HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 22 MAY 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, Alan Shuttleworth, Bob Standley, Michael Wincott and Angharad Davies

District and Borough Council Members
From Eastbourne Borough Council, Hastings Borough Council, Lewes District Council, Rother District Council, and Wealden District Council

Voluntary Sector Representatives
Julie Eason, SpeakUp
Jennifer Twist, SpeakUp

Please note that the meeting will be available to view live or retrospectively on the internet via the HOSC website: www.eastsussexhealth.org

You can subscribe to updates on Twitter: @ESCCScrutiny

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. **Urgent items**

4. **East Sussex Healthcare NHS Trust (ESHT): Care Quality Commission (CQC) Quality Report** *(Pages 7 - 64)*

   The purpose of this report is for HOSC to consider and comment on the Care Quality Commission Quality Report on services provided by East Sussex Healthcare NHS Trust. HOSC will hear evidence from a number of witnesses.

   Witnesses will give evidence in the following order:

   a) The Care Quality Commission (CQC)

   b) East Sussex Healthcare NHS Trust (ESHT)

   c) East Sussex Clinical Commissioning Groups (CCGs)

   d) Trust Development Authority (TDA)

   e) Healthwatch

5. **Any other items previously notified under agenda item 3**

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Cresent
LEWES BN7 1UE

14 May 2015

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Future HOSC meetings: 10am, Tuesday, 16 June 2015, County Hall, Lewes
10am, Thursday 1 October 2015, County Hall, Lewes
10am, Thursday 3 December 2015, County Hall, Lewes

Map, directions and information on parking, trains, buses etc
Map of County Hall, St Anne's Crescent, Lewes BN7 1UE

County Hall is situated to the west of Lewes town centre. Main roads into Lewes are the A275 Nevill Road, the A2029 Offham Road and the A26 from Uckfield and Tunbridge Wells. The A27 runs through the South of the town to Brighton in the West, and Eastbourne and Hastings in the East. Station Street links Lewes train station to the High Street.

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Enter via the main gate in St Anne's Crescent and follow the road round to the left past the main reception and into the east car park. You will see parking spaces set aside for HOSC guests. Please note that the number of spaces is limited. Visitors are advised to contact Simon Bailey on 01273 481935 a couple of days before the meeting to arrange a space. Email: simon.bailey@eastsussex.gov.uk

By train

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By bus

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28/29 – Brighton, Ringmer, Uckfield, Tunbridge Wells
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121 – South Chailey, Chailey, Newick, Fletching
122 – Barcombe Mills

123 – Newhaven, Peacehaven
166 – Haywards Heath
VR – Plumpton, Ditchling, Wivelsfield, Hassocks, Burgess Hill.

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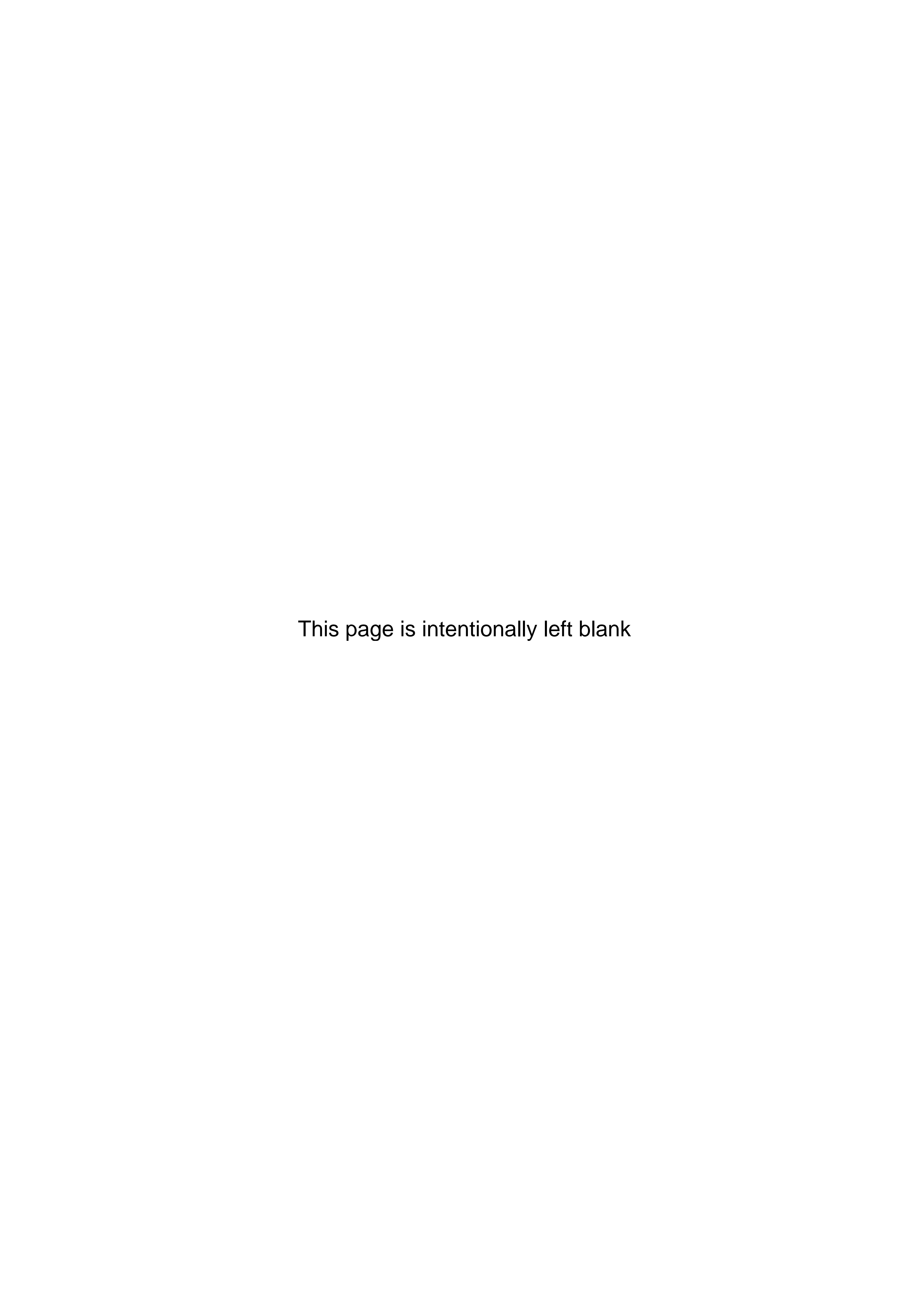
Commonly Used Acronyms Glossary

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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Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date: **22 May 2015**

By: **Assistant Chief Executive**

Title of report: **East Sussex Healthcare NHS Trust (ESHT): Care Quality Commission (CQC) Quality Report**

Purpose of report: **To consider the recent CQC Quality Report on ESHT**

RECOMMENDATIONS

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

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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 inspection has been undertaken more recently, but findings from this have not yet been published or sent to ESHT to check for factual accuracy. Given this, it will not be possible to discuss details of this second inspection at the May 22 HOSC meeting.

1.2 When the CQC inspects acute hospital trusts, specialist mental health services and community health services, its inspection findings are discussed at a quality summit. This is a meeting with the care provider and partners in the local health and social care system. Quality summits are typically held in advance of the publication of an inspection report. However, there has to date been no quality summit for the ESHT report.

1.3 NHS trusts are required to publish and implement action plans in response to CQC Quality reports. ESHT has accordingly published a Quality Improvement Plan detailing its actions in response to the initial CQC inspection reports. (This plan is included as **Appendix 2** to this report.) It is likely that the Quality Improvement Plan will require some further revision once the findings of the second CQC inspection have been published.

1.4 It should be noted that the ESHT Quality Improvement Plan details only actions in direct response to the CQC inspection, and does not capture the totality of ESHT quality improvement work, which is considerably broader in scope. In order to fully appreciate the trust's plans for improvement, it is important that the Quality Improvement Plan is viewed in the context of this wider strategic planning.

1.5 In September 2014 the CQC inspected the following eight 'core' services at both the Conquest Hospital, Hastings, and Eastbourne District General Hospital:

- Accident & Emergency services including Minor Injuries Units
- Medical Care including care of older people in both acute hospitals and community settings
- Surgery
- Critical Care
- Maternity services
- Services for Children & Young People
- End of Life Care
- Outpatient services.

The CQC also inspected four 'core' community services:

- Adult services
- Inpatient services
- Children's services
- End of Life Care services.

1.6 The CQC evaluates NHS trust core services in terms of five key categories, asking whether each service is: *safe*, *caring*, *effective*, *responsive to people's needs*, and *well-led*. Each service receives a rating in terms of each of these categories. The possible ratings are: *excellent*, *good*, *requires improvement*, and *inadequate*. The CQC uses a composite of these service ratings to 'score' each individual hospital managed by the trust against all five categories, and also to rate the NHS trust in terms of its overall provision.

1.7 The CQC Quality Report for ESHT rates the trust as *inadequate* overall. The CQC also rates both the Conquest Hospital and Eastbourne DGH as *inadequate*. Community services are rated as: Adults (*requires improvement*), Inpatient (*good*), Children's (*requires improvement*), End of Life Care (*requires improvement*). The overall Quality Report for ESHT is included as **Appendix 1** to this report; the additional CQC reports can be accessed at: http://www.cqc.org.uk/provider/RXC.

1.8 ESHT has produced an action plan for improvement in response to these reports, which may be subject to some revision following the publication of the second inspection report. Implementation of this action plan will be overseen by the Trust Development Authority (TDA). The TDA is the body responsible for overseeing the performance management of non-Foundation NHS trusts.

1.9 HOSCs have an important role to play in ensuring that local NHS services are of a good quality, and East Sussex HOSC will consequently need to be assured that ESHT's action plan for improvement is robust and has the confidence of the TDA and of commissioners. The HOSC may therefore wish to consider the Quality Improvement Plan in some detail - perhaps initially via a working group of members - and subsequently to monitor its implementation.

1.10 Prior to more detailed examination of the trust's Quality Improvement Plan, HOSC members may wish to seek assurance that:

- there is broad agreement between the CCGs, ESHT and the TDA regarding the actions required to improve local hospital services
- the respective roles to be played by the TDA and by East Sussex CCGs in monitoring the implementation of the action plan are clear
- the TDA and East Sussex CCGs are in a position to performance manage ESHT effectively going forward.

Members may also wish to discuss with NHS partners how the HOSC can best engage with the process of service improvement; and how to determine whether the implementation of the action plan has in fact led to better quality services.

This may require the establishment of a member working group to report back to a subsequent HOSC meeting.

1.11 At the 22 May 2015 HOSC meeting, the running order for this item will be as follows:

- The CQC will introduce their Quality Report, outlining their role and explaining the inspection process
- ESHT will outline the actions they are taking in response to the CQC Quality Reports, focusing on the overall Quality Report for ESHT (see **Appendix 1**) and on the key core services of maternity and surgery. These actions will be explained in the context of the trust's wider programmes of quality improvement. There will be a PowerPoint presentation. (This will be finalised the day before the meeting so as to be as up to date as possible. For

this reason copies of the presentation will not be distributed to members in advance of the meeting.)

- East Sussex CCGs will be invited to comment on the CQC report and the ESHT actions in response
- The TDA will be invited to outline its role in terms of the CQC report and consequent service improvements at ESHT
- Healthwatch will be invited to comment on the CQC report
- HOSC members will discuss what actions to take next.

2. Conclusion and recommendation

2.1 HOSC is asked to: 1) consider and comment on the Care Quality Commission Quality Report on services provided by East Sussex Healthcare NHS Trust; and 2) to agree lines of enquiry and monitoring on the ESHT action plan.

PHILIP BAKER
Assistant Chief Executive

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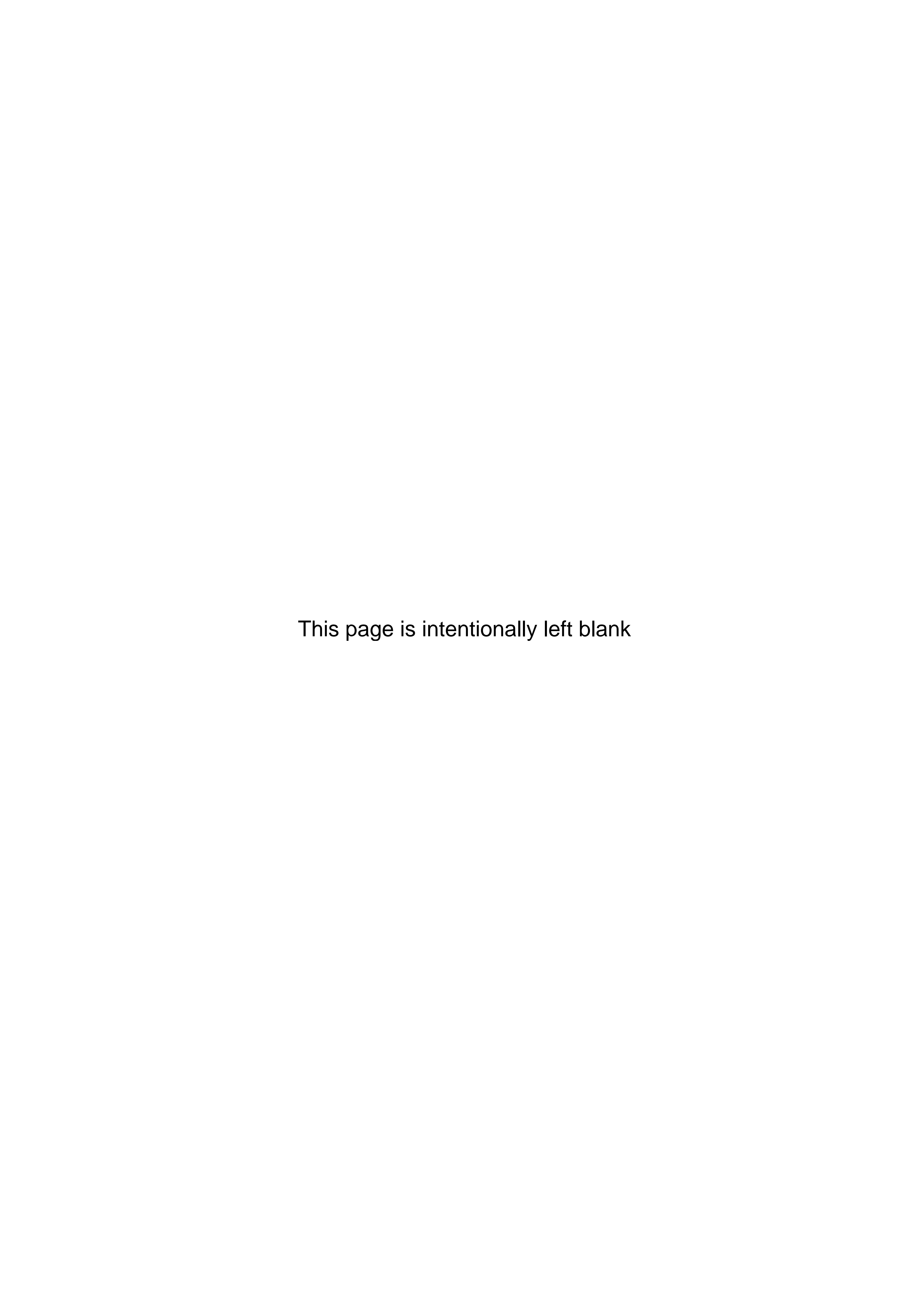
Please contact for paper copies of any of the reports mentioned above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Appendix 1

East Sussex Healthcare NHS Trust

Quality Report

Kings Drive
Eastbourne
East Sussex
BN21 2UD
Tel: 01323 417400
Website: http://www.esht.nhs.uk/

Date of inspection visit: 9 – 12 September 2014
Date of publication: 27 March 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**

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Summary of findings

Overall summary

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

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

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

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

We received concerns about the provision of pharmacy services. We looked at this in our unannounced visits using a team of CQC pharmacists. As the issues identified are across the whole hospital (rather than within one core service), we have included our findings on pharmacy as a trust wide service in the provider report.

In consultation and with the support of the Clinical Commissioning Groups who commission their services and the Health Overview and Scrutiny Committee of East Sussex County Council, the trust had recently made permanent what had previously been a temporary reconfiguration of services. The temporary reconfiguration had been in response to safety concerns. In July 2013 a group of consultant obstetricians working in both hospitals had raised concerns about the safety of maternity services. The reconfiguration moved consultant led maternity services from the Eastbourne District General Hospital site to a single consultant-led unit at the Conquest Hospital. Eastbourne District General Hospital retained a small midwifery-led unit. As a consequence of moving maternity services, gynaecology and children's services also had to be moved to the single site provision. There is much local opposition to the changes and concern about maternal and child safety within the Eastbourne population. Additionally, some surgical services (including trauma and orthopaedic services) are now also centralised at the Conquest Hospital. The additional travel costs and times between the two hospitals has also been a concern for local people. There was some reconfiguration of other services but we heard less about these from local people.

The trust had followed guidance on both consultation and reconfiguration set out by the Secretary of State for Health. The consultation process was led by the local Clinical Commission Groups and has been assessed by an audit of its corporate governance. The assessment of this process by internal audit company provided assurance to the board and stakeholders that "Corporate governance, in relation to the maternity project specifically,

considered to be executed to a high standard and in compliance with the selection of Good Governance Institute outcomes examined". It also set out that "Structures and decision-making processes clearly set out and followed".

We inspected the 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 were as follows:

- The trust board recognises that staff engagement is an area of concern. Despite this we found a disconnect between the trust board and its staff.
- We saw a culture where staff were afraid to speak out or to share their concerns openly.
- We found that management of outpatients' reconfiguration has led to service deterioration and a failure to respond to the needs of people using the service.
- We saw that waiting times in outpatients were excessive and did not meet government targets.
- 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.
- In a number of areas; we were concerned about medicines management and pharmacy services.
- The trust board had taken steps to secure stakeholder engagement in the development of its plans and has worked in partnership with commissioners to ensure stakeholders have been engaged in the consultations on service reconfiguration.
- Despite this work there remained a poor relationship between the board and some key stakeholders. This has led some of the public to lose confidence that the service configuration meets their needs. A much higher than expected number of people attended the listening event and contacted us with their concerns.

We saw several areas of outstanding practice including:

- Clinical leadership and consultant presence in critical care.
- Introduction of a handheld electronic system for recording patients' observations
- Nurse-led discharge.

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

Importantly, the trust must:

- Rebuild the relationship with its staff grounded in openness, developing a culture of the organisation with regard to people feeling able to speak out.
- Undertake a root and branch review across the organisation to address the perceptions of a bullying culture.
- Improve relationships with stakeholders and the population it serves; specifically relating to their concerns about service configuration.
- Review and improve the trust's pharmacy service and management of medicines.
- Review the reconfiguration of outpatients' services to ensure that it meets the needs of those patients using the service.
- Review the length of waiting time for outpatients' appointments such that they meet the governments RTT waiting times.
- Ensure that health records are available and that patient data is confidentially managed.
- Review staffing levels to ensure that they are sufficient for service provision.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

Are services safe?

We saw a number of issues that led to a rating for safety at the trust of inadequate.

We saw low staffing levels in Surgery, Maternity and Pharmacy specifically.

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.

We were concerned about medicines management, particularly in surgery and in outpatients. Pharmacy services across the trust were also of concern.

Patients' records were not securely stored in outpatients. Medical records were unavailable and in poor state of repair. Clinicians had difficulty locating information upon which to base a decision.

We observed staff, in the main, following 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.

In many areas the hospital was clean and tidy; however we had concern over the cleanliness in some areas of Maternity services.

Inadequate

Are services effective?

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

Policies were out of date and compliance with them was poorly monitored.

Surgical teams did not undertake morbidity and mortality reviews regularly and consistently.

At the time of our inspection, the trust also had a higher than expected mortality levels measured by the Summary Hospital Level Mortality Indicator.

A backlog of referrals was delaying patients accessing timely care.

The trust was following NICE guidance where appropriate

Requires improvement

Summary of findings

Are services caring?

Good

We found that services across the trust were caring and have rated this good. We received many positive comments from patients and their carers.

We had a higher number of people attend our listening event than would be expected for a trust this size. We heard a number of experiences from patients and carers before our visit. Some of these were harrowing; some related to care and compassion; some to the responsiveness of the organisation. Whilst we noted these stories and empathise with those families who had poor care from the trust, during our visit talking to patients on the ward all experiences we heard were highly positive and patients praised the staff at both sites.

Are services responsive to people's needs?

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.

The redesign of outpatients' services had been poorly implemented. Essential tasks had been missed in the service redesign.

In maternity, there was a 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.

Are services well-led?

Inadequate

The trust had just undertaken a major and contentious reconfiguration of some of its clinical services. We did not see a clear vision for the trust going forward from this.

Following the reconfiguration, there was a loss of trust from some of the stakeholders in the trust management.

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.

There was a disconnect between the trust board and the staff.

We saw a culture of concern and sometimes fear from staff in the trust about raising their concerns.

Summary of findings

We had a much larger than expected number of staff contact us who were not prepared to reveal their identity until we could assure their confidentiality.

Staff across a number of areas told us of their experiences about their perceived failure of managers to act on their reported concerns.

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.

Pharmacy service leadership was lacking.

Summary of findings

What people who use the trust's services say

Friends and Families Test score for inpatient services in June 2014 was 67. This is below the England average for NHS organisations of 73 and the Surrey and Sussex average score of 74. The quarter one scores nationally ranged from 67 to 78. However, more recent Friends and Family data showed improvement: 95% in August - Surrey and Sussex Area Team Average and England Average were both 94%; 94% in September - Surrey and Sussex Area Team Average and England Average both 93; 94% in October – the same as Surrey and Sussex Area Team and England average. This data was not available at the time of the inspection visit.

The Cancer Patient Experiences Survey (CPES) 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) showed the trust was rated below the national averages for all four key areas of cleanliness; food; facilities and privacy, dignity and wellbeing

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 is higher than would be expected for a trust of this size. More recent data from Patient Led Assessments of the Care Environments (PLACE) showed the trust has made improvements in all of the 4 key areas. The trust is now in line with the national average and above the national average for food.

The NHS Choices website rates trusts with a star rating based on feedback and reviews by people using the service. East Sussex Healthcare NHS Trust scored 3.5 stars overall (out of a maximum of 5 stars). Both acute hospitals had an overall score of 3.5 stars based on patient reviews.

Between August 2013 and July 2014 CQC received feedback from 16 people who used our 'Share your knowledge' forms. The Issues raised in these comments included: medications/pain relief not being given, rehabilitation services not being offered, dissatisfaction with the complaints process, long waiting lists/times, ineffective discharge of a patient to their home, staffing levels (and its effect on dignity, medications, pain relief and answering of call bells), operation delays, patient charts being completed incorrectly, poor administration, attitude of nursing staff and poor treatment in the accident and emergency department.

The CQC Inpatient Survey 2013 showed that the trust was performing, 'about the same' as other trusts for

11 of the 12 key performance indicators. The trust was performing better than other trusts on the final indicator which was related to delays in discharges. In general, scores for each indicator had improved on the previous year's figures. There were four exceptions to this trend which related to whether people had sufficient emotional support and found someone to talk to about their worries and fears, whether they felt sufficiently involved in decisions about their care and whether they received sufficient assistance to eat.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

The trust must:

- Improve the relationship with its staff, specifically the culture of the organisation with regard to people feeling able to speak out.
- Undertake a review of the culture specifically looking at the perceived bullying allegations.

Summary of findings

- Improve relationships with the population it serves; specifically relating to their concerns about service configuration.
- Review and improve the trusts management of medicines in clinical areas.
- 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.
- Review staffing levels across the organisation to ensure there are sufficient staff to meet the needs of the service.
- Review the impact of the maternity reconfiguration.
- Ensure that health records are available and that patient data is confidentially managed

Good practice

- Consultant presence on critical care 7 days per week.
- Good leadership in ITU
- Nurse led discharge
- Introduction of VitalPAC

East Sussex Healthcare NHS Trust

Detailed findings

Hospitals we looked

Conquest Hospital, Eastbourne District General Hospital, East Sussex Community Services

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Chair: Dr Mike Anderson, Chelsea and Westminster NHS Foundation Trust.

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

The team included CQC inspectors and a variety of specialists: The team of 52 that visited across the trust on 10, 11, 12 September and the team of five who visited the two district general hospitals on 23 September 2014 included senior CQC managers, inspectors, data analysts, inspection planners registered and student general nurses and a learning disability nurse, a consultant midwife, theatre specialist, consultants and junior doctors, a pharmacist, a dietician, therapists, community and district nursing specialists, experts by experience and senior NHS managers.

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

In 2012, 22.0% of adults are 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 ongoing deficit.

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

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

At the time of the inspection there was a stable trust board which included a chairman, five non-executive directors, chief executive and executive directors. The chair was appointed in July 2011 for a period of four years. The chief executive officer joined the trust in April 2010 and his appointment was made substantive in July 2010.

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

* rate per 100,000 population

Why we carried out this inspection

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 July 2014 Intelligent Monitoring show the trust as a band one 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. More recent data has been made available subsequent to the inspection and they are no longer a mortality risk. The case was closed post inspection

Key Intelligence Indicators

The trust flagged on our monitoring as an outlier for Summary Hospital Level Mortality Indicator (SHMI); although since our visit, these data have improved to within acceptable levels.

Additionally, the trust was highlighted as an outlier for times for Referral to Treatment (RTT).

The NHS Staff Survey showed three areas where the trust was rated worse than expected:

- Proportion of staff receiving support from their line manager.
- Staff who thought the incident reporting procedure was fair and effective.
- Proportion of staff reporting good communication between staff and senior management.

Detailed findings

How we carried out this inspection

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

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

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

- Accident and emergency services including the Minor Injuries Units
- Medical care including care of older people in both acute hospitals and community settings
- Surgery
- Critical care
- Maternity services
- Services for Children and Young People
- End of Life Care
- Outpatient services

We also inspected four core community services

- Adult services
- Inpatient Services
- Children's Services
- End of Life Care services

Before the announced inspection we reviewed the information we held about the trust and asked other organisations to share what they knew about the services being provided. These included the local Clinical Commissioning Groups, Trust Development Agency (TDA), NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Royal Colleges and the local Healthwatch. We also approached local voluntary organisations and other NHS trusts for comments and information.

We held two public listening events in the week preceding the inspection. One in Hastings and one in Eastbourne, both on 4 September 2014. The one in Eastbourne was particularly well attended.

We met with members of local voluntary and campaign groups to listen to their concerns and comments about services being provided by the trust.

We made an announced inspection of the trust services on 10, 11, 12 September 2014 and an additional unannounced inspection visit to both acute hospitals on 23 September 2014. We interviewed clinical and non-clinical staff of all grades, talked with patients and staff across all areas of the hospitals and in the community. We observed staff interactions with each other and with patients and visitors. We reviewed records including staffing records and records of individual patient's care and treatment. We observed how care was being delivered. We held focus groups to listen to staff working in different areas of the trust.

On 23 September we looked in depth at how medicines were being managed and operating theatre practice.

On 3 September 2014, CQC requested the CEO, Mr Darren Grayson to email staff and ask them not to attend the public listening events unless they were attending with the intention of sharing their experience from a patient perspective. This was to ensure that members of the public had a chance to talk freely to CQC about their experiences, and had an equal opportunity to talk to inspectors. CQC arranged staff specific focus groups during the inspection, and we facilitated several extra sessions during the inspection and gave staff alternative ways to contact us to ensure that all staff had an opportunity to talk to us. However we are concerned that a message sent from the CEO, at our request, was interpreted by some as an attempt by Mr Grayson to prevent staff talking to CQC. This was not the case.

Inadequate

Are services safe?

Summary of findings

We saw a number of issues that led to a rating for safety at the trust of inadequate.

We saw low staffing levels in Surgery, Maternity and Pharmacy specifically.

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.

We were concerned about medicines management, particularly in surgery and in outpatients. Pharmacy services across the trust were also of concern.

Patients' records were not securely stored in outpatients. Medical records were unavailable and in poor state of repair. Clinicians had difficulty locating information upon which to base a decision.

We observed staff, in the main, following 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.

In many areas the hospital was clean and tidy; however we had concern over the cleanliness in some areas of Maternity services.

Our findings

Safeguarding

- Staff knew how to report safeguarding issues.
- The process of safeguarding was both understood and followed.

Incidents

- Staff in surgery were not reporting incidents as they should do. The reason for this was both lack of feedback and lack of staff to enable this to happen.
- Agency staff did not have open access to the trust's system nor did they understand how to use it.
- Staff in maternity were not using the appropriate processes to report incidents and not escalating issues for appropriate action.
- Outpatients' reporting of incidents was inconsistent and used different methods. Problems with notes were rarely reported.
- The trust was losing valuable opportunities to learn from these incidents and improve patient care.

Cleanliness, infection control and hygiene

- In many areas we saw that the trust was clean and tidy.
- We had concern over the cleanliness in some areas of Maternity services; particularly (but not exclusively) the post natal ward.
- In Surgical services and in Maternity services we saw staff not following the trust hygiene policies. In some of these we saw that senior staff were failing to follow clear local and national guidance.
- In some areas, we saw that staff understood the infection control policies and processes and were following good practice guidance.

Staffing

- Surgical services had insufficient staffing for the duties required.
- The number of pharmacists employed by the trust is on the trust risk register, and has been there since October 2013.
- The skills mix of the medical staff at Conquest Hospital showed the same level of consultant grade staff (34%) as the England average. There was a higher proportion of middle career doctors employed (32%) compared to the England average of 8%. These middle career doctors had completed at least three years as a junior doctor. The proportion of medical staff of registrar grade (34%) was less than the England average of 51%. This meant that there was overall a higher proportion of less experienced medical staff available.
- A review of the outpatients' process had altered patient flow. This failed to ensure the correct staff were in the right location for the overall patient care process.
- Mandatory training of staff was below target in some areas.

Environment and equipment

- In most areas of the trust environment were fit for purpose, enabling staff to undertake their roles safely.

Records

- We saw that access to patients' hospital records were a major challenge in outpatients.

- We heard of (and saw reports of) clinics where a number patients were seen with temporary notes as the full set were not available.
- We saw that in part this related to the fact that the trusts processes for bringing records to site for clinics was insufficient (i.e. notes were available but not present in clinic).
- We saw a number of examples of poor storage of patients' confidential medical records.
- We saw a number of hospital records in a poor state of repair.

Medicines and Pharmacy Services

During and after our inspection, CQC received was contacted by a number of whistleblowers raising concerns over the way that pharmacy services across the trust are being run and of the quality of care they are offering to patients. We were concerned by the allegations and held two unannounced visits to pharmacy services at both Eastbourne and Conquest Hospitals.

As these services are trust wide; we have included them here.

- An audit of sample of drug charts at Eastbourne showed that only 33% of the charts had a medicine reconciliation within 24hrs of admission at the Eastbourne site. This falls significantly below the national average or recommended level.
- An audit of a sample of drug charts at Eastbourne showed between 50% and 60% of the charts had a pharmacy medicine reconciliation within 24hrs of admission at the Eastbourne site. National guidance recommended pharmacists are involved in medicines reconciliation as soon as possible after admission.
- The pharmacy service provides chemotherapy and other medicines ready for administration, due to the associate risks these areas have been externally audited nationally since 1997. The most recent audit from March 2014 identified 15 major, 8 moderate and 4 minor deficiencies.
- There was a trust wide system to report incidents. The staff we spoke to told us that they raised an incident form when they recognise that an error had occurred. At ward level some nurses told us that feedback was not provided from the incidents raised unless they requested it.
- There was a poor pharmacy service at Eastbourne Hospital because of a problem with recruitment. One consultant told us that it was 'A shame that it is difficult to recruit as pharmacist support is essential and crucial to junior doctor's as part of their training and development.' The pharmacy department had managed this shortfall in staffing by targeting their service to more critical areas of the hospital. Other areas had a minimal service or no service at all. All staff spoken to were happy with whatever little support they received from the pharmacy service.
- A gap analysis and action plan dated December 2013 showed that trust's pharmacy service was partially compliant with the Royal Pharmaceutical Society (PRS) professional standards for hospital pharmacy standards guidance. The major cause was the ongoing staffing issues. There was anxiety amongst pharmacy staff as to what the imminent restructure will mean to them.
- The pharmacist inspector visited six wards or departments at the Conquest Hospital and medicines were stored securely. However, on one ward medicines for epidural use were kept in the same cupboard as other injectable medicines.
- On one unit at the Conquest Hospital we were shown professional samples that had been received by the unit. As they were via an unofficial route we could not be assured of their probity or if they had been stored correctly prior to receipt by the service. Staff on the Special Care Baby Unit told us that on one or two occasions they had been out of stock of a critical medicine.
- On two wards at the Conquest Hospital medicines were being stored outside of their recommended temperature ranges. On one unit a medicine requiring refrigeration was not stored in a refrigerator and the other ward was above 25C when inspected.
- We had concerns about the process and control of internal movements of controlled drugs within theatres and recommend that the trust reviews these.
- Feedback from staff working in the community services highlighted that patients may be transferred from the acute sites without all their medicines, some lacked dispensing labels and on occasions the community site identified medicines that had been omitted in error since the patient's initial admission.
- We were told by nurses on two wards we visited that communication about non-stock or out of stock medicine was not communicated clearly to the ward by pharmacy staff, making it difficult for the ward staff to

revise the treatment plan. Similarly, the community team told us that information about 'out of stock' items did not have further information like the anticipated delivery date to allow an informed decision on the next plan of action.

- The number of pharmacists employed by the service has been recorded on the pharmacy risk register since October 2013. The register entry states that the service has a lack of pharmacists when benchmarked to comparator trusts and £300K will be invested this financial year on pharmacy staff. Whilst carrying these vacancies the service has been continually prioritising the cover provide to wards and departments.

Requires improvement

Are services effective?

(for example, treatment is effective)

Summary of findings

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

Policies were out of date and compliance with them was poorly monitored.

Surgical teams did not undertake morbidity and mortality reviews regularly and consistently.

At the time of our inspection, the trust also had a higher than expected mortality levels measured by the Summary Hospital Level Mortality Indicator.

A backlog of referrals was delaying patients accessing timely care.

The trust was following NICE guidance where appropriate.

Our findings

Evidence based care and treatment

- In August 2014, as part of an ongoing 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.

Patient outcomes

- 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.
- Our intelligent monitoring shows that a summary hospital mortality indicator at the trust was higher than expected. Although since our visit, these data have improved to within expected levels.
- A backlog of referrals and follow-up visits in ophthalmology services were delaying patients accessing timely care.
- Some services had very long waiting lists to be seen; delaying patients beginning their clinical treatment for their condition.

Multidisciplinary team (MDT) working

- In medical care services and A&E we saw effective MDT working.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- We saw that staff followed the principles of the mental capacity act in dealing with patients.
- Where patients lacked the capacity to consent, staff acted appropriately and followed appropriate processes.

Pharmacy Services

During and after our inspection, CQC received from a number of whistleblowers concerns over the way that pharmacy services across the trust are run, and of the quality of care they are offering to patients. We were concerned by the allegations and undertook two unannounced visits to pharmacy services at both Eastbourne and Conquest Hospitals.

- Based on the Trust Development Agency Medicines Optimisation and Pharmaceutical Services Self-Assessment the trust had developed a medicines optimisation strategy in August 2013. This initial assessment had found the scores across all six domains at around 50% of the best possible score. The action plan developed from the self-assessment described 36 areas of which 26 require further work to be undertaken.
- At the conquest site an omitted dose audit was undertaken in July 2014, 60 drug charts were reviewed 588 omitted doses were identified of which 66 were for critical medicines, 69 lacked a reason and for 459 the actions taken were not recorded. Review meetings held with the Kent Surrey Sussex Deanery had identified that a lack of staff was limiting the opportunity for staff to undertake work related training
- The Pharmacy service has recently updated the “transfer of care gap analysis action plan”, the main changes are the slipping of target dates mainly by 12 months due to either the need for additional resources or “lack of engagement”.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Some of the equipment within pharmacy needed updating. Staff told us that the portable IT system used on the wards at Eastbourne often crashed. This meant that the time to do the job was reduced when there were already time constraints.
- The aseptic unit was deemed obsolete by design by the specialist team that reviews aseptic units.

Good

Are services caring?

Summary of findings

We found that services across the trust were caring and have rated this good. We received many positive comments from patients and their carers.

We had a higher number of people attend our listening event than would be expected for a trust this size. We heard a number of experiences from patients and carers before our visit. Some of these were harrowing; some related to care and compassion; some to the responsiveness of the organisation. Whilst we noted these stories and empathise with those families who had poor care from the trust, during our visit talking to patients on the ward all experiences we heard were highly positive and patients praised the staff at both sites.

Our findings

Compassionate care

- We saw good care provided across the trust.
- Patients commented positively on their care and on the staff providing it.

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.

Emotional support

- The trust provided support for patients where required.

Pharmacy Services

We held two unannounced visits to pharmacy services at both Eastbourne and Conquest Hospitals.

- Patients spoken to all expressed no issues with their medicines and were happy with the way their medicines were handled. The nursing staff counselled patients and provided information about their medicines. The pharmacy technicians and sometimes the nurses reconcile medicines when patient were admitted into hospital. We spoke to one patient who was managing their own medicines. We saw that their medicines were not stored safely.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

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.

The redesign of outpatients' services had been poorly implemented. Essential tasks had been missed in the service redesign.

In maternity, there was a 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.

Our findings

Service planning and delivery to meet the needs of local people

- We heard a considerable anxiety from the public about the recent service reconfiguration, the changes to provision and the impact of those changes.
- Many people told us that the trust had not listened to their concerns.
- 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 service on two sites.
- We were approached by many people to tell us their experience of care and how the new service provision model failed to meet their needs.
- It is of note that the Eastbourne locality have formed two groups to campaign against the changes.

Meeting people's individual needs

- The majority of the people we spoke to gave us comments intended to help the trust improve its services. We were frequently told by people, "I don't want others to experience what I did".
- 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 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 the inspection visit the data for the PLACE has shown and improvement by the trust.

Access and flow

- The new service redesign in outpatients had been 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.
- Essential tasks had been missed in the service redesign, as staff were not consulted about the job roles that they completed. As a result, essential documentation about patient pathways was not being completed.

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. Full analysis of the reduction has not been completed but the consensus with staff was that waiting times had reduced and care was more person centred now than it had been previously, and that these factors had improved the patient experience.
- 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.
- A large number of people contacted the CQC before, during and after the inspection to tell us their experience and some to raise concerns about the trust.

Are services responsive to people's needs?

(for example, to feedback?)

- 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.
- 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.
- LiA (Listening Into Action) group 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

Pharmacy Services

We held two unannounced visits to pharmacy services at both Eastbourne and Conquest Hospitals.

- The pharmacy service hold Pharmacy User Group meetings with the ward and department managers to review the pharmacy service provided and agree changes to improve or prioritise service delivery
- We were told by nurses on two wards visited at Eastbourne that communication about non stock or out of stock medicine was not communicated clearly to inform the next treatment plan.
- Similarly the community team told us that information about 'out of stock' items did not have further information of the delivery date to allow informed decision on the next plan of action.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust had just undertaken a major and contentious reconfiguration of some of its clinical services. We did not see a clear vision for the trust going forward from this.

Following the reconfiguration, there was a loss of trust from some of the stakeholders in the trust management.

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.

There was a disconnect between the trust board and the staff.

We saw a culture of concern and sometimes fear from staff in the trust about raising their concerns.

We had a much larger than expected number of staff contact us who were not prepared to reveal their identity until we could assure their confidentiality.

Staff across a number of areas told us of their experiences about their perceived failure of managers to act on their reported concerns.

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.

Pharmacy service leadership was lacking.

Our findings

Vision and strategy

- The chief executive's presentation to the CQC at the beginning of the inspection made it clear that the trust were aware of many of the issues that we found on our inspection.
- The trust had recently completed a major and contentious reconfiguration of clinical services. This had consumed a great deal of the board and executive directors' time over the preceding eighteen months.
- We noted the trust did not have a clear forward 5 year strategy, although there was a business plan in place

Governance, risk management and quality measurement

- The trust board had a Quality and Standards Committee. There had been a recent review of its terms of reference.
- Staff we spoke with were 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.
- We were not assured that clinical governance, risk and quality management was effective and were not confident that the governance, risk and quality boards influenced or impacted at 'shop floor' level. Our interviews with governance leads indicated "there was a lot to do" in the trust.
- We were also made aware that the occupational health department struggled to ensure the trust delivered its duty of care to staff. They had insufficient resources to support staff suffering from stress related conditions including burnout or to support staff returning back to work.
- 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.

Leadership of the trust

- We asked staff how involved they felt members of the board were in what happened in their clinical areas. They told us "we know they are there" and "they are interested but in a disconnected kind of way".
- The most recent NHS staff survey showed the trust performing badly in most areas (18 out of 20 metrics).
- Staff reported feeling supported in their teams and by their immediate line managers and colleagues of a similar grade. However, staff told us that they did not feel supported by middle management.
- Many people made positive comments about the Director of Nursing.

Culture within the trust

- The trust was an outlier in the scale of representation made to CQC before and during the inspection by both patients and staff from the trust.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

- Equally, the level of concern and anxiety from staff about the impact of this and their concern of being identified was almost unprecedented.
- CQC were contacted by an unusually high number of staff (some of whom were classified as whistleblowers) before, during and after the inspection, who told us that they did not feel supported by middle and board level management and the human resources (HR) department.
- The themes identified related to how change was implemented, the quality of staff consultation or in some cases lack of consultation, low morale, bullying and harassment culture from senior management.
- It was evident from the various methods used by staff to protect their anonymity when making initial contact with CQC, that they were genuinely worried. This indicated there was an unhealthy culture which did not promote effective listening.
- There were numerous examples of staff reporting the impact of low staffing levels which were seen in incident reports.
- An unusually high number of staff contacted us before and during the visit to share their concerns.
- Major service changes had been implemented and whilst the trust demonstrated its efforts to engage staff, the majority of staff we talked with felt it was insufficient and ineffective

Public and staff engagement

- We had a high level of contact with the public before, during and after the inspection.
- 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 trust had recently reconfigured some of its services and changed the location from which they were provided.
- The consultation process, led by the local Clinical Commission Groups, which preceded the reconfiguration, had been subject to an audit of its governance which had been very positive about the management of the process.
- Despite this, the reconfiguration had faced strong objections from the public and had led to a breakdown in external relationships with some stakeholders and an element of the local community.
- There was a strong feeling amongst staff and by some members of the public that they were not listened too, or engaged with by the senior leadership.
- CQC are aware that the relationship between the trust board, some local patient representation groups and a local MP had deteriorated, resulting in communication difficulties.
- We were unable to identify a clear strategy that sought to deal with these concerns.
- The trust had a staff awards incentive in operation.
- Staff groups in many areas did not appear to be engaged with the change programme.

Pharmacy Services

- We held two unannounced visits to pharmacy services at both Eastbourne and Conquest Hospitals. After speaking to a number of pharmacy staff they referred the inspection team to a previous report published by The Healthcare Commission January 2006 entitled "Investigation into allegations of bullying and harassment and the process for handling complaints at East Sussex Hospitals NHS Trust". The staff felt that the issues identified in this report had not been fully resolved and were compromising patient care.
- The trust has a medicines optimisation strategy and work is ongoing to review and update this document in line with best practice; however the strategy score had not increased between August 2013 and May 2014.
- During our visit and following our visit several pharmacy staff spoke with us about internal tension. This impacted on the service not working together to deliver effective care and treatment. One example given was that information needed to suggest an alternative medicine for a patient was not passed on within pharmacy due to the culture of the department.
- The trust has since informed us that they are aware of these problems and there is a programme in place to improve working relationships.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Records 20. (1) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of— (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and. (b) such other records as are appropriate in relation to—. (i) persons employed for the purposes of carrying on the regulated activity, and. (ii) the management of the regulated activity. (2) The registered person must ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are— (a) kept securely and can be located promptly when required; (b) retained for an appropriate period of time; and. (c) securely destroyed when it is appropriate to do so. **Why you are failing to comply with this regulation:** • The outpatient department was not protecting patient's confidential data. Patient records were left in public accessible areas without staff present and failing to comply with the Data Protection Act 1998. • The outpatient department were not tracking patient health records because this job had not been considered during the redesigning of the service. The location of medical records were often unknown and

This section is primarily information for the provider

Compliance actions

resulted in delays or temporary notes being used. Trusts have a responsibility to track all patients' health records (Records Management - NHS Code of Practice Part 2 January 2009).

Ensure that medical records and other sources of confidential personal information are managed such that the service is compliant with the requirements of the Data Protection Act 2003 and the guidance issued by the professional associations and Royal Colleges.

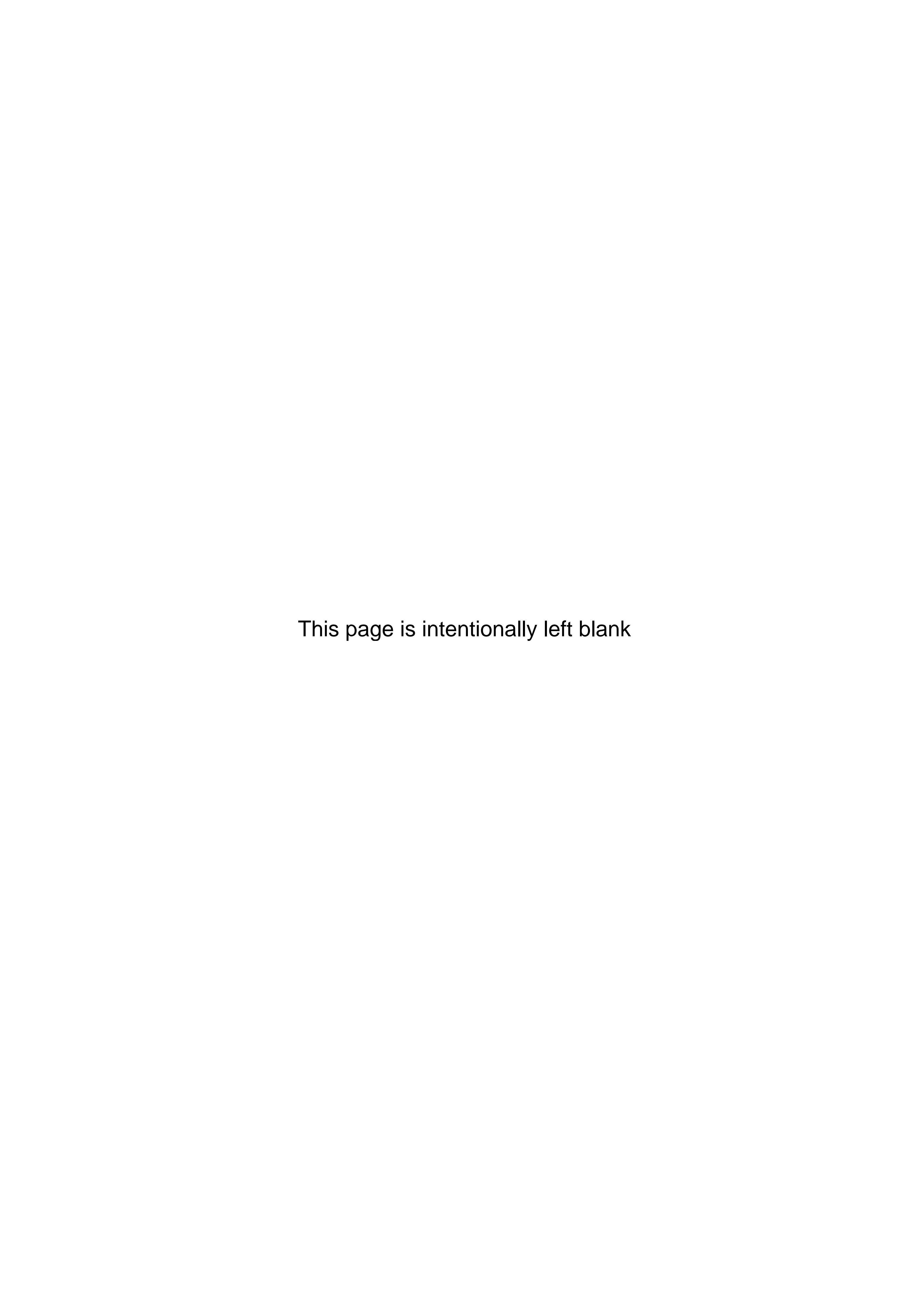
Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider had not ensured that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed in order to safeguard the health, safety and welfare of service users **Why you are failing to comply with this regulation:** • Staffing in Maternity, Surgery and Pharmacy should be reviewed to ensure it meets the needs of service provision. • Staffing in Children's services should be reviewed to ensure that there are sufficient staff of the appropriate grades to take a leadership/management responsibility on each shift.

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider had not ensured effective operation of systems was in place to, regularly assess and monitor the quality of the services provided and identify, assess and manage risks relating to the health, welfare and safety of service users and others. **Why you are failing to comply with this regulation:** • The trust has not managed the concerns of the local population with regard to service reconfiguration.

This section is primarily information for the provider

Compliance actions

- Service users and stakeholders remain concerned with many anxieties still unaddressed.
- Staff groups remain disengaged with the reconfiguration process.
- Waiting times in outpatients exceed to governments RTT (referral to treatment) target.
- Service reconfiguration in outpatients has not been effective in meeting the needs of those using the service.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Quality Improvement Plan

Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
OVERARCHING EAST SUSSEX HEALTHCARE NHS TRUST											
Improve the relationship with its staff specifically the culture of the organisation with regard to people feeling able to speak out											
Work force / Staff Engagement Group	Improve staff engagement and satisfaction. Staff should be aware of the Trust vision and values and have an understanding of the Trust and 'direction of travel' for their service	Corporate	1	Develop a communication plan to support new ways of working and communicating by encouraging the use of appropriate social media The Staff Engagement and Operations Group will develop actions, propose solutions, organise events, and provide reports etc. Time, energy and input will be required from staff across the organisation at all levels	0	Significant improvement in staff employee relations demonstrated through the annual staff survey	Monica Green Op Lead Lorraine Mason	Mar-16 A	Staff Engagement Operations Group established with representation from across the Trust. Action Plan developed		
			2	Trust wide Schwartz rounds to be implemented	0	Staff are supported to discuss psycho social and emotional issues	Alice Webster Op Lead Christian Lippiatt	Oct-15 A	Programme developed		
			3	Improve multidisciplinary team working at the Conquest Hospital	0	Effective MDT working supporting better care	David Hughes Op Lead James Wilkinson	Sep-15 A	Discussions taking place with CU leads in the Clinical Leaders Forum		
			4	Engage in effective listening with staff to improve efficiency.	0	Improve Ward to Board relationships by Senior professional managers visiting clinical areas on a regular basis to spend time with staff and patients and to listen to their thoughts, ideas and concerns	Monica Green / Alice Webster Op Lead Lorraine Mason	Jul-15 A	Exec leads aligned to each CU		

Appendix 2

Quality Improvement Plan

Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
Board	Integrate Executive level staff with the workforce at a local level, allowing them to observe practice and assess the impact of changes at departmental and individual level.	Corporate	5	Review the quality walk process	0	Staff will feel valued and supported to deliver a high level of care and to our patients through a seamless ward to board approach to care	Amanda Harrison Op Lead Hilary White	May-15 G	Quality walks schedule available Annual feedback at ESHT Board level schedule available	Schedule from board Minutes of board meetings with quality walks feedback	
			6	Publicise the feedback from the quality walks within the organisation				Oct-15 G	A copy of the feedback form completed by the Director undertaking the Quality Walk is sent to the Unit/Ward Manager/Matron and copied to the Head of Department so that it can be shared with relevant staff.	Feedback forms Quality Walk Schedule	
			7	Ensure the quality walks are reported upon and any actions taken as a result of them recorded.				Oct-15 G	A summary report of themes of findings is submitted to the Board and Quality and Standards Committee every 2 months.	Reports Minutes of meetings	

Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
MUST DO: Undertake a review of the culture specifically looking at the perceived bullying allegations											
Workforce/Staff Engagement Group	Staff should work in an environment where the risk of harassment and bullying is assessed and minimised. Staff must feel able to raise concerns about bullying without any fear of recrimination.	Corporate	8	Identify and address inappropriate staff behaviour toward patients, relatives and staff.	0	Positive response to questions in the staff survey in relation to raising concerns. Trust can demonstrate year on year improvement to this aspect	Monica Green Op Lead	Aug-15 A	Scope the problem by interrogating the complaints and datix reports triangulated with the staff survey and develop a plan of action		
			9	Set up a series of Listening into Action events to engage staff in supporting solutions	0	Staff feel supported and able to say why some feel this is happening and influence changes to the culture of the organisation.	Monica Green Op Lead Lorraine Mason	Aug-15 A	LiA events being organised and publicised in CEO's weekly newsletter and other for a.		
			10	Highlight to staff how they can report concerns and raise the profile and availability of the Trust Senior Independent Director	0	Staff fully aware of the process and options available to them	Monica Green Op Lead Lorraine Mason	Apr-15 G	Include detail in CEO Weekly Message	Weekly message 24.4.15	
			11	Look at best practice from other Trusts in respect of "speak up guardians" to develop a similar model across the Trust	3	Independent process in place for staff to raise concerns with fear of recrimination and confidence that actions will be taken if appropriate.	Monica Green Op Lead Lorraine Mason	Aug-15 A	Exploring best practice.		

Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
Improve relationships with the population it serves specifically relating to their concerns about service configuration											
Complaints / Patient Experience Group / PSCIG	Robust management of the complaints process. With Learning from complaints disseminated to staff ensuring changes are fully embedded	Corporate (Conquest and Eastbourne)	12	Fill vacancy for Trust complaints lead.	0	The Complaints and PALS Manager vacancy is filled to provide leadership and support to the Complaints Team	Alice Webster Op Lead Emily Keeble	May-15 A	Interim complaints advisor appointed, substantive complaints and PALS manager out to recruitment. Interviews to take place 22.5.15		
			13	Review the pathway for complaints management and develop an effective process	0	The revised Complaints Policy has been reviewed, updated, ratified and shared with staff. Staff aware of the complaints process	Alice Webster Op Lead Emily Keeble	Jul-15 A	Complaints pathway currently being reviewed by the Interim Complaints Advisor. Once ratified clear communication and training will be provided to all staff		
			14	Ensure that process is appropriately followed, complaints are prioritised within the CU and each complaint has an identifiable CU lead who will be responsible for the investigation and timely response	0	100% of complaints answered within time. Evidence of learning articulated through CU action plans and staff able to identify areas of learning/change in practice following complaints. Positive patient feedback about the complaints process.	Alice Webster Op Lead Emily Keeble	Jul-15 A	Interim Complaints Advisor has met all Clinical Units, attended TNMAG and Grand Round. A new quality assurance process has been implemented to quality check responses before they are sent		

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Patient Experience Group	Improve patient access to translation services and other forms of media	Corporate	15	Audit translation services to ensure that patients requirements is being fulfilled and act on recommendations	3	Improved process for access of translation services demonstrated by re audit of process for patient access to services	Alice Webster Op Lead Emily Keeble	Aug-15 A	The Equality and Diversity Lead is currently reviewing the translation services provided for patients		
			16	Obtain patient experience feedback on the service		A survey has been completed which provides the Trust with feedback on the translation services available	Alice Webster Op Lead Emily Keeble	Sep-15 A	A post translation service survey is being planned		
			17	Ensure that patient information is available in languages other than English and in other formats so that it is accessible to people with disabilities.		Patient information is available in languages other than English and in other formats	Alice Webster Op Lead Emily Keeble	Sep-15 A	Current information and formats is currently being reviewed		
Patient Experience Group	Improve communication with stakeholders	Corporate	18	Communicate with stakeholders to raise awareness of the positive impact that have happened following changes to services	2	Effective communications plan in place	Amanda Harrison Op Lead Simon Purkiss	Oct-15 A	Communications strategy being developed		

Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
Review the reconfiguration of outpatient services to ensure that it meets the needs of those patients using the service											
Outpatients Clinical Unit	Ensure that Resuscitation equipment provided in outpatients is fit for purpose	Conquest Outpatients	19	Remove any unnecessary equipment and ensure necessary equipment is available - i.e. resus equipment and suction machine	0	Equipment is readily available and is fit for purpose	Richard Sunley / Alice Webster Op Lead Deidre Connors	Sep-14 G	Completed	Review of equipment in situ	

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Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
Outpatients Clinical Unit	Ensure clear strategies are put into place to improve outpatient waiting times against the national average.	Outpatients	20	Develop a plan for managing Rheumatology / Gastroenterology specialism's	5	Compliant with National Guidance and best practice	Richard Sunley Op Lead: Sandra Field	Jul-15 A	Rheumatology recovery plan implemented with support from medinet Consultant posts out to advert Implementation of weekend working Job planning Block booking of temporary and agency staff Admin staff ensuring that all slots are booked Reducing need for consultant follow up appointments, to be undertaken by Specialist nurse Dermatology not breaching 18 weeks Outsourcing of work Used of advanced nurse practitioner capacity, consultant job planning and optimised theatre capacity to directly address the pressures in this crucial area.	Review by Snr Exec Group weekly. Review by CCG at least Monthly. Review by TDA weekly and, formally, monthly	

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			21	Develop robust team meetings to monitor the plan		Compliant with National Guidance and best practice	Richard Sunley Op Lead: Sandra Field	Sep-15 A	Gastroenterology Recovery plan in place Full time consultant and 2 locums 18 week back log recovery by June 2015 Full recovery scheduled by Sept 2015 Weekly department meetings to discuss activity v capacity Additional lists at weekend		
Outpatients	Ensure that patients are managed effectively through the departments and patients are sent to the correct areas of the OPD and are expected by staff in those areas when they arrive. Staff should be able to track patient journeys through the department.	Outpatients	22	Patient pathway is understood by members of the OPD team	0	Improved Patient Experience for those attending the Trusts OPD	Alice Webster Op Lead: Jenny Crowe/ Deidre Connors / Jayne Cannon	Mar-15 G	Completed	Minutes of meetings Decrease in number of complaints and PALs contacts re OPD	
			23	Monitor the numbers of complaints and FFT comments and discuss at OPD meetings	0	OPD is robustly learning from complaints and making alterations as necessary.	Alice Webster Op Lead: Jenny Crowe/ Deidre Connors / Jayne Cannon	Oct-15 A	In place through Clinical Unit meetings.	Minutes of meetings Decrease in number of complaints and PALs contacts re OPD	
			24	Review the reconfiguration of outpatients services to ensure that it meets the needs of those patients using the service.	£100,000	Optimal OPD configuration delivering good patient experience.	Richard Sunley Op Lead: Liz Fellows	Aug-15 A	Currently reporting a 50% reduction in PALS cases	Reductions of the numbers of complaints / pals contact relating to Patients	

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Review the length of waiting time for outpatients appointments such that they meet the governments RTT waiting times											
Outpatients	Ensure that the Trust is obtaining correct data regarding patient pathways and recording accurate data for 18 week pathways and two week waiting times	Outpatients	25	Review the length of waiting time for outpatients' appointments such that they meet the governments RTT waiting times.	5	Patients are seen within the governments RTT requirements	Richard Sunley Op Lead: Gary East	Jul-15 A	RTT and Cancer metrics reviewed and reports in place	Weekly cancer and RTT meetings with CUs	
Review staffing levels across the organisation to ensure there are sufficient staff to meet the needs of the service											
Work force Group	Review appropriate levels of staff for nursing and midwifery to ensure that patient acuity and turnover is taken into consideration	HR	26	Implement 'TRAC' recruitment system which allows recruitment managers real time information on how recruitment is progressing.	0	Improved patient care demonstrated through reduction in clinical incidents related to nursing and medical care	Monica Green Op Lead: Edel Cousins	Mar-15 G	TRAC recruitment system gone live March 15 Staffing levels are reported to each Board and we are currently meeting the majority of NICE indicators and on track to meet all.	System on extranet Staff training	
			27	Establish a Safer Staffing and Workforce Capacity Group	0			Oct-14 G	Group established October 2014 which meets monthly to review safe staffing reports, and recruitment reports.	Minutes of meetings and reports	

Quality Improvement Plan

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			28	Implement a generic recruitment process for nursing posts to speed up process.	0			Mar-15 G	Generic recruitment process in place		
			29	Ensure that workforce considerations are fully integrated into service relocation plans.	0	Ensure that workforce considerations are an integral part of service redesign including relocation	Andy Slater Op Lead: Pauline	May-15 A			
Work force Group	Appropriate management of staff sickness absence.	HR	30	Up date and review and fully implement current policy	4	Reduction of staff sickness to within national average	Monica Green Op Lead: Moira Tenney	Apr-15 G	Policy ratified	Policy on extranet (1.4.15)	
			31	Develop and implement an on line training module for managers				Sep-15 A			
			32	Develop and implement a Health and Wellbeing Action Plan				Feb-15 G	Action plan developed and being implemented	Action plan and progress on extranet	
			33	Carry out an internal audit of sickness controls				Mar-15 G	Audit undertaken, reasonable assurance given to Audit Committee	Audit report Audit Committee minutes	
			34	Review sickness absence trend data				Mar-15 G	Data reviewed, report submitted to F&I committee with detailed actions	Report F&I minutes	
			35	Absence management workshops to be held with CU management.				Sep-15 A			
			36	Proposed a 6 month project to support RTW interviews 2x Band 6 HR Advisers				May-15 A			

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			37	Review occupational health and HR support mechanisms and resources for staff on long-term sick leave who require support to ensure the trust can meet its duty of care to its workforce				Aug-15 A			
Work force Group	Review Maternity staffing	Maternity	38	Undertake a thorough review of midwifery workforce and skill mix and models to include community .	£250,000	BR+ labour ward acuity tool will demonstrate 1:1 care in labour 100% of the time. Specialist midwives in post Community midwives have caseloads of 100 and are working within EWTD	Monica Green / Alice Webster Op Lead: Jenny Crowe	Jul-15 A	Birth-rate Plus to be reviewed, models of care paper currently being developed. Vacancies being recruited to, an education /preceptor ship midwife now in post, specialist midwives being recruited to. Infant feeding specialist out to advert for second time. Mental health specialist mw to be advertised in April along with bereavement specialist. Obesity/diabetes specialist to follow. Community mw caseloads currently being reviewed due to appointment of new staff. EWTD not yet compliant		
			39	Develop a staffing model of care to enable one to one care in labour		Reduction in the use of the escalation policy for maternity and usage of temporary workforce		May-15 A	1:1 care in labour at both MLU's and homebirths is 100%. Conquest labour ward currently 55-78%.		

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Work force / Senior HR Group	Improve compliance for attendance at Trust mandatory training and appraisals for all staff groups this must include long term temporary staff	Corporate	40	Review all roles and associated competencies to give assurance that each role has the right level and frequency of mandatory training.	0	90% compliance to mandatory training evidence in annual training report produced for the Trust board CU Directors accountable for meeting the 90% Trust Target.	Monica Green Op Lead: Edel Cousins	Oct-15 A	Review currently underway		
			41	Focus on areas with lowest compliance.	0			Apr-15 G	CEO/HRD meetings with areas/units that have lowest compliance taken place Feb/March 2015. Additional large group sessions have run from Nov 14 to April 15.	Mandatory training audit attendance. Reports on attendance rates provided for CU Performance Reviews. Action Plans to address any non compliance to training.	
			42	Develop e-assessments to reduce no's of staff needing to be released for training.	0			Oct-15 A	These continue to be developed and enable staff to do a quick online assessment of their competency in their work location to avoid having to do further classroom or e-learning training		
			43	Ensure all staff have an appraisal	0			Oct-15 A	Focussed actions in place and appraisal rate improving		
			44	Ensure all agency and transient staff have a full induction in clinical areas which is formally recorded.	0			Jun-15 A	Pilot in place		

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Review the impact of the maternity reconfiguration											
Estates Group	Improve security of labour and postnatal ward Conquest.	Maternity	45	Daily audit of unit to ensure security has not been breeched. Purchase electronic baby tagging system	0	Baby tagging system in place. Signs on fire door, regular security patrols.	Richard Sunley Op Lead: Jenny Crowe	Apr-15 A	Review of emergency doors at Conquest on Security Patrol SOP. Signage and possible alarm to be introduced. Security tagging system in place but not used. Risk assessment to be completed by HoM	Reviewed 25/3. Achieved by regular security patrols. There is a single fire door that must remain secured, remaining three fires doors are not fire doors and can be opened. Additional prohibitive signs ordered 25 March 2015.	
Estates Group	Improve labour ward environments for low risk women.	Maternity	46	Capital investment to be considered to provide appropriate low risk birth facilities	5	Appropriate low risk birth rooms on all sites	Richard Sunley Op Lead: Jenny Crowe	Aug-15 A	Changes have been agreed. Programme of work with CCGs. Midwifery Lead treatment.		
			47	Investigate providing facilities to accommodate the needs of women in early labour where repeated journeys between their home and the hospital may be inadvisable.		Appropriate availability of places to stay	Richard Sunley Op Lead: Jenny Crowe	Sep-15 A	Currently considered on a case by case basis		
Women & Children / Estates Group	Ensure appropriate area on labour ward at Conquest for hand over of care.	Maternity	48	Obstetric and midwifery staff to undertake hand over in the consultants office on labour ward.	1	Confidential hand over undertaken at all times	Alice Webster Op Lead: Jenny Crowe	Feb-15 G	Handover takes place in office		

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			49	TV screens to be purchased and placed on labour ward wall in place of white board and one in consultant office.	1	Equipment available to support the provision of confidential hand over	Alice Webster Op Lead: Jenny Crowe	Jun-15 A			
	Develop a clear and explicit vision for maternity services	Corporate	50	Develop a strategic plan created in collaboration with key stakeholders, staff and service users	0	Strategy in place aligned to commissioning intentions.	Amanda Harrison Op Lead: Jenny Crowe	Ongoing engagement taking place. Review Mar-16 A	Trust obstetric and midwifery managers are working closely with the CCG's on a project 'Better Beginnings' for re-modelling of maternity care for low risk women. This includes review of the working patterns of community midwifery staff to provide care within the community and the midwife led units and to support midwives on the acute site to provide midwife led care to low risk women.		
			51	Make comprehensive written information available to women using services in relation to the choices of place of birth available	£10,000	Women aware of the choices available for place of birth	Amanda Harrison Op Lead: Jenny Crowe	Sep-15 A	Information available for women considering birth at Crowborough Birth Centre. 'Virtual' tours available for Conquest and CBC on the Trust web site		
	Review the impact of the maternity reconfiguration	Corporate	52	Review data available of patient outcomes	0	Impact reviewed and considered by the Board.	Richard Sunley Op Lead: Dexter Pascall	Apr-15 G	Data collection and presentation to Board Seminar	Minutes Board Seminar 25.3.15 HOSC Minutes 22.3.15	

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Ensure that health records are available and that patient data is confidentially managed											
Health Records Steering Group	Review the management; storage and movement of medical records ensuring data confidentiality is maintained.	Corporate	53	Full revision of the current process with the design team and the clinical unit service managers/general managers to discuss storage and filing of notes in clinical areas and possible options for significant improvement	£800,000	Significant improvement demonstrated with reduction in datix reported incidents around lack of available patient notes Management of health records meets both the national standards and requirements and does not impinge on clinic activity	Richard Sunley Op Lead: Liz Fellows	Jul-15 A	Staff asked to report incidents (an increase has been noted) and monitor with medical records the numbers of incidents and actions taken. Temporary sets of notes are provided by admin staff as soon as they are made aware Gp surgeries are willing to fax referral letters with reason for referral and patients medical history Previous clinics letters pathology radiology and endoscopy results are available to view and down load from e-searcher	Storage increase in Apex Way in September. RFDI tagging of all Medical Records from July	
			54	Purchase lockable trolleys for relevant areas and remind staff of the need to ensure records are removed or securely stored	2	Fully Compliant with national and local policy	Richard Sunley Op Lead: Deidre Connors	Mar-15 G	Lockable trolleys purchased Staff at reminded of the need to ensure records are removed when finished and areas re stocked and locked.	Trolleys in situ	

Quality Improvement Plan

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Health records	Improve issues with the storage and accessibility of patient health records.	Corporate	55	Ensure robust process implemented re the management of health records being tracked and risks to be clearly identified and managed within the CU and escalated as necessary	£800,000	Management of health records meets both the national standards and requirements and does not impinge on clinic activity Active and up to date Risk Register for clinical admin	Richard Sunley Op Lead: Deirdre Connors and Liz Fellows	Jul-15 A	Interim measure: Matrons working with service manager and Admin managers to improve this risk. Risk register reviewed at clinical admin meetings. Temporary sets of notes provided by admin staff as soon as they are made aware Gp surgeries willing to fax referral letters with reason for referral and patients medical history Previous clinics letters pathology radiology and endoscopy results are available to view and down load from e-searcher See box below for EDM update.	Storage space increased at Apex Way in September. RFDI tagging of all records from July. OPD Matrons to report on Date weekly on incidents in relation to records	
			56	Improve state of repair of health records		Health records will be adequately maintained	Richard Sunley Op Lead: Deirdre Connors and Liz Fellows	Apr-16 A	A rolling programme to repair/mend records in preparation for barcoding goes live in July 15. Electronic document management commences April 16		

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			57	Support staff in medical records to report incidents consistently through online system and review incidents at weekly central admin meeting.	0	Data on datix shows reviews of incidents and actions	Richard Sunley Op Lead: Deirdre Connors and Liz Fellows	Jun-15 A	Staff encouraged to report incidents there has been an increase Staff to report to the CU to monitor with medical records numbers of incidents and actions taken.		
Review pharmacy services, specifically ensuring they undertake activity appropriate to their licence											
Pharmacy / Senior Pharmacy Team	Review pharmacy services specifically to ensure that activity undertaken is appropriate to current licences	Pharmacy	58	Decide if ESHT should be in the business of supplying medicines to 3rd parties	0	Review undertaken and decision taken as to appropriate business model.	David Hughes Op Lead: Ian Bourns	Mar-15 G	Paper about pros and cons to be presented to CME at March meeting - agreed to withdraw providing services	Paper and minutes	

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			59	Continue with existing MHRA WDL application	1	Licence in place if required	David Hughes Op Lead: Ian Bourns	Sep-15 A	Discussions taking place with current customers about switch of supplier to obviate need for license. Until that is confirmed application still in place		
			60	Continue with existing Home Office CD Licence applications	1	Licence in place if required	David Hughes Op Lead: Ian Bourns	Sep-15 A	Discussions taking place with current customers about switch of supplier to obviate need for license. Until that is conformed application is being progressed and DBS being acquired by HR in support of that.		
			61	Discuss other dispensing options regarding hand off 3rd party dispensing services If other options not possible begin GPhC registration process for Conquest site	0	Review undertaken and decision taken as to appropriate business model.	David Hughes Op Lead: Ian Bourns	May-15 A	Discussions taking place and data about supply volumes are being shared and costings developed.		
Review and improve the trusts management of medicines in clinical areas											
Pharmacy / Senior Pharmacy Team	Ensure that medicines particularly controlled drugs on the maternity unit at Conquest are managed in accordance with the Trust Policy	Maternity	62	HONs to monitor that all areas using CDs are aware of their responsibilities regarding CDs and that their staff are complying with that policy	0	Staff are aware of their responsibilities and audit of controlled drugs evidences compliance with Trust policy.	Alice Webster Op Leads: HON's	Apr-15 G	Communication sent to staff, monitored by matrons		

Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
			63	Confirm pharmacy oversight is working by Pharmacist carrying out quarterly CD audits to be cross checked against areas being supplied with CD stocks to ensure none are missed. Audits look at documentation as well as stock balances	0	Audit of controlled drugs evidences compliance with Trust policy.	David Hughes Op Lead: Ian Bourns	Mar-15 G	Audits confirm compliance, CD incident now closed following review.		
Crowborough War Memorial Hospital	To ensure accurate recording of medicine administration at Crowborough	Community inpatients	64	Advise staff of their responsibilities and accountabilities Ensure all staff have received the current guidance and policy information Audit as part of the meridian process	0	Area fully compliant with medicines administration.	David Hughes Op Lead: Debbie Cooke	Oct-15 G	Completed	Audit available	
Pharmacy / Senior Pharmacy Team	Ensure safe processes are in place for prescribing in ophthalmology outpatients	Outpatients	65	Eye drops issued to patients by the department must be labelled in accordance with legal requirements.	0	Evidence that opthalmology medication is appropriately labelled.	David Hughes Op Lead: Ian Bourns	Mar-15 G	Issue discussed with Assistant Director of Nursing (East) and interim plan implemented to address labelling requirements..		
Pharmacy / Senior Pharmacy Team	Minimise medicines omissions where not clinically justified	Pharmacy	66	Continue to audit medicines omissions, assess impact on this of new drug chart and identify any lessons for further corrective action	0	Omitted medicines minimised to greater than 90%	David Hughes Op Lead: Ian Bourns	Apr-15 A	January and February audit data has been collected and audit report will be considered by SPT in April meeting	Feb 2015 data shows 96.3%	

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Pharmacy / Senior Pharmacy Team	Ensure there are robust systems in place for medicines deliveries to community hospitals	Pharmacy	67	Community Health Pharmacy team to audit the timeliness of supply from community pharmacy providers and assess the scale of risk for dispensed items	0	Risk appropriately assessed and actions in place if required	David Hughes Op Lead: Ian Bourns	Oct-15 A	Meeting 13.4.15	Risk assessments	
			68	Review the arrangements for delivery of stock medicines and implement a stock delivery audit trail apply corrective action if required	0	Effective process in place for the delivery of medicines across the Trust	David Hughes Op Lead: Ian Bourns	Jun-15 A			
Pharmacy / Senior Pharmacy Team	Out of temperature storage of ward medicines	Pharmacy	69	Advise nursing staff to ensure ward and outpatient meds are stored at correct temperature at all times	0	Evidence of compliance with Policy and Guideline	Alice Webster Op Leads: Jenny Crowe/ Deidre Connors / Jayne Cannon	Oct-15 G	Completed	Recording sheets available	
Pharmacy / Senior Pharmacy Team	Ensure fridge storage is effective by implementing temperature checks and recording of all medication fridges in line with policy	Pharmacy	70	Implement monitoring process of ward and outpatient fridge & freezer temperature recording and audit its effectiveness	0	Full compliance with equipment checks	Alice Webster Op Leads: Jenny Crowe/ Deidre Connors / Jayne Cannon	Oct-15 G	Conquest A&E (now resolved as automatically recorded by Omincell cabinet with electronic alert of out of temperature states to both nursing and pharmacy staff) other areas completed	Recording sheets available	

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			71	Submit application to CAG for funding to implement enhanced ward medicines storage (Omnicell)	£900,000	Application submitted and funding in place	David Hughes Op Lead: Ian Bourns	May-15 A	Time frame is dependent upon capital allocation. This would address all security, CD record keeping and cold storage monitoring issues		
TRUST WIDE ACTION - Ensure appropriate reporting and learning from incidents											
Incident Reporting / PSCIG	Ensure appropriate reporting of incidents	Corporate	72	Update policy	0	Updated Policy is approved and available on the Trust Extranet	Alice Webster Op Lead: Emily Keeble	Apr-15 G	Policy approved by CME 13.04.15 Available on extranet 27.04.15	Minutes of CME meeting Policy on extranet	
			73	Audit incidents to determine that correct process is followed	0	Cross referencing of data demonstrate appropriate reporting	Alice Webster Op Lead: Emily Keeble	Jun-15 A	Datix team review incidents and provide feedback to the incident handler to ensure appropriate processes are followed - to date this has not been audited but will be.		

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			74	Support staff to report incidents	0	Staff feel confident and able to report incidents with appropriate means or access to reporting	Alice Webster Op Lead: Emily Keeble	Oct-15 A	Training of staff to use datix system continues. The Trust Lead has developed a new train programme. A series of LIA Staff Conversations on Incident Reporting runs through May and June 2015.		
			75	EOLC incidents to be reported to the End of Life Steering Group	0	EOLC Incidents are extracted from Datix and presented to the Steering Group	Alice Webster Op Lead: Emily Keeble	Apr-15 G	The Datix Team have set up search queries on Datix to search incidents on key words (rather than adding a specific question or using a sub category which can be subjective). The EOLC team have been trained to use these search queries to run reports and have advised this is working well and reports are going to the group	Incident reports at EOLC Steering Group	
	Ensure learning from incidents are communicated to all staff	Corporate	76	Review how serious medical incidents are managed and escalated to ensure there is oversight from doctors with appropriate training to enable an in-depth analysis to be completed and clear learning identified and that management staff are involved at an early stage to oversee actions	0	Appropriate medical engagement with clear learning objectives.	David Hughes Op Lead: Emily Keeble	May-15 A	In light of new National Framework and revised Trust Policy, Head of Governance, Patient Safety Lead and Medical Director to review process for management of Serious Medical Incidents		

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			77	Further develop the Quality Improvements Plan to incorporate shared learning from incidents and the way in safety initiatives and developments are shared across the organisation and learning embedded	0	Clear evidence in clinical areas that learning has taken place obtained through minutes of meetings PDR's and other forms of staff communication.	Alice Webster Op Lead: Emily Keeble	1st review Oct-15 A	Head of Governance and Workforce development manager are developing human factors and simulation training provision within the trust The Trust joined the 'Sign up to Safety' initiatives in Sept 14, following this the Safety Improvement Plan was submitted to the NHSLA Jan 2015 The trust is actively participating in the KSS Safety collaborative programme e DON and MD to meet with the KSS patient safety collaborative co director May 2015		
			78	Develop a Patient Safety Lead Programme to include Medicines Management Leads to foster cross unit learning and access to expertise	0	Lead nurses identified	Alice Webster Op Lead: Emily Keeble	Jul-15 A	May/June 2015 a series of events is being held to determine progress key challenges and developments required regarding incident management		

Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
			79	Provide monthly feedback reports for each ward area and across CU as necessary Cross CU learning to be shared via Trust induction; through e-learning; Trust wide meetings i.e. matrons meeting and Nursing and Quality meetings	4	Ensure that staff receive feedback from managers and supervisors on practice.	Alice Webster Op Lead: Emily Keeble	Apr-15 A	Clinical Units receive monthly incidents reports for discussion at their monthly risk meetings. Version 12.3 of datix installed Oct 2014 prompting incident handlers to provide feedback to the incident reporter. Looking at automated feed back to incident reporters - at a cost to manage the 'final approval' process Q3 'You said, we did' report drafted		
			80	Develop a Patient Safety page on the Extranet.	0	Patient Safety page developed and updated	Alice Webster Op Lead:	Jul-15 A			
			81	Local CQUINs to be negotiated that reflect the area of need in terms of safety and quality	0	Agreed CQUINS in place	Alice Webster Op Lead: Lindsey Stevens	Apr-15 G	CQUINs agreed with commissioners to reflect high priority quality and safety areas.	CQUIN information	
	Improve the way information is collected and used	Corporate	82	Strengthen and streamline the governance and incident reporting structure to ensure that data is sufficiently accurate and robust to be used to inform service improvements	£180,000	A Learning organisation able to utilize data from incidents to improve care.	David Hughes /Alice Webster Op Lead: Emily Keeble	Jul-15 A	Governance Team centralised Oct 14 and in interim structure. Formal consultation on proposed permanent structure commences 28.04.15		

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TRUST WIDE ACTIONS - (CONQUEST/EASTBOURNE)											
Estates Group	Make sure privacy and dignity of patients is upheld by avoiding same sex breaches in CDU's	A&E	83	PLACE assessments to be reviewed and acted upon within Estates and Facilities and the CU.	0	Full compliance to PLACE audits actions No mixed sex breaches Separate toilet facilities	Richard Sunley Op Lead: Sarah Wilmer	Jun-15 A	Requires capital investment in Both EDs		
			84	Separate areas/cubicles to be used at all times to maintain patient dignity and privacy	*	Dependent on outcomes of Full Business Case		Apr-15 A	Requires capital investment in Both EDs		
			85	Separate toilet facilities to be made available	*	Dependent on outcomes of Full Business Case		Mar-15 G	Made available through interim building work.	New build.	
Estates Group	Ensure emergency bell in Day Surgery EDGH is audible	Surgery	86	Repair or replace bell	0	Completed bell now audible	Richard Sunley Op Lead: Paul Relf	Apr-15 A	Likely to be Littlington. Needs to link to Main Theatres Coordinators desk. Director of Nursing chasing progress.		

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Consent Group	Improve the understanding of staff around the processes for consent to treatment ensuring that staff understand the need for robust recording and documentation in particular around capacity to consent.		87	Review and update Policy	0	Updated Policy	David Hughes Op Leads: Simon Walton Brenda Lynes-O'Meara	Apr-15 A	Policy being reviewed	Policy on extranet	
			88	Develop and implement an audit to monitor adherence to policy by audit	0	Fully compliant with policy through Audit reports		Apr-15 A	Consent group reviewing	Compliance with audits	
			89	Develop a shared learning in practice on Consent to care and treatment	0	Greater knowledge of 'consent' through the organisation	Op Lead: Emily Keeble	May-15 A	Discussed at PSCIG - need to raise awareness following recent Supreme Court legal case.		
Safeguarding Group	Ensure that MCA assessment are of a high quality		90	Regularly review the quality of MCA (mental capacity act) assessments and ensure that they are clearly documented.	0	Compliance with MCA	Alice Webster Op Lead: Brenda Lynes-O Meara	Aug-15 A	MCA training audits being completed		
Critical Care	Improve bed management processes to ensure that patients do not remain in ITU longer than required, which can impact on their privacy and dignity	Eastbourne Surgery	91	All exceptions are reported and reviews completed on all exceptions to identify key learning and implement actions	0	Once a critical care patient has a plan for transfer to a more appropriate setting this occurs within 4 hours.	Richard Sunley Op Lead: Michele Elphick	Oct-15 A	CQUIN to deliver discharge within 12 and then 4 hours. Reported to Start the Week meetings weekly. Reported to Site Meetings 4 times a day. Escalation plans in place	Delivery of CQUIN	
Clinical Unit Governance meeting	Address the long waiting times for oral and maxillofacial surgery for adults with learning disabilities	Surgery	92	Reviewing waiting list and pathway for adults with learning disabilities requiring oral and maxillofacial surgery	0	Effective pathway in place	Richard Sunley Op Lead: Michele Elphick	Apr-15 G	Continue to run theatre 11 .	Evidence of no long waiters	

Work stream/ Group	Objective	Service	No	Key Actions	Cost Impact	Measure of success/Outcomes	Executive Board Lead/ Operational Leads	Date of Delivery/ RAG rating	Progress	Evidence	Strength of Current Evidence (i.e. Good / Weak/ insufficient)
Audit Working Group	To undertake audits in order to comply with national and local guidelines and regulations such as NBM, VTE and Pre-eclampsia.	Corporate	93	Conduct a Trust wide review of venous thromboembolism (VTE) compliance as a matter of urgency	0	Completed audit reports	David Hughes Op Lead: Emma Jones-Davies	Jun-15 A	There have been VTE and audits covering pre-eclampsia on the clinical audit forward plan in 2014/15. No evidence of NBM audits however they will be added to the 20/15 forward plan		
COMMUNITY											
	Ensure effective management information systems are in place	Community Children's services	94	Review the Child Health Information Systems (CHIS) so that robust and reliable data is produced	0	CHIS provides reliable and robust data	Vanessa Harris Op Lead: Anne Singer	Sep-15 G	System now able to provide robust and reliable data	No incidents reported relating to inaccurate data	
			95	Review the establishment of administrative staff and ensure there are sufficient numbers to support the service, especially during periods of unstable CHIS and delays in the implementation of	0	Appropriate levels of administrative support in place	Richard Sunley Op Lead: Anne Singer	Sep-15 G	Staff recruited and at full establishment April 15		
			96	Implement a system to monitor key performance indicators (KPIs) and service delivery to meet service specification.	0	KPI metrics developed and reviewed to support effective service delivery	Richard Sunley Op Lead: Anne Singer	Sep-15 A	Being developed as part of project in conjunction with knowledge management		
			97	Develop an audit programme to monitor quality and safety of service.	0	Effective audit programme in place and learning shared.	Richard Sunley Op Lead: Anne Singer	Sep-15 A	Being developed as part of project		

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