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# HOSC Briefing Paper

*A briefing on the support provided to  
East Sussex Healthcare NHS Trust*

"It takes a minute to feedback, but the difference could last a lifetime"

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# Contents

Executive summary ..... 3

Healthwatch East Sussex visibility within the Trust..... 3

    Observations..... 3

Making Complaints Personal - independent review of the complaints process (Report 1) ..... 4

    Observations and findings..... 4

Maternity Review - summary of on-line responses (Report 2a) ..... 4

Special Measures, to special moments - an overview of maternity services (Report 2b) ..... 5

    Noticeable observations and findings..... 5

Round the clock care - 24 hours in ESHT Acute Hospitals, The patients view (report 3) ..... 6

    Noticeable observations and findings..... 6

Conclusions ..... 6

Contact us ..... 7

Disclaimer..... 7

## Executive summary

East Sussex Healthcare NHS Trust (ESHT) and Healthwatch East Sussex (HWES) agreed to work collaboratively on a series of projects linked to the ESHT improvement plan aimed at strengthening ESHT's patient and public engagement and promoting a culture of continuing quality service improvement.

The projects include:

- Increasing Healthwatch East Sussex visibility within the Trust.
- Completing an independent lay review of the complaints process; and
- Undertaking a programme of Healthwatch East Sussex Enter and View activity.

## Healthwatch East Sussex visibility within the Trust

Information volunteers support two pop-up 'Info hubs' situated in the main reception areas of both acute hospitals. The main aims are to raise the profile of HWES with staff and patients; improve the overall relationship between the Trust, HWES and its volunteers; and to generate an increase in patient feedback.

### Observations

- Some ESHT Board members have visited HWES volunteers in the reception areas.
- Noticeable changes have been observed with interactions between the Trust's staff and Healthwatch volunteers as more staff understand the role of local Healthwatch.
- More staff are aware of local Healthwatch.
- Communication within the Trust has improved when Healthwatch representatives visit the wards; and
- The overall relationship has noticeably improved since the beginning of this project.



## Making Complaints Personal - independent review of the complaints process (Report 1)

The review team looked at a random selection of complaints received by ESHT, with each complaint scrutinised for process. A total of **66 cases** were reviewed.

### Observations and findings

It was clear there was a process and a structure of acknowledgement in place and that it was generally followed. There was also evidence of:

- Responses which were generally sympathetic.
- The Trust communicating well with other agencies when more than one organisation was involved.
- Long delays for complainants at various points of the process.
- Some delays stretching over six months from the initial point of contact.
- No fast track system for more serious complaints.
- Clinical and formulaic responses which could lead to the complainant feeling that they are outside the process and not being treated as an individual.

## Maternity Review - summary of on-line responses (Report 2a)

A working group was created to look at all **197 on-line responses**, following the call out for evidence. (January - February 2016) The experiences women shared through this on-line survey were largely related to the service at the Conquest Hospital (80%). Key themes, actions and learning points include:

- **Staff attitude** - the experiences reported by women contributed to an overall negative experience in some instances.
- **Special Care Baby Unit (SCBU)** - very complimentary references to staff and the community midwives.
- **Ante-natal care** - a number of women commented on their belief that they had undergone an unnecessary emergency caesarean section and on the waiting times for induction.
- **Labour care** - overall largely positive experiences, the most negative experiences were reported at the Conquest Hospital; whilst women giving birth at the Eastbourne unit were very complimentary.
- **Post-natal care** - the highest proportion of respondents were critical of their experience at the Conquest Hospital. However where the feedback was positive, care was described by women as 'excellent', 'fantastic' and 'supportive', across both sites.
- **Cleanliness and hygiene** - most of the negative comments received related to the showers and bathrooms at the Conquest Hospital.

## Special Measures, to special moments - an overview of maternity services (Report 2b)

Authorised Representatives visited both units over a three day period in mid-April 2016 (including a weekend).

- Maternity units at Eastbourne District General Hospital (EDGH) and the Conquest Hospital.
- Women who had used the service were involved in the planning and shaping of this review.

A total of 50 survey interviews were completed.

### Noticeable observations and findings

- Women on both units at the time of the visit shared mostly positive experiences about their interactions with nursing and midwifery staff.
- The midwife led unit at Eastbourne was very highly rated by women and their partners and described by some as a 'gold standard service'.
- Travel between the two units led to some negative responses, especially in relation to transferring back to Eastbourne from the Conquest.
- Delays were mentioned at both units by women having labour inductions.
- Frank Shaw ward was observed as being very busy at times and staff appeared stretched.
- It was suggested that better information for fathers and partners could be provided including information on access arrangements to wards at night.



## Round the clock care - 24 hours in ESHT Acute Hospitals, The patients view (report 3)

A total of 252 people shared their views and experiences over a 24 hours period across both acute hospitals starting at 08.00 hrs on the 21<sup>st</sup> April and concluding at 08.00 hours Friday 22<sup>nd</sup> April 2016.

- We talked to patients, carers, relatives and some staff.
- We asked people to rate the care and treatment they received, whether their care met their expectations and how well they were communicated with.

### Noticeable observations and findings

- Patient and relative's experiences of care during the 24 hours were largely reported positive and complimentary.
- Authorised representative's observations of care during the 24 hours were also positive and complimentary.
- Inappropriate attendances at A&E department were a particular issue at EDGH.
- Proactive communication with patients around waiting times in A&E needs to significantly improve.
- More public information and education is required to deter inappropriate attendance at A&E departments.

## Conclusions

**Healthwatch East Sussex will continue to work with the Trust in taking forward the learning identified in this review and where further activities remain outstanding i.e. the Complaints Review.**

We will follow up with a programme of reflective interviews and develop early intervention strategies, seeking to address issues at an early stage and avoid complex complaints.

We are also exploring the introduction of a Maternity Guardian role in East Sussex; this would be an independent access point for women, to share experiences and concerns.

## Contact us

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## Disclaimer

This report relates to findings observed on the specific dates set out in the report. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

We will be making this report publicly available by 30 June 2016 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

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