coastguard and ambulance services, and the Samaritans. The Chair specifically wanted to commend the work of Cllr Beryl Healey, who as well as being a founder HOSC member, had been Chair of Eastbourne Samaritans for a number of years.

9.9 In response to questions about SPFT's CQC rating of "requires improvement" for leadership, Mr Waterhouse told the committee that this specifically concerned arrangements for holding data centrally and communicating it to the trust board. These concerns were being addressed. In terms of whether the trust was too large to function effectively, the move to a locality system of service provision, with local service *and* clinical directors, was intended to address this issue. Amanda Philpott added that, although East Sussex CCGs have expressed concern at the size of SPFT, the new trust leadership has been very active in building good relations with local commissioners, and the CCGs are confident that SPFT is both committed to, and in a position to successfully undertake, the necessary reforms.

9.10 In answer to a query about referrals to the Crisis Resolution & Home Treatment team (CRHT), Mr Waterhouse told members that East Sussex GPs have expressed concerns that some of their referrals to the CRHT have been turned down. This may be principally due to SPFT staff and GPs having differing views on what constitutes a high risk patient. These issues will be actively addressed as part of the East Sussex Better Together (ESBT) programme to which SPFT are committed.

9.11 In response to questions about safety at SPFT in-patient units, Mr Waterhouse told the committee that the changes indicated by the CQC had already been made at the East Sussex rehabilitation unit. The CQC rating of "inadequate" was based on conditions at the Hanover Crescent unit in Brighton which has subsequently been closed. Hanover Crescent was in any case scheduled for closure, and patient numbers were being run-down. East Sussex rehabilitation services have recently received good feedback from the CQC, and SPFT is confident that services are good. There are more serious concerns about conditions on older people and dementia wards. The trust has plans in place to improve these facilities, which include long term works to estates. There is also a short term improvement plan.

9.12 In answer to queries about the cleanliness and privacy & dignity (in terms of gender segregation) of SPFT wards, Mr Waterhouse told members that all East Sussex wards are clean, although some ward environments are not as good as they should be. Gender segregation is a challenge, given the estates that the trust has to work with, which do not always permit single-sex wards. SPFT does the best that it can here, ensuring that all bays are single-sex and that female patients need not pass through male bays in order to access washing and toilet facilities.

9.13 **RESOLVED –** that the committee agrees to scrutinise the issue of the CQC inspection report of SPFT services initially via the informal joint Sussex HOSC.

10. RE-PROCUREMENT OF COMMUNITY SERVICES: HIGH WEALD LEWES & HAVENS CCG (HWLH)

10.1 Ashley Scarf, Director of Strategy, HWLH CCG, informed the committee of the progress of the CCG's re-procurement of community services.

10.2 Mr Scarff told members that a preferred bidder had now been identified, and it was anticipated that a contract would be signed by the end of July 2015. The new contract gave commissioners the opportunity to address some unique challenges, given the fact that the majority of High Weald, Lewes & Havens residents 'flow' out of the county to

access secondary healthcare services. Re-designed community provision will be key to the success of East Sussex Better Together (ESBT).

10.3 This procurement has not been approached in a conventional way. Instead, the CCG has developed a process of competitive dialogue with potential bidders, asking them to present their ideas on how they could deliver a range of outcomes. There has been an emphasis on the innovative use of technical solutions, and also an emphasis on using patient and carer experience and satisfaction as key outcomes measures. There has been excellent patient engagement throughout the process.

10.4 It is intended that the contract will go live in early November 2015. The CCG is working closely with the current service provider (ESHT) to ensure a smooth transition to the new arrangements.

10.5 The CCG would welcome the opportunity to attend a future HOSC meeting with the new provider, Sussex Community Trust (SCT), to give a more detailed presentation on their plans for services.

10.6 Asked to list his two 'headline hopes' for the new service, Mr Scarf told members that he hoped to see better integration, both between health and social care services, and between primary, community and secondary healthcare. Secondly, he wanted to see community hospitals revitalised, becoming true community hubs for a range of services.

10.7 In response to a query as to whether the change in providers might threaten the progress of ESBT, Mr Scarf told the committee that the requirements of ESBT were central to the procurement. SCT is very experienced in delivering high quality integrated working, and the CCG is confident that this change will enhance ESBT.

10.8 Asked how the success of the contract would be judged, Mr Scarf informed members that a number of Key Performance Indicators would be monitored. Central to performance measures will be user satisfaction.

10.9 **RESOLVED –** that the information be noted and HWLH CCG and SCT be invited to the October 01 2015 HOSC meeting to provide a further update on their plans for the new community services contract.

11. CO-COMMISSIONING OF GP PRACTICES IN EAST SUSSEX

11.1 This item was introduced by Amanda Philpott, Chief Officer, Hastings & Rother CCG.

11.2 Ms Philpott told the committee that NHS England (NHSE) was charged with commissioning primary healthcare services by the Health & Social Care Act (2012). However, in 2014 an option was introduced allowing CCGs to be delegated the responsibility for commissioning local GP services.

11.3 CCGs polled their members asking whether they wanted to take on these responsibilities. Members of HWLH CCG and EHS CCG opted to take on GP commissioning at the first opportunity. However, members of HR CCG voted to delay taking on additional commissioning responsibilities for one year. Members across all CCGs expressed a range of views, notably around the degree of risk involved in taking on GP commissioning. There are particular difficulties associated with the recruitment and retention of GPs in the Hastings area and this may have influenced thinking. The Local Medical Council was involved in this process and advised its members to delay for a year until more details of how localised GP commissioning will work in practice emerge.

11.4 In the longer term it seems likely that there will be further delegations of commissioning to CCGs, potentially including other primary care services and aspects of specialist commissioning.

11.5 Whilst there are risks to early adopters in taking on responsibility for the recruitment and retention of the local GP workforce, there are also risks inherent in not being in the first wave of GP commissioners. These are hard to quantify, but will consist mainly of reduced opportunities to take advantage of local knowledge and working relationships. However, the risk to Hastings & Rother should be mitigated by its very close working relationship with Eastbourne, Hailsham & Seaford CCG.

11.6 As local commissioning of GPs develops, GPs can expect to see better funding flows and simplified payment mechanisms for Practices, particularly for additional 'locally commissioned' services. However, in the very short term the focus will be on ensuring a smooth hand-over of responsibilities.

11.7 There is a potential conflict of interests involved in having CCG GPs commission GP services. To avoid this, all CCG commissioning decisions relating to GP services will be made by bodies with a majority of non-GP members.

11.8 In response to a question on the risks associated with GP retention, Ms Philpott told members that this was a major concern. 90% of NHS 'contacts' are made in primary care, but primary care services only receive 7.5% of the NHS budget (a reduction from 10% a few years ago). East Sussex Better Together aims to increase the proportion of funding for primary care. There will also be an increased focus on GP training and recruitment, and greater emphasis on evolving the role of GPs: using them more effectively as a core part of multi-disciplinary teams. In addition, the federation of GP practices will be encouraged where practices wish it.

11.9 **RESOLVED –** that the report be noted.

12. HOSC FUTURE WORK PROGRAMME

12.1 Members agreed (at item 5 above) to establish a Scrutiny Review Board to examine ESHT's implementation of its quality improvement planning in relation to the CQC inspection reports.

12.2 Members also agreed to establish a Scrutiny Board to examine the implementation of the outstanding recommendations from the Better Beginnings maternity review. This will explicitly include scrutiny of Mr Richard Hallett's paper on High Weald maternity pathways (circulated informally amongst HOSC members).

12.3 Members agreed (at item 6 above) to undertake initial scrutiny of the SPFT CQC inspection report via the Sussex informal joint HOSC (due to meet with SPFT on June 30).

12.4 The committee agreed that items for its 01 October 2015 meeting should be:

- Report back from the ESHT Scrutiny Review Board (see 9.1 above)
- Report back from the Maternity Scrutiny Review Board (see point 9.2 above)
- Report back from the informal joint HOSC meeting with SPFT (see point 9.3 above)
- Community services: report and presentation from HWLH CCG and Sussex Community Trust on the new HWLH contract for community services.

12.5 members agreed that the issues of managing GP vacancies and of ESHT urology/incontinence services should be added to the committee work programme.

12.6 **RESOLVED –** that the HOSC work programme be amended as indicated above.

(The meeting ended at 12.15 pm)

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**1 October 2015**
By:	**Assistant Chief Executive**
Title:	**East Sussex Healthcare NHS Trust (ESHT): Care Quality Commission (CQC) Follow-up Inspection Report**
Purpose:	**To consider the recent CQC Follow-up Inspection Report on ESHT**

RECOMMENDATIONS

HOSC is recommended to consider and comment on the Care Quality Commission Quality Report on services provided by East Sussex Healthcare NHS Trust

1. Background

1.1 The Care Quality Commission (CQC) carried out an inspection of East Sussex NHS Healthcare Trust (ESHT) in September 2014. The results of this inspection were published as a series of CQC Quality Reports in March 2015. A further CQC inspection, focusing on those services that the CQC had rated as inadequate, was undertaken at the end of March.

1.2 The CQC and ESHT held a Quality Summit for stakeholders on Friday 18 September 2015, and the CQC consequently published its follow-up report on Tuesday 22 September. The summary report is included for information as **Appendix 1** to this report. The full reports are available on line: http://www.eastsussexhospitals.nhs.uk/about-us/cqc-report/

1.3 The HOSC decided, at its June 2015 committee meeting, that detailed scrutiny of ESHT's quality improvement work in response to the CQC inspection process would be undertaken by a Scrutiny Review Board. The Scrutiny Review Board has five sub-groups, focusing on: surgery, maternity, patient records, outpatients, and pharmacy. The Board will also examine cross-cutting issues around ESHT's corporate culture. The remit of the Board and its sub-groups includes scrutinising the findings of the follow-up CQC report.

2. Conclusion and recommendation

2.1 HOSC is asked to consider and comment on the follow-up CQC report on ESHT.

PHILIP BAKER
Assistant Chief Executive

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East Sussex Healthcare NHS Trust

Quality Report

King's Drive, Eastbourne,
East Sussex BN21 2UD
Tel: 01323 417400
Website: http://www.esht.nhs.uk/

Date of inspection visit: 24, 25, 26 March and 10 April 2015
Date of publication: 22/09/2015

This report describes our judgement of the quality of care at this trust. 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 trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

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 706 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. Services 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.

In September 2014 we identified concerns about the provision of pharmacy services. We looked at this in our unannounced visits by a CQC pharmacist. 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 an 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. Despite the process, many people we spoke to said that they felt their concerns had not been listed to, and they had not been well engaged.

We met with the trust and Trust Development Authority (TDA) representatives on 23 March 2015 to hear about the action they had taken since the comprehensive inspection in September 2014. Details of the action plan were shared with us, with a copy of the draft plan being provided to us on 26 March 2015. Since then the trust has amended and finalised the action plan, making it more robust and focussed.

Summary of findings

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 state 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 is reflected in the national NHS Staff survey.
- The most recent NHS staff survey showed the trust performing badly in most areas. It was below average for 23 of the 29 measures, and in the bottom 20% (worst) for 18 measures.
- Overall the trust was amongst the bottom 20% of all trusts in England for staff engagement. Only 18% of staff reported good communications between managers and staff against a national average of 30%.
- The trust was also in the bottom quintile for staff reporting that they had the ability to contribute towards improvement at work.
- The trust told us they were disappointed by the results; but we saw no direct programme to address this or to change the position.There remained a poor relationship between the board and some key community stakeholders. We found the board lacked a credible strategy for effective engagement to improve relationships.
- We saw a culture where staff remained afraid to speak out or to share their concerns openly. We heard from several sources about detriment staff had suffered when they raised concerns about patient safety.
- Staff remained concerned when they contacted us of the risk of doing so.
- We saw that there remained little public engagement in the wider benefits of the reconfiguration. The trust had followed its original strategy. We saw this had failed to engage significant elements of the community. We saw no new plan to address this issue.
- We saw that local managers had taken some steps that had resulted in an improved patient experience in the outpatient areas but there remained long delays in the referral to treatment time. The trust had taken steps towards improvement but these were yet to demonstrate a sustainable improvement.
- Patients were not being seen for follow-up appointments within the timescale requested by their clinician.
- The call centre for outpatient appointments was not effective. Patients were often unable to make contact with the staff.
- Clinics were sometimes cancelled, and patients had not been informed, or informed at very short notice. There was a lack of appropriate staff to ring patients; who arrived for their appointment and found the clinic was not being held.
- Within the trust, we did not see a cycle of improvement and learning based on the outcome of either risk or incidents.
- 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.
- The risk register was not capturing risks in a robust way.
- We saw a redesign of the governance structure, but were unable to yet see any significant benefits or improvements from this.

Summary of findings

- We saw low staffing levels that impacted on the trusts ability to deliver efficient and effective care.
- In maternity we saw some small improvements had been made to the governance systems but the major improvements needed to bring about sustainable improvements, such as staffing as yet remained unchanged.
- We saw that surgical services and outpatients' services did not report incidents in a way that would lead to the trust improving services from that learning. We saw that in maternity and surgery there had been improvements in incident reporting but learning was still limited and lessons learned were not embedded.
- We had concerns about the accuracy and robustness of data provided to external stakeholders and the board.
- Training for safeguarding for medical and nursing staff fell well below acceptable levels.
- In a number of areas we remained concerned about medicines management and pharmacy services.
- Checks on controlled drugs were inconsistent in ED, and remained sporadic in surgery, despite a drug register in one area noting an incidence of drugs missing.
- 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.
- There was little consideration for affording privacy to people attending the OPD and radiology where patients changing and waiting facilities were unsuitable and where weighing and other procedures were carried out in corridors.
- The trust healthcare records and records tracking systems remained inadequate.
- The trust was failing to meet the requirements of the National Schedule for Cleanliness in the NHS. Scores from cleanliness audits provided by the trust did not match the aggregated scored from the cleanliness audits we were provided with.
- Staff we spoke with were unaware of their responsibilities regarding the Duty of Candour. Staff we spoke to had not received 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 therefore unable to describe the processes the trust had in place.
- The trust does receive a higher than average number of complaints for its size although numbers of complaints have fallen over the last two years. We found a complaints system that gave both poor support for people who wished to raise a concern, and concerns on how the trust handled complaints.

We identified some good practice including

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

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- 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
- The board needs to 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 in September 2014 but we are not yet assured from the action plan and speaking with the lead executive officer that this had begun to be addressed.
- The board needs to create an organisational culture which is grounded in openness, where people feel able to speak out without fear of reprisal. This was a requirement following our inspection in September 2014 but we are not yet assured that this work was underway.

Summary of findings

- 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 waiting time for outpatients' appointments such that they meet the governments RTT waiting times, and that this is sustainable.
- Ensure that health records are available and that patient data is confidentially managed.
- Review staff deployment in maternity services to ensure that they are sufficient for service provision such that the organisation meets the recommendations made by the Royal Colleges. This was a requirement following our inspection on September 2014 but we are not yet assured from the action plan and data provided by the trust that this has been fully addressed.
- Reduce the proportion of OPD clinics that are cancelled at short notice and develop systems to ensure that where this is unavoidable, that patients are informed in a timely manner.
- Develop achievable succession planning to minimise the impact of staff movements.
- Improve the governance of incident reporting systems to ensure that the number of incidents reported via the electronic system reflects all the incidents that happen.
- Ensure sustained compliance with the National Schedule for Cleanliness.

Additionally the trust should

- 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.
- Develop sustainable systems to ensure equipment checks are carried out as required by trust policy and national guidance.
- Develop sustainable systems to ensure that VTE assessments and management are conducted in accordance with the guidance from the Royal Colleges.

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

Background to East Sussex Healthcare NHS Trust

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

In 2012, 22% of adults in East Sussex were classified as obese. The rate of alcohol related harm hospital stays was 543*, better than the average for England. This represents 3,007 stays per year. The rate of self-harm hospital stays was 145.2*, better than the average for England. This represents 719 stays per year. The rate of smoking related deaths was 263*, better than the average for England. This represents 1,037 deaths per year. Estimated levels of adult physical activity are better than the England average. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average. The rate of new cases of malignant melanoma is worse than average. Rates of statutory homelessness, violent crime, long term unemployment, drug misuse and early deaths from cardiovascular diseases are better than average.

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

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

* 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 of 29 people that visited across the two hospitals and the birthing unit on 24, 25 and 26 March 2015 included senior CQC managers, inspectors, senior registered general nurses, two consultant midwives and an obstetrician, a theatre specialist, consultants in surgery and emergency medicine, a pharmacist and experts by experience, data analysts and inspection planners.

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?

Summary of findings

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

- Accident and emergency services
- Surgery
- Maternity services
- Outpatient services

We made an unannounced inspection of the trust services on 24, 25, 26 March 2015 and our pharmacist visited 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 that we reviewed. 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 on both sites to listen to staff from different areas of the trust. All staff were invited.

The Head of Hospital Inspection telephoned the most senior executive officer available at 3.00pm on Tuesday 24 March 2015 to inform them that we would be making an inspection visit that afternoon. Our inspection team then commenced their visits to the hospitals.

What people who use the trust's services say

The most recent published Friends and Families Test (FFT) overall score for inpatient services in April 2015 was published at the time of our inspection. Across the trust the FFT showed 95% of people using inpatient services would recommend the service. There was little variance between the two acute sites. These scores include those for community services which may make this difficult to compare with other trusts.

The national Cancer Patient Experiences Survey 2014 showed that the trust was in the middle 60% of trusts for 23 of the 34 key performance indicators. It was in the top 20% of trusts for a further 10 key performance indicators of this survey. In general, scores had risen for each question from the previous year. There was only one 'red rated' area from this survey where the Trust was in the bottom 20% of trusts which related to whether people were given enough privacy when discussing confidential issues.

The Patient Led Assessments of the Care Environments (PLACE) published in August 2014 showed the trust was just below the national average scores for cleanliness (96% against 97%), facilities (90% against 92%) and below the national average for privacy and dignity (84% against 88%).

The number of complaints has decreased since 2011/12 by around 10%, following a nearly 20% increase in complaints between 2010/11 and 2011/12. The number of complaints remains higher than would be expected for a trust of this size and a higher than expected number of complaints are accepted by the Parliamentary and Health Services Ombudsman for investigation.

The NHS Choices website rates trusts with a star rating based on feedback and reviews by people using the service. Both acute hospitals had an overall score of 3.5 stars based on patient reviews. This rating has remained unchanged since September 2014.

We continued to receive higher than expected levels of feedback from people using services and their relatives. Whilst a small number of contacts made positive comments, the overwhelming majority expressed concern and dissatisfaction with the service. The themes we identified included poor patient experiences, staffing concerns, poor communication and staff attitude, an unsatisfactory complaints process, poorly planned discharges, inadequate assessment and management of pain, delays in outpatient treatment and the treatment of people with mental health difficulties in the accident and emergency departments. All the trends identified were related mainly to maternity, surgery, accident & emergency and outpatient services.

The last published CQC Inpatient Survey 2014 showed that the trust was performing, 'about the same' as other trusts for nine of the 11 key performance indicators.

Summary of findings

The trust performed worse for two indicators relating 'hospital and ward' (which is driven by single sex accommodation which we have highlighted in our ED section) and 'operations' (relating to explanations of the risks and benefits of surgery).

Facts and data about this trust

Context

- Approximately 706 beds plus community services
- Serves a population 525,000
- Employs around 6,942 whole time equivalent members of staff

Activity

- 741,706 outpatient attendances in 2013/2014
- 41,846 inpatient admissions across trust hospitals in 2013/2014
- 101,744 accident and emergency department attendances in 2013/2014 (excluding Minor Injuries Unit figures).
- 3,329 births across trust sites, including homebirths, in 2013/2014

Intelligent monitoring

Data from our March 2015 Intelligent Monitoring showed the trust as being recently inspected (relating to the September 2014 visit) but the proportional risk score increased to 6.8%, which is equivalent to band two risk (where band one is the highest risk and band six is the lowest risk). This position had become worse over the past 12 months with three elevated risks related to the staff survey and two other risks identified. The situation is seen to have deteriorate further with the latest intelligence monitoring reports published with the trust showing an increase to four elevated risks and 7 risks.

Key Intelligence Indicators

The trust remains highlighted as an outlier for times for Referral to Treatment (RTT) which measure the waiting time for outpatient and inpatient treatments.

The 2014 NHS Staff Survey showed minimal change since 2013. For 23 out ot 29 areas the trust was rated worse than the national average for acute trusts. The trust was in the bottom 20% (worst) in the country for 18 of these.

The trust was in the bottom 20% overall for staff engagement. Only 18% of staff reported good communications between senior managers and staff which was worse than the national average of 30% for all acute trusts. We recognise that East Sussex Healthcare NHS Trust is a combined trust providing both acute and community services so therefore the results may be indicative rather than directly comparable.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We saw a number of issues that led to a rating for safety at the trust of inadequate. We noted some limited progress in some areas since our last inspection in September 2014. We saw low staffing levels in ED, Surgery, Maternity and Pharmacy. In some areas, incident reporting, the feedback from incidents and the learning by both the organisation and individual staff was not as good as it should have been. Learning from incidents was not well demonstrated, even when incidents were reported. We did see some improvements but staff still told us that time constraints caused by low staffing levels meant they, "did not have time to report everything". In surgery we found the threshold (tolerance) for staff reporting an incident via the electronic system was high and this had led to a potential under reporting. In the OPD we found that reception staff had been told not to report incidents through the proper channels. Instead of reporting incidents of missing notes, staff were keeping a local record of this. This meant that the outcomes were not being reported through the trusts governance process. Patients' records were not securely stored in outpatients. Medical records were often unavailable and when they were present, they were in poor state of repair. Clinicians had difficulty locating information upon which to base a decision. There was also an issue with the physical quality of records in surgery. There were times when records could not be found and this resulted in temporary files being created. The trust had a new records management system planned but this was not yet implemented. We observed staff, in the main, followed good hygiene and hand washing practices. However we saw some areas where we were concerned by lack of compliance with good hand hygiene and trust policy, as well as staff who appeared to lack basic understanding of the policy. We noted that Radiology services were demonstrating good practice in this area.	**Inadequate** 

Summary of findings

Duty of Candour

- The trust described the process they would use to inform patients of instances where harm or near miss had occurred. We did not see this in use during our inspection, but we reviewed two incidents in maternity that showed the trust followed its duty in this area.
- We noted that the PALS team had introduced duty of candour training across the trust.
- Staff we spoke to had not received 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).
- Some staff we spoke with across the trust were aware of the duty of candour and understood their responsibilities. Some staff also told us they would feel happy raising concerns with their immediate line manager on issues relating to patient harm and safety.
- Others (a much larger proportion) were unaware of their responsibilities regarding the duty of candour. They also felt the organisation was not receptive to concerns being raised and felt they would suffer if they spoke out about risk or poor practice. Many were anxious for it not to be known that they had spoken with us.

Incidents

- National Reporting and Learning Service (NRLS) data suggested that the trust was a good reporter of safety incidents.
- The governance department were in the process of developing benchmarking across different clinical units within the trust to ensure that reporting was consistent across the organisation. However, the NRLS data provided was at some variance with the findings from our inspection visit.
- On the surgical wards we found staff had a high tolerance and threshold for reporting incidents on Datix and were under reporting.
- Incident reporting, the feedback from incidents and the learning by both the organisation and individual staff was not as good as it should have been. We did not see evidence of learning; nor did we see a systematic approach to sharing information or a culture to support this.
- We were not able to review all the root cause analysis (RCA) reports as, while we asked to seem those since our last inspection, the trust did not provide all of them. The trust told

us that they were not able to provide all of the RCAs as investigations were either on-going or reports were in early draft and had not been through the trust's internal review process.

- The trust was losing valuable opportunities to learn from these incidents and improve patient care. There were systems in place to ensure action following serious incidents had taken place but no evidence that there were objective measures identified and monitored to ensure that the actions had resulted in sustainable improvements.
- In maternity services there was also evidence that lessons learned were not embedded. For example, prior to the inspection of maternity services in September 2014 a number of incidents in maternity relating to poor interpretation and a lack of action when pathological cardiotocography recordings (CTGs) were seen. We saw an incident investigation report that demonstrated that this continued to be a problem subsequent to the inspection visit.
- Reception staff in OPD had been told not to report incidents relating to hospital notes through the proper channels. Instead of reporting incidents of missing notes, staff were keeping a local record of this. This meant that the outcomes were not being reported through the trusts governance process.

Safety Thermometer

- We saw poor use of the safety thermometer, and in some areas (e.g. surgical wards) data were left blank or remained out of date.

Cleanliness, infection control and hygiene.

- There was a variable response to infection prevention and control. It was clear that the trust did not have a strong oversight of this important issue.
- In ED and Maternity we saw staff complying with the trust hygiene policy while in Outpatients we saw some staff not compliant.
- Outpatients and Surgery did not meet the requirements of the national cleaning schedule.
- Maternity were unable to evidence compliance of cleaning through audits.

Safeguarding

- Mandatory safeguarding training was not always completed. In maternity services we saw, from the training matrix provided by the trust, that 78% of all staff had completed safeguarding adults training.

- The adult safeguarding training uptake for medical staff was lower, with a 75% completion rate.
- .In ED 24 nurses had completed level 3 safeguarding for children. This was not all the nursing staff who should have done so in line with the intercollegiate recommendations.
- Of the senior medical staff in ED only 45.5% had completed level 3 safeguarding training for children. This is a requirement for all medical staff in ED.
- In maternity, the training for children's safeguarding was better, with 85% of staff receiving this training.

Environment and Equipment

- The waiting room in ED on the Eastbourne site was not designed to allow the staff to have clear sight of patients waiting to be seen, which is important should a patients condition deteriorate while waiting to be seen or treated.
- We saw that since our last visit, some areas of the trust had improved their checking of emergency equipment (e.g. theatres), while in other areas (e.g. surgical wards) the same progress was not evident.
- Testing of equipment was variable. In one area (OPD) we found only one out of five pieces of equipment within their test date.
- We did see adequate equipment available within services.
- Radiology had undertaken all necessary checks on their X-ray equipment.

Medicines

- We saw trust wide issues relating to the management of medicines.
- We saw improvements overall in the management of medicines in maternity.
- We saw gaps in the checking of controlled drugs. We had noted these in our last inspection and we continued to have the same level of concern.
- Checks on controlled drugs were inconsistent in ED, and remained sporadic in surgery, despite the register noting an incidence of drugs missing.
- We noted a lack of pharmacy audit in all areas.
- Fridge temperature checks were not consistently recorded which meant there was a risk of medicines being stored at temperatures which could render them ineffective.
- We saw not all Consultants followed the trust prescribing guidelines for medication. Syntocinon (in Maternity) was being used by some consultants outside of trust guidelines. this led to confusion for junior medical staff and lack of consistency.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

- We saw that staff followed the principles of the mental capacity act in dealing with patients. We did however still continue to see problems in the recording of this in patients records.
- The trust had made appropriate Deprivation of Liberty Safeguards (DoLS) applications and notified CQC as required under the current legislation. However, comparing the number of notifications regarding DoLS applications from East Sussex Healthcare NHS Trust the levels are comparatively low suggesting that either not all staff are aware when an application is necessary or that the correct process is not being followed whenever it is necessary to place restrictions on a patient's freedom to make choices.

Staffing

- Surgical services had insufficient nurse staffing for the duties required.
- There was a high reliance on agency staffing in surgical services. There was no documentary evidence to show temporary staff had received induction or were made familiar with the area. Theatres and recovery had a better oversight of the issues than surgical wards.
- In some areas, e.g. ED, data on staffing was poor and the trust was unable to provide information on the use of staff resources (for example on the use of locums to cover shifts).
- Staffing in ED relied heavily on locum doctors. Medical staffing in ED did not meet the College of Emergency Medicine guidance. Nurse staffing had high sickness levels and often reported running short staffed.
- The staffing arrangements on the obstetric led maternity unit at the Conquest hospital still failed to provide for one to one care in labour and a supernumerary labour ward co-ordinator as recommended in 'Safer Childbirth - Minimum Standards for the Organisation and Delivery of Care in Labour' (2007). There had been no significant improvement in this since our inspection in September 2014. The midwifery led birthing centres did provide one to one care for women who gave birth there.
- We saw evidence that staffing levels across the trust continued to impact on patient care. We had two recent examples one from the intensive care area where in February 2015 an elderly patient suffered a severe hypoglycaemic attack which led to anomalies in their ECG tracing. The Root Cause Analysis (RCA) report identified that the staffing fell short of the Core Standards for Intensive Care (2013). On the night the incident occurred the unit staffing did not meet the planned

establishment. Neither was there a supernumerary clinical co-ordinator or additional supernumerary nurse as recommended in the core standards. Another example came from maternity services where a first time mother with established and efficient contractions was sent home in a distressed state and unable to have the requested opiate analgesia from the Crowborough Birthing Centre in April 2015 because of staffing shortages at the Conquest hospital.

Pharmacy Services

- Following the report from our last inspection in September 2014 the pharmacy department had considered all the shortfalls we identified and devised an action plan. Much of this was, "in discussion". We note the work on progress in this area.
- There were on-going concerns that the aseptic unit was not meeting the required standard and posed a significant risk.

Are services at this trust effective?

Requires improvement

We found that the effectiveness of services at the trust required improvement.

Some policies were out of date and compliance with them was poorly monitored. There were clear examples of where the trust staff were not following best practice guidance and the trust policies. The trust has subsequently told us that they have made significant improvements and now have 118 policies requiring review and that of these, only 26 of these relate to clinical areas.

Surgical teams did not undertake morbidity and mortality reviews regularly and consistently, although we saw a minor improvement since our September 2014 inspection.

Systems to ensure availability of hospital notes were being put into place; but much of this was not yet implemented and the problems remained. We remained concerned over the physical condition of some health records.

Evidence Based Care and Treatment

- We found the mortality overview group were aware of the variable submissions of morbidity and mortality reports from different clinical units, yet no firm action had been taken to address this. The risk adjusted mortality rate for the trust had, however, fallen during both 2013 and 2014.
- The Mortality and Patient Safety Dashboard for Surgery for the period January 2014 to December 2014 showed that the trust

surgical services performed less well than the peer trust group in 12 out of 20 key performance measures. In five of these East Sussex Healthcare NHS Trust was rated red, at the bottom end of the scale for patient safety outcome measures.

- We did see an improvement in the use of morbidity and mortality meetings since our last inspection.
- The trust was following NICE guidance where appropriate but was not meeting the recommendations of national professional bodies (such as the Royal College of Midwives/Royal College of Gynaecologists and Obstetricians and the Intensive Care Society) in relation to the quality of care provided.
- In August 2014, as part of an on-going review and monitoring process, 239 hospital policies were recorded as being out of date. This demonstrated that the trust policies were not always being monitored or reviewed regularly. We were unable to ascertain how many policies had been reviewed and updated prior to the inspection.
- We asked how the trust could be certain clinical areas were following the correct policies. We were told that one way of measuring this was through senior managers carrying out quality walks.
- We saw examples such as the management of venous thromboembolism (VTE) where trust staff did not always act in accordance with the guidance issued by NICE.
- We saw evidence that the trust staff did not always follow guidance published by the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Nursing when determining pre-operative fasting times. This resulted in some people being without food or drink for excessive periods.

Access to Information.

- Outpatients had begun to address the issue of access to notes raised from our 2014 visit. The previous problem of brining in notes from off-site was now largely resolved.
- We recognise the trust has a plan to address electronic tracking of notes and records. This is expected to be in place during 2015.
- We remain concerned about the physical condition of some of the health records.

Patient Outcomes

- The pain team configuration was inadequate to provide a service across both sites with the resources provided.
- We noted that data supporting outcomes show a variable picture.
- The trust participated in a number of clinical audits.

Summary of findings

Are services at this trust caring?

Good

We found that services across the trust were caring and have rated this as good.

We received many positive comments from patients and their carers but were also contacted by a number of people who talked less favourably about the way trust staff had treated them.

Operational staff spoken to were all clear that they saw patient care as their main driver for performing well. Some said this was difficult within the current culture and resourcing but that being able to make a difference to patients was why they continued to turn up to work even when things were difficult.

Compassionate Care

- We saw kind care provided across the trust.
- Most patients that we spoke with commented positively on their individual care and on the staff providing it. We do continue to hear stories from individuals who felt their care was not compassionate or kindly delivered.
- Staff we spoke to saw patient care as their main driver for performing well. Some said this was difficult within the current culture.

Understanding and involvement of patients and those close to them.

- Patients reported being involved in their care. Services were able to describe the processes they used to involve patients.
- Patients in ED (through the A&E Survey) reported being involved in their care.
- During the inspection people told us that their care and treatment options were explained to them.

Emotional Support

- Emotional support for patients was good. We observed staff giving support to patients and their relatives. We saw this being given in sympathetic surroundings.
- Patients gave very positive feedback about the one to one support from staff at the trust.
- The trusts chaplaincy service was widely available to patients.
- The support for staff was less readily available. The occupational health service was not able to meet the demands of the many staff who needed their services.

Summary of findings

Are services at this trust responsive?

Requires improvement 

The responsiveness of the trust's services requires improvement. The trust had consistently not met the operating standard for NHS consultant-led referral to treatment times (RTT) over the past year (the national standard is 18 weeks for patients who do not have a suspected cancer diagnosis).

Some specialties had longer waiting times than others. For example, rheumatology, where patients were left waiting 48 to 49 weeks for an appointment and then struggled to get follow up treatment. We were told by a senior member of staff that consultants in this speciality refused to see patients for follow up who had their initial consultation with a locum consultant; this was clearly detrimental to patient care. We met with a member of the executive team who shared the trust plans for addressing the backlog but these were yet to provide an effective solution to the delays experienced by patients. We were unable to see that these were sustainable, as they relied on additional capacity (through locums) to reduce the backlog that would not be available at a later date.

The redesign issues had begun to be addressed in outpatients. Progress was being made, but was far from complete.

Recruitment remained a challenge for the organisation; yet we saw lack of succession planning for senior individuals key to delivering clinical pathways.

The trust failed to meet single sex accommodation in the CDU on a regular basis.

The number of complaints received by the trust is higher than comparable organisations. We note from patient feedback that the quality of response remains a concern.

Service planning and delivery to meet the needs of local people

- The redesign of outpatients' services had previously been poorly implemented. Essential tasks had been missed in the service redesign. The trust had taken steps to address this since our last inspection. We noted that while this had begun, there was still much to do in this area. In radiology we found that the service began working before the reception desk opened, leaving patients unable to book in or register their arrival.
- The call centre for outpatient appointments was not effective. Patients were often unable to make contact with the staff.
- Clinics were sometimes cancelled, and patients had not been informed, or informed at very short notice. There was a lack of appropriate staff to ring patients; who arrived for their appointment and found the clinic was not being held.

- In maternity, there was a continued failure of the trust to respond effectively to the fears and anxieties of the people it served. Ineffective communication meant that many of the public did not understand the advantages of midwifery-led care to pregnant and postnatal women and their babies. For others, the threat of closure of the midwifery led units made them reluctant to book to a service that they might not be able to access when necessary. Women who used the midwifery led units were very positive about the experience.
- The lack of replacement for consultants that had left the trust had caused significant difficulties and increased waiting times for patients.
- A backlog of referrals was delaying patients accessing timely care.

Meeting Individual Needs

- In one speciality, permanent consultants refused to provide follow up care to patients who were initially seen by locum consultants.
- The Patient Led Assessments of the Care Environments (PLACE) showed the trust was rated below the national averages for all four key areas of cleanliness; food; facilities and privacy, dignity & wellbeing. Although subsequent to our inspection visit the data for the PLACE has shown and improvement by the trust.
- The trust was breaching the provision of single sex accommodation requirements frequently and regularly but not identifying or reporting these.
- We saw that the trust had dementia champions and link nurses to support people living with dementia.
- We saw the trust had facilities for relatives of patients who were seriously ill. In ED there was an area where relatives could make a drink.
- In OPD we saw patients with learning difficulties, dementia and mental health needs were prioritised in clinic.
- There were no appropriate areas in ED for people with mental health needs.
- Information was available in different languages if required.
- In maternity, the trust did not have midwives with role specific responsibilities. For example there was not a midwife leading on teenage pregnancy or bereavement.

Access and Flow

- Patients were not being seen for follow-up appointments within the timescale requested by their clinician. There were no alerting systems in place to warn staff that patients had not been seen for follow-up appointments in a timely manner.

- The new service redesign in outpatients had been previously poorly implemented. As a result, patients were waiting in long queues, being sent to the wrong areas, and being lost in the hospital and missing their appointments, due to computer systems that were not fit for purpose. The trust had put systems into place to address this issue since our last inspection. We noted that while these issues were not fully resolved, they had improved.
- Local changes in the patient pathway and system organisation for people attending outpatients had resulted in some improvements but these were insufficient to overcome the systemic issues.
- When we asked for a report giving the number of out of hours discharges for all locations including Crowborough, since October 2014, the trust advised us that they are unable to provide this information due to technical problems with their electronic system. We asked because we had been made aware of one woman being sent home at 1.00am to accommodate staff moves.
- In outpatients, the trust was not meeting its referral to treatment (RTT) times. In February 2015, the overall number of patients on the waiting list was 20,530. this had increased from the previous month. We saw work underway to reduce this; but we were not clear this was sustainable.
- In ED, whilst the trust failed to meet the national standard for the A&E 4 hour target; the trust performed better than the England average in this area.

Learning from Complaints and Concerns

- The trust does receive a higher than average number of complaints for its size although numbers of complaints have fallen over the last two years.
- The majority of the information we reviewed highlighted a deficient complaints system covering both poor support for people who wished to raise a concern, and how the trust handled complaints.
- The most recent (May 2015) CQC Intelligent Monitoring publication corroborates this. The trust had two risks relating to complaints, those referred to the PHSO and those received by CQC
- NHS choices website is also used to gather feedback about the service provided at the trust. We noted that when people complained on the website they were responded to and urged to contact the PALS department to discuss their concerns further.

Summary of findings

- A large number of people contacted the CQC during and after the inspection to tell us their experience, mainly to raise concerns about the trust.
- We have reviewed a sample of written responses from the trust which did not assure us that the trust had adequately addressed their individual concerns.
- The Listening Into Action (LiA) group had been set up to aid learning from incidents and patients feedback. This group encourages people who have raised a complaint to come and talk to health care professionals to give a first-hand account of their experiences. CQC was contacted by members of the public who contributed to this group who expressed their satisfaction with the learning that had occurred from their complaints

Are services at this trust well-led?

Inadequate

The trust had just undertaken a major and contentious reconfiguration of some of its clinical services, which was made permanent in July 2014; this continued to dominate the trust board and executive officers responses to failings. We did not see a clear vision for the trust going forward from this.

We note an internal audit report on the reconfiguration recognising the trust followed its processes, but we saw the engagement of local people had largely failed.

The trust executive were very defensive of challenge from a number of areas.

Culture in the trust remained one of fear and concern from staff about speaking out. We have been contacted by staff before, during and since this inspection to share their concerns regarding the trusts culture.

Low substantive staffing levels and sickness levels remain a challenge for the trust.

The trust scored below average for 23 of the 29 questions in the NHS staff survey; and scored in the bottom (worst) 20% for 18 of these questions.

There remains a clear disconnect between the views of the staff and those of the executive leadership. We saw examples where the staff view was a clear contradiction (more negative) from this in senior leaderships position. We remain convinced that the executive leadership is not acknowledging this as a significant challenge for the future of the trust.

Summary of findings

Vision and Strategy

- The chief executive's presentation prior to CQC inspection in September 2014 made it clear that the trust were aware of many of the issues that we found on our inspection. These issues had not been adequately addressed despite the trust seemingly already aware of them and having persisted for some time.
- The trust had completed a major and contentious reconfiguration of clinical services during the previous two year period. It is acknowledged that this reconfiguration had brought many challenges and strong criticism from community groups and some staff. However, the trust executive was unable to articulate a clear strategy for re-engaging the local community following these changes. It appeared that the trust continued to believe that it was a small but powerful cohort of local people who opposed these changes and were the cause of the trust problems. An executive told us that they were not prepared to consider alternative strategies saying, "We won't change it, we work around it".
- The senior executive officers remained convinced that the root cause of the trust problems was malicious objection to the reconfiguration, rather than any failings by the trust board and executive team. This was not what staff and local people told us during and subsequent to the inspection.
- We noted the trust still did not have a clear forward 5 year strategy, although there was a business plan in place which was being monitored and discussed at board meetings.
- Major service changes had been implemented and whilst the trust demonstrated its efforts to engage staff, the majority of staff we talked with continued to feel it was insufficient and ineffective.
- We were unable to identify a clear strategy that sought to address the breakdown in communications between some staff groups, members of the public and community groups and one local MP. When we spoke with senior staff about the communication strategy post reconfiguration they acknowledged that it wasn't working but said they were going to continue with it regardless of the lack of effectiveness.

Governance, risk management and quality measurement

- We did not see within the trust a culture of reporting, managing or improving based on risk and incidents. We were not able to evidence a cycle of improvement.
- Staff we spoke with were still unable to identify the governance structure or provide us with any feedback on its function, successes or any learning that had led to changes in practice.

- Some staff remained unconvinced of the benefit of reporting incidents, some staff had been told by managers to record incidents in a different way to the trust policy. The trusts governance system cannot be effective if it is unable to consider all areas of risk.
- We found little evidence that the large amount of data collated through governance and incident reporting systems was used to drive quality improvement or to demonstrate that improvements had been sustained. For example, one of the medical directors when asked how they knew the service had improved since our previous inspection visit said, “It feels better”. We requested data based evidence to support this assertion but it was not supplied.
- The trust wide audit plan titled, ‘2014-15 On-going Audits @26.03.15’ showed that there was limited participation in the National Clinical Audit and Patient Outcomes Programme. Some audits, such as the audit against the NICE Quality Standard 33 for the management of Rheumatoid Arthritis were started but clinicians had refused to participate in data collection due to a lack of resources. Others such as the trust priority audit in consent were simply poorly managed and failed to deliver against the planned audit programme.
- A recent review of the trust governance structure had been completed. It had resulted in clearer lines of accountability which should enable the organisation to effectively manage the quality and safety of the services it provides. It was too early to judge if this would be effective.
- The trusts Quality and Governance Strategy set out quality and governance meetings that fed into the patient safety and clinical improvement group.
- We saw that the trust had a risk register. We saw that this was not robust. For example the staffing issues in maternity were added only after our draft report from our last inspection was sent to the trust. Additionally, nurse staffing risks were removed from the surgical risk register before the plan was complete (i.e. before the risk was removed)
- Staff remained unclear about their lines of accountability and some told us, “We never know who our manager is from one week to the next. They do a 'knee jerk reaction' and then everyone gets moved around again”.
- We saw specific examples of trust level issues, including regular short notice cancellation of outpatient appointments, lack of robust data in ward level dashboards and failure to meet RTT waiting times targets.

Summary of findings

- Following our last inspection, the trust CEO told us that the inspection 'told us very little we didn't already know'. The trust told us they were well sighted on many of the issues we raised.
- We saw that the trust had governance groups and structures. We recognised in our previous inspection that the governance structure didn't flow well. Given that many of these issues still existed even though the trust was aware of them; we have concluded that the governance structures were not effective in dealing with significant issues for the organisation.
- We were also made aware that the occupational health department still struggled to ensure the trust delivered its duty of care to staff. We received a letter with a very powerful and sad story of the impact of this lack of support to one particular member of staff who despite requests was not provided with the occupational health support that they need.
- Low staffing levels were compounded by high and increasing sickness levels. The papers presented to the Board dated 25 March 2015 showed a trend of increased sickness from August 2014 to January 2015. The annual sickness rate in January 2015 was 4.8% against a target of 3.3%.
- Concerns were also raised about the quality of support received from the HR department. CQC received comments from several staff who felt that they were not supported by the HR team. We were told of instances where staff had received inappropriate support and given misleading information.
- We found a lack of succession planning for posts where it was known that the post holder would be leaving or retiring. No forward measures had been taken to address the impact of this. This had occurred in spinal surgery, rheumatology and gastroenterology where there were long gaps where the consultant capacity was significantly reduced and left the team unable to respond to local needs.
- We saw an action plan prepared by the trust in response to our last inspection (report published March 2015). This set out the trusts response to many of the issues we identified.

Leadership of the Trust

- Staff across a number of areas told us of their experiences about their perceived failure of managers to act on their reported concerns. They also gave us specific examples of where managers had behaved very poorly when concerns were raised with them.
- We asked staff how involved they felt members of the board were in what happened in their clinical areas. One staff member

told us, “There is a chasm between frontline staff and the managers and that hasn’t changed”. Other staff told us they felt the disconnect had deepened and that relationships between management and staff had never been worse.

- During a drop-in sessions a number of frontline staff did raise concerns with us about the culture and leadership of the organisation. This was despite a disproportionate number of managers, including associate directors, being present.
- Following our inspection, we received a number of emails from managers and senior managers describing how they felt the leadership and culture in the trust was good. We also received a larger number of emails from staff telling us of their concerns. We saw that the senior management of the trust saw a different view of the challenges than the non-management staff.
- The most recent NHS staff survey showed the trust performing badly in most areas. It was below average for 23 of the 29 measures, and in the bottom 20% (worst) for 18 measures. Overall the trust was amongst the bottom 20% of all trusts in England for staff engagement. Only 18% of staff reported good communications between managers and staff against a national average of 30%.
- The trust was also in the bottom quintile for staff reporting that they had the ability to contribute towards improvement at work.
- The trust told us they were disappointed by the results; but we saw no direct programme to address this or to change the position.
- Staff told us that they could always email the Chief Executive’s Office with any concerns. They told us that although emails were always acknowledged, they did not always receive a response. We were shown emails that confirmed the CEO and head of HR were made aware of both the patient safety concerns and the problems raising these had caused for the member of staff. The issues of one member of staff being very poorly treated by their line manager were dismissed as a breakdown of relationship and mediation was suggested as the way to resolve 'the situation'. At no point was the manager held to account for their behaviour.
- As a consequence of the broken relationships, we received a significant amount of concerns from patients and the public, raising concerns about care. We had been overwhelmed by the number of people contacting us prior to the previous inspection in September 2014; high levels of contact from staff during and following this inspection demonstrated that the situation remained unchanged.

- The themes identified related to the quality of staff engagement, low morale, and a bullying and harassment culture from senior management.
- The Staff Survey 2014 showed that the trust score for the percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice was 58% against a national average for acute trusts of 67%.
- On 19 November 2013, the Secretary of State for Health issued his response to the Francis report, in which the Government undertook to fully implement 204 of the 290 recommendations. There was an expectation that trusts would not wait for the final recommendations before taking action to address the recommendations made in the Francis report published on 6 February 2013.
- The Staff Survey 2014 Results Report presented to Board on 25 March 2015 by the Head of Human resources said that the trust would, “Implement the findings from the Francis Report on raising concerns once the final recommendations were published”.
- We saw documentary evidence that the HR department had failed to protect several whistle-blowers and that as a consequence, they suffered on-going detriment.
- Issues such as the travel time and distance between the two hospitals were taking centre-stage in the discussion and eclipsing the issues about managing a complex acute hospital service on two sites.

Culture within the Trust

- A large number of people contacted the CQC before, during and after the inspection to tell us their experience and some to raise concern about the trust. When asked whether there had been any improvements in the culture since the previous inspection, one member of staff said, “The climate of stress and fear is still just as potent.”
- We had a larger than expected number of staff contact us during and subsequent to this inspection visit who were not prepared to reveal their identity until we could assure their confidentiality but who shared detailed information about the way they had been treated as a result of raising concerns. We found a real culture of blame and holding people to account for things they had very little control over. This remained unchanged since the previous inspection.
- There was an on-going disconnect between the trust board and the staff on many things. This was exemplified by attendance at a drop-in session offered to all staff where six senior managers, told us about trust achievements and the positive culture. The

only other staff were a small group of administrative staff who said, “What you are all describing is not the hospital we recognise”. This disconnect was supported through other conversations with staff.

- We saw a culture of concern and sometimes fear from staff in the trust about raising their concerns. We have been provided with evidence from the two years preceding our visit up to the present time where a number of staff have suffered detriment because they raised concerns about patient safety issues. They had tried to raise concerns at all levels, including with the executive officers and felt that speaking to CQC was the only way to make their concerns heard.
- We saw the papers for the Board Meeting in Public dated 25 March 2015. The Director of Human Resources explained that although significant progress had been made in meeting mandatory training targets the 85% target was still not being met. They advised that they had spoken to managers who had told them that clinical pressures were impacting on their ability to undertake appraisals. The chairman said that he had particular concerns around appraisals and that he didn’t feel that good progress was being made around achieving appraisal targets. The finance director said that she didn’t feel that it was good enough to set targets and then to miss them. She felt that sanctions should be made to those that didn’t meet the expected levels of appraisal. This demonstrated a board level attitude that mirrored what staff had told us.
- We experienced a challenging relationship with some senior staff within the trust. We felt that the style of communication employed was inappropriate in a professional arena. There were instances where senior staff chose to misrepresent conversations and interactions with the inspection team.
- In one instance, we found that the trust had directed staff to move evidence relating to patient records which the staff themselves construed as a deliberate attempt to mislead the inspection team.
- We heard about several other example which pointed towards potential misrepresentation of data.
- Some members of the public contacted us to tell us about their positive experiences at East Sussex Healthcare NHS Trust. However, the majority of contact with CQC was to raise concerns about the standard of care and the welfare of the staff. The level of contact was higher than is usually received about a trust around the time of an inspection visit and indicated some very strong feelings about the quality of care being provided.
- During our last inspection of the trust in September 2014, there was a strong feeling amongst staff and by some members of the

public that they were not listened to, or engaged with by the senior leadership. This feeling persisted and many staff remained unhappy and felt unable to speak out for fear of retribution.

- The trust had a staff awards incentive in operation which was publicised through the staff newsletter. This recognised staff who were 'going the extra mile'.
- We noted that the trust had tried to provide reassurance to patients following the publication of our March 2015 report. An open letter was available on the trusts website and within the hospital referring to the trusts action plan.

Overview of ratings

Our ratings for Conquest Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Maternity and gynaecology	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

Our ratings for Eastbourne District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	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

Our ratings for East Sussex Healthcare NHS Trust

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

Overview of ratings

Notes

These ratings form part of the core services of the East Sussex Healthcare NHS Trust. In this responsive inspection we have only inspected four core services.

Outstanding practice and areas for improvement

Outstanding practice

We identified some good practice including

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

Areas for improvement

Action the trust MUST take to improve

Importantly, the trust must:

- The board needs to 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 had begun to be addressed.
- The board needs to 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 in 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, and that this is sustainable.
- Ensure that health records are available and that patient data is confidentially managed.
- Review staff deployment in maternity services to ensure that they are sufficient for service provision such that the organisation meets the recommendations made by the Royal Colleges. This was a requirement following our inspection on September 2014 but we are not yet assured from the action plan and data provided by the trust that this has been fully addressed.
- Reduce the proportion of OPD clinics that are cancelled at short notice and develop systems to ensure that where this is unavoidable, that patients are informed in a timely manner.
- Develop achievable succession planning to minimise the impact of staff movements.
- Improve the governance of incident reporting systems to ensure that the number of incidents reported via the electronic system reflects all the incidents that happen.
- Ensure sustained compliance with the National Schedule for Cleanliness.

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.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that they provide care and treatment in a safe way for service users. They must do this by (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; (i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must ensure that all premises and equipment used by the service provider is secure.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider must respond appropriately (with a comprehensive response shared with the complainant and within the timescales set by the trust) to complaints and must ensure that (1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.(2)The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.(a) complaints made under such complaints system, (b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, (3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of (a) complaints made under such complaints system,

This section is primarily information for the provider

Enforcement actions

(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and

(c) any other relevant information in relation to such complaints as the Commission may request.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that there are comprehensive and effective monitoring and governance systems in place. (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this regulation. The provider must (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (d) maintain securely such other records as are necessary to be kept in relation to —

This section is primarily information for the provider

Enforcement actions

(i) persons employed in the carrying on of the regulated activity, and

(ii) the management of the regulated

activity;

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub paragraphs (a) to (e).

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**1 October 2015**
By:	**Assistant Chief Executive**
Title:	**Sussex Partnership NHS Foundation Trust (SPFT): Care Quality Commission (CQC) Inspection Report**
Purpose:	**To consider the recent CQC report on SPFT services and SPFT planning in response to the report**

RECOMMENDATIONS

HOSC is recommended:

1) To consider and comment on the issue of the Care Quality Commission inspection of Sussex Partnership NHS Foundation Trust (SPFT) services;

2) To make comments on the SPFT report (Appendix 1)

1. Background

1.1 The Care Quality Commission (CQC) is the independent regulator of health and care services in England. The CQC inspects health and social care providers and publishes reports detailing its inspection findings.

1.2 Sussex Partnership NHS Foundation Trust (SPFT) is the main NHS provider of mental health, learning disability and substance misuse services across Sussex, as well as providing specialist mental health services across the region.

1.3 The CQC inspected SPFT services in January 2015 and published its findings as a Quality Report on May 28th. The relevant CQC report(s) can be found here: http://www.cqc.org.uk/provider/RX2

1.4 The CQC held a Quality Summit on 22 May 2015 to present its report to stakeholders ahead of publication. In short, SPFT received an overall grading of "Requires Improvement", although a number of its services were ranked as "Good" or "Outstanding" in one or more of the CQC's quality domains. The CQC expressed confidence in the ability of SPFT's senior management to undertake the organisational improvements that it required. More details of the CQC's findings as they relate to East Sussex services are included in the papers provided by SPFT (**Appendix 1**).

1.5 NHS trusts inspected by the CQC must produce a Quality Improvement Plan (QIP) setting out the changes they intend to make in order to respond to the CQC's findings. A paper from SPFT detailing their actions in East Sussex in response to the CQC's findings is included as **Appendix 1** to this report. The QIP will not be formally signed-off until November, so will be presented to HOSC members at a future meeting.

1.6 SPFT is a pan-Sussex provider, and in recognition of this, an informal joint committee of Sussex HOSCs meets periodically to consider SPFT performance issues. This joint HOSC met with SPFT on 30 June 2015 to discuss the CQC inspection report. Cllrs Ensor and O'Keeffe attended on behalf of East Sussex HOSC. At this meeting the Chief Executive of

SPFT outlined the trust's plans to respond to the CQC inspection reports. The minutes of this meeting have been circulated separately to HOSC members.

2. Conclusion and recommendation

2.1 HOSC members are asked to consider and comment on the CQC Quality Report on SPFT services and on SPFT's plans in response to the report.

PHILIP BAKER
Assistant Chief Executive

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Sussex Partnership NHS Foundation Trust
Report on actions to date in response to the CQC inspection findings

Overview
In January 2015 the Care Quality Commission (CQC) held a planned, week long inspection of services provided by Sussex Partnership NHS Foundation. In the report of this inspection, published on 27 May 2015, the CQC rated Sussex Partnership as an organisation which 'requires improvement.'

We have developed action plans which describe what we are doing in relation to the compliance actions raised by the CQC. These were submitted to the CQC on 30 June 2015 and published on our website www.sussexpartnership.nhs.uk/cqc

As well as specific issues that we need to address, the CQC report highlights issues which require a wider healthcare systems response such as how we deal with delayed transfers of care and respond to pressure upon our services. We will be inviting partner organisations to work with us on a Quality Improvement Programme to explore these issues, building on the Quality Summit hosted by the CQC on 22 May 2015 to share their report on our services.

1. Overall Ratings

Overall rating for mental health services	Requires Improvement	
Are mental health services safe?	Requires Improvement	
Are mental health services effective?	Requires Improvement	
Are mental health services caring?	Good	
Are mental health services responsive?	Requires Improvement	
Are mental health services well-led?	Requires Improvement	

	Safe	Effective	Caring	Responsive	Well-Led	Overall
1. Community Based Mental Health Services for Adults of Working Age	Good	Good	Good	Good	Good	Good
2. Child and Adolescent Mental Health Wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
3. Wards for people with learning disabilities	Requires Improvement	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
4. Long Stay/Rehabilitation Mental Health Wards for Working Age Adults	Inadequate	Requires Improvement	Good	Good	Good	Requires Improvement
5. Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
6. Forensic Inpatient/secure wards	Good	Good	Outstanding	Good	Good	Good
7. Community based Mental Health Services for Older People	Good	Good	Good	Good	Good	Good
8. Community Mental Health Services for people with Learning Disabilities	Good	Good	Good	Good	Good	Good
9. Wards for Older People with Mental Health Problems	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
10. Adult Acute	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
11. Community based Mental Health Services for Child and Adolescents	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement	Good	Requires Improvement
12. Overall Provider Report	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

2. Summary of findings

This section summarises the CQC findings at the time of the inspection.

Overall, the CQC rated the Trust as requires improvement, in relation to;

- Two core services were rated as inadequate under the 'safe' domain.
- The Trust had no plan in place to tackle the high rate of suicide.
- There were significant gaps in the flow of information, particularly around learning from serious untoward incidents.
- There were significant gaps in training, appraisal and supervision for some staff.
- The quality of care planning was inconsistent and did not always demonstrate how people were involved in their care.
- The Trust lacked strategic direction.
- The Trust had gaps in relation to providing the board with assurance.

However, 'caring' was rated as good or outstanding in all but one service and the Trust was considered to be a place of innovation and ideas, aspiring to best practice in many parts of the services provided.

The inspection team found that some areas of care in learning disability and older people's inpatient services were inadequate. The Trust closed Hanover Crescent (part of Brighton and Hove rehabilitation services) to admissions following feedback the CQC's concerns in relation to shortcomings within the building and the lack of clarity regarding the service model.

The CQC recommended a number of requirement notices to be put into force. These relate to ensuring that standards of hygiene are maintained, that staff are properly supported to receive their mandatory training, that risks are properly identified and people are involved in planning their own care.

The CQC found an elevated risk of people self-harming or committing suicide. Many of these deaths happened whilst people were in receipt of services in the community. The CQC found an elevated risk of suicide within 3 days of discharge and within 3 days of being admitted to an acute setting. In total there were 80 deaths in the period from 1 November to 31 October 2014. Whilst the CQC recognise that it is not just the Trust's responsibility to develop a suicide prevention plan, they have urged the Trust to initiate urgent work with public health and community agencies to address this.

The CQC were concerned that staff were not receiving timely feedback in relation to serious untoward incidents. The CQC therefore asked the Trust to supply them with details of length of time it took from notification of a serious untoward incident to time the report and action was completed and circulated. The data supplied suggested that the Trust was struggling to meet timescales, with some investigations having exceeded the time period stated in the policy. They concluded that this may impact on the ability to close the loop on serious incidents and ensure that learning to avoid / prevent similar incidents from emerging is shared.

The staff survey identified that there was an elevated risk to staff working extra hours and feeling stressed. The Trust had a clear action plan to address this which included reviewing the staffing levels and skills mix on inpatient units and re-introducing a three shift rota.

At the time of the inspection, the Trust acknowledged that there was not a system in place to identify clearly where agency staff were used. The Trust raised this with CQC prior to the inspection.

Overall, caring was rated as good, the trust achieved outstanding ratings in community child and adolescent services and forensic services. Staff were found to be compassionate, kind and motivated to go an extra mile for the people they served. Community services for older people, dementia and people with a learning disability were inspected in East Sussex and rated as good. They found a multidisciplinary approach was

used to support people effectively, national guidance and best practice was used to provide care and risk assessments were comprehensive.

Good solid evidence demonstrated that the Trust was sensitive to individual needs, taking cultural, religious and spiritual needs into account. The Trust also provided good information to people and this was available in a variety of languages and formats.

The CQC found that the Trust is a place where innovation is given priority and this enables them to seek new ways of working and bring about change to service delivery. They commented that there is much creativity at a senior level. They recommended that the Trust continues to ensure that the quality of more traditional services is maintained and that the desire to seek new and innovative ways of working is not at the expense of those services.

The inspection found that the senior management team were very positive about the new Chief Executive Officer (CEO). They felt that having been through a difficult and challenging period and that the culture of the board had changed for the better. The senior team came over as open and transparent in their interviews and discussions. The CEO was able to describe the challenges facing Sussex.

The report concluded that the Trust was in a period of some significant change, including a cultural change. Staff and stakeholders said that relationships with the Trust had been difficult to manage at times but that this was becoming more positive. Many felt that the new CEO was responsible for bringing in a more visible and open approach. The Trust did not have a clear strategic direction that was written down and understood by staff at the time of the inspection and also lacked a framework to ensure that the Board was clear about and understood the more detailed risks and challenges facing the organisation. It had identified the principal risks faced by the organisation.

3. Examples of immediate actions the Trust has taken

- Held a CQC improvement plan event with staff from clinical and corporate services.
- Reviewed ligature risks based on the needs of different client groups and took action where appropriate to reduce risk.
- Taken action to improve the fabric of environments in older people's services
- Closed Hanover Crescent...
- Set up a Task and Finish group trust wide, work is underway on developing a policy and 'Delivering mixed sex accommodation (DSSA) plan for gender separation to promote dignity and privacy.
- Completed infection control audits of all inpatient services.
- Became a partner in Sign up to Safety, a national initiative to help the NHS improve patient safety.
- Introduced a 3 shift system within adult services. Staffing and skill mix has been reviewed and is in line with national guidance.

Ongoing actions

- 'My Learning' an electronic system for recording training and providing e-learning has been implemented and already used by about 3,000 staff.
- 'Carenotes' electronic patient record has been implemented in CAMHS and is scheduled to be implemented in adult services later this year.
- A review of governance has been undertaken and will be considered by the Board in September 2015.
- An Executive Assurance Committee has been introduced to ensure risk is appropriately triangulated.
- We developed and launched a five year strategy, Our 2020 Vision, following an engagement process involving staff, patients, carers, partner agencies and public. In our most recent series of public events, held in June / July 2015, we highlighted how people's feedback has been used to shape the strategy and involved them in discussions about what we need to do to achieve it.

4. Services inspected in East Sussex

4.1 Acute wards for adults of working age	Department of Psychiatry, Eastbourne DGH, including Heathfield) Woodlands, Conquest Hospital
4.2 Mental health crisis services and health based places of safety	Department of Psychiatry CRHT and 136 suite Woodlands 136 suite
4.3 Wards for older people with Mental Health problems	St Anne's Centre, Gabriel Ward Beechwood Unit, Uckfield
4.4 Long stay/ rehabilitation mental health wards for working age adults	Amberstone Hospital Bramble lodge
4.5 Community-based mental health services for older adults	St Anne's Centre, Hastings Millwood CMHT, Uckfield Hospital

5. Compliance (East Sussex)

5.1 Wards for older people some areas were rated as 'requires improvement'. All Older Adult wards were found not compliant with Department of Health requirements for single sex accommodation.

Issues highlighted

- Slips, trips and falls
- Out of date risk assessments
- Use of restraint and seclusion
- Access to Occupational Therapy and Psychology
- Holistic, recovery based care planning
- breakaway and de-escalation of violence training for hospitality staff
- access to prompt specialist nursing services e.g. diabetes Nurse
- access to ward pay telephones for use in private
- access care as close to home as possible
- Practice development e.g. Recovery focussed care
- Accredited Inpatient Mental Health service (AIMS).

In addition Gabriel's environment was reported as looking tired and not dementia friendly and the garden was deemed not safe for people with dementia

5.2 Amberstone Hospital which provides longer stay/ rehabilitation was rated as 'requires improvement in some areas.

Issues highlighted:

- Mandatory training.
- Secure medicines storage in bedrooms
- independent Mental Health Advocacy service

5.3 Acute wards for adults were primarily rated as 'requires improvement'. In East Sussex it was noted that some staff had not received supervision, appraisals or undertaken reflective practice in line with Trust policy.

There were some Trust wide issues across services that apply to East Sussex:

- Mandatory training compliance
- Learning from incidents and complaints
- Service Users involvement in care plans.
- Monitoring of the use of 136 suites
- The discharge pathway

We have developed a comprehensive action plan in response to the CQC inspection which includes areas of specific action for the East Sussex division. The action plans are available at:
www.sussexpartnership.nhs.uk/cqc

6. Good Practice

6.1 Examples of good practice highlighted in East Sussex

Safe
On acute wards for adults it was noted that there were good incident reporting systems in place and strong feedback mechanisms in place in order to learn lessons. Risk formulations were also reported as consistently strong, using a recognised methodology. There were good safeguarding practices and good medicine management.

Effective
Staff handovers in older people's wards were reported as ranging from good to excellent. Staff from the crisis teams were working with the police as part of the 'street triage' initiative. This was noted as having a significant impact on reducing the number of people detained and brought to 136 suites by the police. Community based mental health services for older people demonstrated that care was provided in accordance with evidence-based national guidelines and care pathways were used extensively to ensure best practice.

Caring
The environment at Beechwood was dementia friendly with colourful walls and posters/ pictures throughout the unit. The OT on Beechwood was reported as running a weekly 'carers' clinic' looking at improving their experience of the ward. As part of our Crisis and home treatment service, patients are given a 'welcome pack' that included information about what to expect from the crisis service and the care and support available to them.

Responsive
The crisis team were observed to work flexibly with patients to promote their privacy and responded to patients who found it difficult to meet at home by arranging to meet in cafes or in the hospital instead. Rehabilitation services were observed to be recovery orientated and promoted social inclusion and community involvement. The services encouraged positive risk taking and supported patients towards achieving independence

Well led
There was evidence of excellent dementia care practice on Beechwood ward. At the Department of Psychiatry and Woodlands, staff demonstrated a good understanding of their responsibilities in relation to the MHA 1983 and the code of practice. Staff had a clear understanding about MCA and DOLs.

6.2 Examples of good practice identified more generally

Safe
There were services the CQC inspected which they found to be good under the 'safe' domain. This was because they had good systems in place to monitor risk; for instance a 'zoning' system in community services. Staff were able to articulate how to identify abuse and how to implement safeguarding procedures. Some wards had successfully reduced seclusion through implementing a reducing restrictive practices strategy.

Effective
The Trust consistently demonstrated a good awareness of best practice. Staff were able to articulate how NICE guidelines were used. The Trust is clearly committed to using audit as a measure of how services were performing. The Trust has participated in seven national audits and has undertaken a number of local audits. The Trust is creative and keen to innovate and is taking part in national pilots. They are currently participating in the 'Street Triage' pilot, which aims to reduce the number of people detained inappropriately under S136 of the Mental Health Act 1983.

The Trust is also expanding their forensic and secure services. These services were noted for the initiatives they have implemented on patient involvement and improving patient experience.

The Harold Kidd Unit and the electroconvulsive therapy department are all accredited by the Royal College of Psychiatry.

CAMHS and forensic services belong to the Quality Network for Inpatient Care (QNIC) The network aims to demonstrate and improve the quality of inpatient care through a system of review against the QNIC service standard. The CQC saw that forensic services had implemented changes based on recommendations from the QNIC peer review.

6.1. Caring
Caring was rated as good. This was because staff were found to be compassionate, kind and motivated to make a difference. Caring was rated as good across all core services. In some areas this was rated as outstanding.

The inspection team received positive feedback from patients and their carers and observed many instances where staff were kind and compassionate.

6.2. Responsive
Positively, the proportion of patients followed up within 7 days of discharge was in line with the England average of 97%.

6.3. Well Led
It was clear that there have been some significant changes at a senior level of the organisation. Work has been started to ensure that the Trust is open and transparent. The CEO was in the process of developing his team.

The Trust has a set of values and these were set out in the 'better by experience' booklet that lists and describes the five values: We welcome you. We hear you. We work with you. We are helpful. We are hopeful for you.

There was good financial management in place and the Trust had devolved budgets to the level of the clinical team.

Staff overall were very positive about their managers and most core services were rated as good.

7. Areas for Improvement:

7.1. Action the provider MUST take to improve
The CQC identified the following areas where the Trust must improve services across the organisation and specifically in East Sussex. The Trust has now developed action plans to address each of the following areas:

Older peoples' inpatient wards do not comply with DH gender separation requirements

Action taken (Trust wide)
A policy has been drafted to formalise the safeguarding of any patient placed in a bedroom which necessitates them having to walk past toilet/ bathing facilities of the opposite sex and ensures that this is resolved as soon as possible. Currently there is a group working to developing a 'Delivering Same-Sex Accommodation' (DSSA) Action Plan to include the operationalizing of this policy and our intentions with regard to our ward environments.

Some staff on acute wards for adults had not received supervision, appraisals or undertaken reflective practice in line with Trust policy and at Amberstone almost all staff had not completed basic or intermediate life support training and less than half the qualified nurses were up to date with mandatory medicines management training.

Action taken (Trust wide)

The new learning management system "My Learning" is now live and provides self-service and manager access to training compliance records, E-Learning and booking courses. Locally, individuals training records will be looked at in supervision and appraisal as a matter of routine, this means that every member of staff will have a review of their mandatory compliance on a monthly basis. Staff will be required to take action to address training compliance gaps immediately and failure to address gaps within three months will result in disciplinary action.

Action the provider SHOULD take to improve

Older peoples' inpatient services SHOULD ensure:

- Slips, trips and falls training should be cascaded across all older adult wards to support the pilot project on falls reduction
- The Trust should update its procedures on the use of restraint to reflect current guidance on the use of seclusion.
- Therapeutic activities and access to occupational therapy and psychology should be consistently and equally available across all older people's services.
- All patients should have access to outside areas; ward gardens were not safe for people with dementia
- The Trust should ensure all of its older adult inpatient services have access to prompt specialist nursing
- care record documentation should reflect a holistic, person centred recovery approach highlighting strengths of patients
- that staff receive regular updates and refreshers to promote the most current practice e.g. Recovery focussed care
- Consider participating in a national quality improvement plan such as the Accredited Inpatient Mental Health service (AIMS).
- learning from untoward incidents should be shared within and across wards and teams including night staff
- That all staff receive feedback from complaints

Action taken

- Redesigning our two dementia units in East Sussex to provide one new Dementia Intensive Care Unit (DICU).
- Service level agreement needs agreeing with local community NHS Trusts
- Slips trips and falls training now in place across older peoples' services
- Seclusion training included in adult services physical interventions training

- Practice development programme for older adult inpatient wards to be commenced on Raphael October 2015
- Clinical Academic Group (CAG) for older adult services is considering AIMs accreditation
- 'Report and learn' forum set up monthly to share learning from serious incidents and complaints open to staff across adult services and disseminated down to teams.
- Clinical Audit Committee set up to oversee and plan clinical audits and monitor CQiNs, CQC action plans and LIA initiatives and disseminate learning through DLT and report and learn forum via a Clinical audit newsletter.

Community-based services for older people SHOULD ensure;

- The discharge pathway is identifiable with peoples' records.
- That people's risk assessments are up to date.
- That people are actively involved in developing and reviewing their care plans.

Action taken

- Trust wide 'Care notes' electronic patient record is being implemented in CAMHS and is scheduled to be implemented in adult services later this year and will address these issues.
- On-going supervision includes a case note audit to include monitoring of risk assessments and Service Users involvement in care planning
- Clinical audit programme, Trust wide includes auditing of health care records including SU involvement and risk assessments

Amberstone hospital SHOULD ensure:

- patients taking care of their own medicines can safely secure and store medicines in their bedrooms
- Put in place an independent Mental Health Advocacy service so that detained patients have access to an independent Mental Health Advocate

Action taken

- Facilities have been put in place to allow for Patients to safely store medicines in their bedrooms.
- An independent Mental Health Advocacy service is now in place

136 suites providing a 'Place of Safety' SHOULD ensure:

- Monitoring of the use of 136 suites should be reviewed, to improve the experience of patients, as there were gaps in key information about patients, such as arrival and discharge times

Action taken

- There is an on-going monthly 136 monitoring meeting held, which addresses key issues. This is attended by representatives from acute services, Sussex Partnership, adult social care and the Police. There were some gaps in the data collection forms at the time of the CQC visit, but the process has since been tightened up and all forms are now scrutinised to ensure the information is complete.

8. Our 2020 Vision: Outstanding care and treatment you can be confident in

We have taken the CQC's findings into account when in developing our strategy for the next five years: Our 2020 Vision. Is overarching vision is to provide 'outstanding care and treatment you can be confident'. To achieve this, we have developed five strategic goals which will steer us towards where we want to be:

1. Safe, effective, quality patient care
2. Local, joined up patient care
3. Put research, innovation and learning into practice
4. Be the provider, employer and partner of choice
5. Live within our means

Our 2020 Vision describes what we will do over the next five years to improve the services we provide to patients. To help us plan this we've spoken to people about what they think of our services, the care we provide and what they would like us to do in future.

We've looked long and hard at where we know we need to improve. Carers and people who have used our services have told us, for example, that they can find it hard to know where to get help and sometimes feel like they are being passed around 'the system'. Whilst the way mental health services are provided is complex and involves a lot of organisations, this is something patients and carers shouldn't need to worry about. They shouldn't even notice. Our job is to work so well with our partners that people only notice the quality of care and support they are receiving. At the same time, it should be clear about where people should go if they have concerns or complaints at any time about their care.

Many of our services have developed new ideas to improve services for patients, but we are not as good as we should be at learning from these positive examples and putting them into practice elsewhere. More broadly, it can take up to 20 years in the UK for the learning from healthcare research to be used to benefit patients. We want to help reduce that gap. The mind and body continue to be treated separately, whereas it would be better for patients if physical and mental health care were brought more closely together.

8.1 Engagement

The engagement strategy to develop Our 2020 Vision involved:

- six public events in January 2015 which were attended by patients, carers, staff, partner agencies and public.
- discussions with staff.
- discussions with our Board and Our Council of Governors, the latter of which includes patient, carer and public representation.
- sharing the draft strategy with stakeholders and adapting it in response to feedback.
- a further round of six public events in June / July 2015 where we demonstrated how we have used feedback to develop the strategy and invited people to be involved in discussion about how we implement it.

We are planning further engagement activity to continue the conversation with stakeholders how we achieve our vision to provide outstanding care and treatment you can be confident. Our 2020 Vision is available on our public website: www.sussexpartnership.nhs.uk/our-strategy

We are also producing an overarching Quality Improvement Plan which describes what we are doing, in partnership with other organisations we work with, to address the wider issues raised by the CQC. This will be considered by our Board in September 2015 and will be published on our website. The Sussex Clinical Commissioning Groups and Local Authorities have been engaged and are contributing to the plan as not all the actions are within the sole gift of the Trust and will require the support and prioritisation in local plans and resource allocation.

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**1 October 2015**
By:	**Assistant Chief Executive**
Title:	**High Weald Lewes Havens (HWLH CCG): Procurement of Community Services**
Purpose:	**For HWLH CCG and the new provider, Sussex Community NHS Trust (SCT) to present their plans for community services in the HWLH locality.**

RECOMMENDATIONS

HOSC is recommended to consider and comment on HWLH CC and SCT plans for community services in the HWLH locality

1. Background

1.1 HWLH CCG recently went to tender for its adult community services contract. The CCG announced in June 2015 that the preferred bidder for this contract was Sussex Community NHS Trust (SCT). The previous provider of these services was East Sussex Healthcare NHS Trust (ESHT). ESHT remains the main provider of community services across the rest of East Sussex.

1.2 SCT is an NHS trust which already provides a wide range of community services for West Sussex and Brighton & Hove. The Care Quality Commission (CQC) recently inspected SCT services, giving the trust an overall rating of "Good." The CQC report is available here: http://www.cqc.org.uk/provider/RDR

1.3 HWLH CCG and SCT plans to develop community services are outlined in **Appendix 1** to this report.

2. Conclusion and recommendation

2.1 HOSC members are asked to consider and comment on the HWLH CCG and SCT plans to develop community services in the HWLH locality.

PHILIP BAKER
Assistant Chief Executive

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Please contact for paper copies of any of the reports mentioned above

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Adult Community Services re-procurement

Presentation from NHS High Weald Lewes Havens Clinical Commissioning Group and Sussex Community NHS Trust

Context

NHS High Weald Lewes Havens Clinical Commissioning Group (CCG) has undertaken a procurement exercise in order to transform local community services as part of a strategic vision for the provision of health and social care for the future. Excellent community services are essential to any high performing local health economy, but nowhere more so than in High Weald, Lewes, and the Havens, where patients requiring acute hospital care are required to travel outside of the CCG area. Integration between hospital and out of hospital services is of paramount importance to support natural geographical patient flows and to optimise patient care.

The CCG vision, entitled 'the Green Triangle' set out to bring services closer to home, delivering integrated packages of care which achieve the best health outcomes for the patient and keeping them out of acute hospital settings wherever possible. It suggests that to meet the needs of an ageing population with increasing health and social care needs, services can better support patients if they are genuinely designed to meet the needs of the local population, and fully integrated with all the hospitals that patients use.

This vision was informed by local and national drivers, the strategic context, which led to the design of a framework and objectives by the CCG, with input from patients, local clinicians, and examples of national good practice. In this context, the procurement of community services is a major piece of the CCG's strategy.

This also fits within a broader context of the *East Sussex Better Together Programme* (ESBT) through which the CCG is working with East Sussex County Council and the other two East Sussex CCGs on a programme of service transformation to better integrate delivery of health and social care and to develop new models of provision. These developing models have critically informed the service requirements the CCG has sought through this programme.

History

Given the pivotal role of community services in delivering the CCGs strategic vision, a range of discussions were held with the current provider to secure the level of transformation of services required. Ultimately the discussions failed to secure the level of engagement required from the provider. Following

discussions with the CCGs wider membership the CCG decided to serve notice on the contract in order to engage with a range of providers (including the incumbent) to discuss how services could be delivered differently and more effectively.

To inform these discussions, and better understand the issues behind the challenges to effective delivery of community services, a quality review of the current community services was undertaken by the CCG. It was found that though the current service has dedicated staff, providing good quality direct patient care, the service model within which they work is fragmented and does not fully integrate with primary, secondary and community care. Systems such as information technology, workforce, quality and governance specific to community services require improvement to improve flexibility and responsiveness and identify shortages and gaps to enable early intervention.

A market engagement in the summer of 2014 made it clear there was a range of providers who could potentially provide services to HWLH and in so doing could bring real innovation to service design and delivery. Therefore, given there was every indication that current services would benefit from a whole service transformation; and there were likely to be alternative options for delivery available to the CCG, the decision was taken to undertake a full procurement of services.

Most importantly the transforming community services project has been clinically led from the outset and continues to be so; and has benefited from comprehensive, extensive and on-going patient and public involvement (PPI). By undertaking a competitive dialogue procurement process, a range of stakeholders, including patients and local GPs, were able to engage in discussions with potential providers to build a clearer picture of what the optimum service would look like; and how this could be delivered. This dialogue included formal presentations and subsequent questions and answers, as well as more informal 'break out' discussions with CCG subject matter experts which focussed on specific aspects of delivery such as Primary Care interface, adult social care, Information and Technology, Finance, and patient engagement.

Procurement process

The outcome of the procurement process demonstrated a clear result with a preferred bid identified. The preferred bid was from the Sussex Community NHS Trust (SCT) presented as the Sussex Alliance. The preferred bid scored the strongest or joint strongest across the board for all criteria. The outcome was recommended to the Governing Body who agreed the recommendation.

Improving adult community services in High Weald Lewes Havens

SCT will be providing the following services from 1st November:

- District/community nursing.
- Minor injuries and illness units.
- End of life care.
- Intermediate care beds.
- Specialist nursing.
- Community diagnostics.
- Community dietetic.
- Community heart failure.
- Community neurological rehabilitation.
- Community occupational therapy.
- Community respiratory service.
- Continence.
- Speech and language therapy.
- Tissue viability service.

SCT has created Sussex Healthcare Alliance to bring together a number of local providers to work collaboratively to improve outcomes for the people of HWLH and to create more seamless pathways between primary, community and acute services.

The Alliance Steering Group will be led by SCT and contains representatives from Brighton and Sussex University Hospitals NHS Trust, Maidstone and Tunbridge Wells NHS Trust, Brighton & Hove Integrated Care Service (BICS), Queen Victoria Hospital NHS Foundation Trust, Age UK East Sussex, Sussex Partnership NHS Foundation Trust and East Sussex County Council.

Improving adult community health services is wholly aligned to the East Sussex Better Together (ESBT) programme, which SCT has joined as a stakeholder and provider.

SCT is excited to be providing adult community services in High Weald Lewes Havens and is working together with its staff, partners and other health and social care organisations. Joining the ESBT programme will help SCT to transform services to better meet local needs and deliver better outcomes.

Initially safe transfer of services is of paramount importance as well as providing clarity and support for staff. SCT is committed to increase staffing levels and to use technology to free up more time to spend on direct patient care.

SCT and BICS are working closely with local GPs to develop communities of practice to bring primary and community care closer together.

This commitment and focus aims to improve patient outcomes and experience

of care.

Sussex Community NHS Trust

Sussex Community NHS Trust (SCT) was awarded the contract to provide adult community services from 1st November 2015 by NHS High Weald Lewes Havens Clinical Commissioning Group (CCG) in June. Contracts were signed by both NHS organisations in July.

Who are SCT and what do they do?

SCT was formed in October 2010 and is the main NHS provider of community health and care across adults and children's services in West Sussex and Brighton & Hove. And from the 1st November 2015 will be providing adult community services in the High Weald Lewes Havens area of East Sussex.

90% of NHS care is provided in the community by GPs and by community health and care providers like SCT who care for people in a range of settings:

- Mainly in peoples' own homes i.e. community/district nursing.
- Community hospitals, urgent treatment centres, minor injury units, child development centres and other locations.
- In care homes, GP surgeries and acute hospitals.

Across the age range SCT cares for some of the most vulnerable people:

- Babies, young children and mothers through its healthy child programme including health visiting.
- Young people and adults with long-term conditions e.g. diabetes, asthma and heart failure with support from specialist doctors, nurses and therapists.
- Multi-agency and multidisciplinary community teams caring for the frail elderly and for people at the end of their lives e.g. proactive care in West Sussex and the Palliative Care Partnership with The Martlets in Brighton & Hove.

SCT employs around 4,500 staff including community and specialist nurses, therapists, healthcare assistants and support staff. It also has over 550 vibrant volunteers.

Currently in East Sussex SCT provides Chailey Heritage Clinical Services, Abdominal Aortic Aneurysm (AAA) screening, Chronic Fatigue Syndrome/ME Service and Sussex Rehabilitation Centre out-patient service.

Quality of care is its top priority and provides high quality medical, nursing and therapeutic care to more than 8,000 people a day. Its vision is to deliver: ***excellent care at the heart of the community***.

Recent achievements

In March 2015 the health and social care regulator, the Care Quality Commission (CQC), rated SCT services overall as ***Good***, following its inspection of the trust in December 2014. This provides confidence to local communities that SCT services are safe, caring, effective, responsive and well-led.

For the second year running SCT secured the *Health Service Journal* 120 Best Places to Work in the NHS.

SCT is also on track to be authorised as an independent community NHS foundation trust in 2016 and is expected to move to the Monitor phase towards the end of 2015. Monitor is the sector regulator for health services in England.

Presentation to the HOSC

HWLH CCG and SCT are jointly presenting to the committee and will cover:

- Geographical area and services included in this procurement.
- The need to undertake the procurement process.
- How and when.
- Engagement.
- What it means to our patients/community.
- Introduction to SCT – who they are, what they do.
- Working together.
- Improving services.

Contacts

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- Siobhan Melia, Commercial Director, SCT – siobhan.melia@nhs.net

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Work Programme for Health Overview and Scrutiny Committee

healthscrutiny east sussex

Future work at a glance

Updated: October 2015

Please note that this programme is correct at the time of updating but may be subject to change. The order in which items are listed does not necessarily reflect the order they will appear on the final agenda for the meeting.

Future Committee agenda items		***Author***
3 December 2015		
Dementia Strategy	To consider a progress report on the development of dementia services in East Sussex, including Memory Assessment Services and the dementia pathway work in HWLH.	Jessica Britton, EHS/H&R CCGs and Ashley Scarff, HWLH CCG; Martin Packwood, ESCC ASC/CCGs
Scrutiny Review Board: ESHT Quality Improvement Plan	Report back on progress	Giles Rossington

Potential future scrutiny issues

This table lists issues which have been identified for potential inclusion in the Committee's work programme. Initial investigation is often undertaken (e.g. by requesting further information) to determine whether further work, or an agenda item, is needed.

Issue	***Objectives / Evidence***	***People / HOSC timescale***
GP vacancies	To investigate recent media reports of high levels of GP vacancies, notably in the Hastings area. Initial information request to be sent to NHS England and CCGs.	Letter to NHS England – December 2014
HIV diagnosis	To consider the approach being taken to maximising HIV diagnosis in East Sussex	16 January 2015 – meeting of Cllr O'Keeffe with public health commissioners. Cllr O'Keeffe to report back to Committee.
CQC inspections	To submit evidence (as available), contribute to Quality Summit and review outcomes of CQC inspections of local Trusts: • ESHT – inspection September 2014, Quality Summit and report expected early 2015. • MTW – Quality Summit and report expected early 2015 • SPFT – inspection January 2015, Quality Summit and report dates tbc	Ongoing – liaise with CQC and Trust leads
Maidstone and Tunbridge Wells NHS Trust Clinical Strategy	To consider any proposed service changes arising from the Trust's strategy which would impact on East Sussex residents, for example any proposed changes to stroke services at Tunbridge Wells Hospital.	MTW to keep HOSC informed of proposed changes. Ongoing liaison with Kent HOSC
ESHT Clinical Strategy	Ongoing monitoring of clinical strategy implementation, including progress of reconfigured services (stroke, general surgery and orthopaedics) and Full Business Case for capital funding. Visit to EDGH stroke unit to be arranged	Data workshop to be held to consider ongoing monitoring requirements – date tbc Date tbc
Bowel Cancer Screening	To consider how East Sussex compares to other areas in terms of implementation of the national screening programme.	Information request tbc
Lewes Victoria Hospital clinics	To check the situation regarding reported withdrawal of pacemaker and audiology clinics at the hospital.	Information request to HWLH CCG – December 2014

Documents circulated for information

This table lists significant documents/briefings which have been circulated to the Committee since the last HOSC meeting, or which remain 'active' because further action is anticipated.

Issue	***Summary and date***	***Contact***
Integrated musculoskeletal (MSK) service commissioning	Briefing on the MSK service in High Weald Lewes Havens and Eastbourne, Hailsham & Seaford CCG areas. Procurement process from autumn 2013-summer 2014. *14 August 2013: circulated by email to HOSC.* *29 August 2014: update briefing circulated to HOSC detailing the new contract.* *November 2014 – CCG response to HOSC Chair's questions circulated by email to HOSC.*	Ashley Scarff, HWLH CCG
MTW: CQC report/Vision	MTW CQC report was published early 2015 (Requires Improvement). HOSC agreed in Sep 14 to have a future item on MTW provision, so could potentially ask trust to present on both	
ESHT urology services	Request for an update on any plans to vary services (Nov 14 HOSC)	
Impact on local NHS provider landscape of future NHS restructuring plans (e.g. move from acute to community services)	Request for a briefing Sep 14 HOSC	

If you have any comments to share about topics HOSC will be considering, as shown above, please contact:
HOSC Support Officer: Giles Rossington, 01273 335517 or giles.rossington@eastsussex.gov.uk

Acronyms
A&E – Accident and Emergency department
ASC – Adult Social Care
AT – Area Team (of NHS England)
BSUH – Brighton and Sussex University Hospitals NHS Trust
EDGH – Eastbourne District General Hospital
CCG – Clinical Commissioning Group
CQC – Care Quality Commission
EHS – Eastbourne, Hailsham and Seaford
ESCC – East Sussex County Council
ESHT – East Sussex Healthcare NHS Trust
H&R – Hastings and Rother
HOSC – Health Overview and Scrutiny Committee
HWLH – High Weald, Lewes, Havens
MTW – Maidstone and Tunbridge Wells NHS Trust
NHS – National Health Service
SECAMB – South East Coast Ambulance Service NHS Foundation Trust
SPFT or SPT – Sussex Partnership NHS Foundation Trust
TBC – to be confirmed
TDA – Trust Development Authority

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Project Initiation Document

healthscrutiny east sussex

Scrutiny Review	ESHT Quality Improvement Plan
Responsible Committee	HOSC
Author	Giles Rossington
Version	1
Date	30 July 2015

Aims of the Review

To receive assurance that the ESHT Quality Improvement Plan (QIP) properly addresses the findings of the CQC inspection(s); that ESHT meets its QIP commitments; and that the QIP actions lead to improved performance – particularly in terms of outcomes for patients.

Scope of the Review

The review will focus on five key service areas identified by the CQC in its initial (March 2015) inspection reports: surgery, maternity, patient records, outpatients, and pharmacy. The review will also include some related issues: (1) the implementation of the Better Beginnings Scrutiny Review recommendations – to be considered as part of maternity; (2) problems with ESHT communication with patients (e.g. cancer letter) – to be considered as part of outpatients; (3) data security (e.g. lost memory sticks) – to be considered as part of patient records.

The review will also address issues relating to ESHT's corporate 'culture', including complaints, whistleblowing, staff survey, sickness absence, bullying & harassment, incident reporting, and the Friends & Family test.

Areas outside the scope of the review

The review will not consider the substantive issues of the reconfiguration of ESHT surgical or maternity services. The review will not consider the financial position of ESHT as a substantive issue.

Background

The Scrutiny Board was established following the CQC inspection reports on ESHT services published in March 2015. The Board will also take into account the follow-up CQC inspection report (due to be published Sep 15).

Review methods

Board members will form five sub-groups of 3-4 members to explore each of the key service areas (see above). Sub-groups will study the CQC reports and the ESHT QIP; will interview the relevant lead ESHT officers, and potentially also selected stakeholders; and will report back to the Scrutiny Board. The Scrutiny Board will make final recommendations. Recommendations will be to the NHS quality regulators: e.g. the CQC and the TDA rather than directly to ESHT or to CCGs.

Issues relating to ESHT's corporate culture (see **Scope of the Review** above) will either be scrutinised by an additional sub-group or by the whole Review Board. This will be determined by Board members.

The work of the Scrutiny Board will be supported by the Scrutiny team. However, given the scale of this work, it will not be possible for officers to support all activity and sub-group members will be expected to arrange some meetings and to take their own meeting notes etc. Officers will draft the final report for approval by Board members.

Potential witnesses for oral and/or written evidence:

- Lead ESHT clinicians for the key service areas
- ESHT CE, Head of HR and Improvement Director
- CCG commissioners (esp. in terms of analysis of ESHT performance)
- Stakeholders (e.g. Mr Richard Hallett for HW maternity pathways)

Review Organisation and Responsibilities

Project Manager

Giles Rossington

Timetable

Activity	**Date**
Review Board Meeting 1 •	Late Oct 15
Review Board Meeting 2 •	Late Nov 15
Final Review Board Meeting 3 •	TBC
Draft Scrutiny committee covering report and finalise Review Board report.	Feb 16
Deadline for Report Dispatch	End Feb 16
Report to HOSC	March 16