About this document

Why are we producing a Quality Account?

The purpose of the Quality Account is to share information about the quality of our services, and our plans to improve even further, with patients, their families and carers. Since 2010 all NHS trusts have been required to produce an annual Quality Account.

What are the required elements of a Quality Account?

The National Health Service (Quality Accounts) Regulations 2010 specify the requirements for the Quality Accounts. We have used these requirements as a template around which our Account has been built. Our 2012/2013 Quality Accounts are presented in three parts:

Part 1
- A statement on quality from the Chief Executive of East Sussex Healthcare NHS Trust.

Part 2
- Priorities for improvement in 2013/2014 – this section identifies our priority areas for improvement and associated improvement initiatives.
- Statements relating to the quality of NHS services provided by East Sussex Healthcare NHS Trust.

Part 3
- Review of our quality Performance in 2012/2013
- Statements from our key stakeholders

How did we produce our Quality Account?

In addition to ensuring that we have included all of the mandatory elements of the account, we have engaged with staff, patients, volunteers, commissioners and other stakeholders to ensure that the account gives an insight into the organisation and reflects the priorities that are important to us all. As a result, we have identified specific and measurable improvement initiatives in each of our priority areas. These initiatives will support improvement in the priority areas.

We appreciate that some of the language used may be difficult to understand if you don’t work in healthcare. We have therefore included a glossary at the end of our Quality Account to explain some of the words that we use every day. We are keen to ensure that the account is a useful document which helps patients, families and the public to understand our priorities for delivering quality care. If you have any suggestions for next year’s Quality Account, or any queries regarding this year’s document, please contact us at enquiries@esht.nhs.uk.
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On behalf of our Trust, I am pleased to present this Quality Account which looks back at our quality achievements for 2012/2013 and sets out our quality priorities for 2013/2014.

We see and treat thousands of people in our hospitals and through our services in the community each year. The quality of the care we deliver and the safety of our patients are fundamental to what we do. Improving quality makes our services safer, more clinically effective and patient focussed.

Over the last few years there has been a significant amount of work across the organisation to improve quality and I am incredibly proud of the achievements we have made. The Care Quality Commission’s recent reports are a testimony to this when, following unannounced visits in January 2013, the regulator found our two acute sites to be compliant with their standards. The reports recognise the considerable progress we have made since 2011.

Over the last year we have also been listening to patients, their families, carers and our staff; recognising that their feedback is invaluable in improving our services. This has included:

- Holding our first “Patient Experience Conference” in February 2013 which highlighted the improvements we have made and considered our plans for the future.

- Implementing the “What matters to you matters to us” campaign with a positive response of on average over 83% of people who use our services stating that they would strongly recommend us.

- Launching “Listening into Action” as a new way of working in our organisation. This is about achieving a fundamental shift in the way we work and lead, bringing staff together, to come up with great ideas and empowering them to get on and make the changes we all want to see.

- Board meetings open with a patient story and Board members regularly visit our clinical services to speak to patients and staff and report back on what they find.
We still have more to do, quality improvement is a continuous cycle and we must continue to develop so we can deliver excellence in all aspects of the care we provide. Over the next year we will begin implementing our Clinical Strategy: Shaping our Future which will ensure we will deliver high quality and sustainable services in the future and continue to provide excellent, safe healthcare for every patient, every day of the year.

Finally, on behalf of the Board, I would like to thank our staff and volunteers for putting quality and patient safety at the forefront of everything we do and taking pride in doing the very best for each and every person they meet.

I confirm, in accordance with my statutory duty, that to the best of my knowledge the information provided in these Quality Accounts is accurate.

Darren Grayson  
Chief Executive - East Sussex Healthcare NHS Trust
About our Trust

East Sussex Healthcare NHS Trust provides acute hospital and community health services for people living in East Sussex and surrounding areas.

Our services are provided from two district general hospitals, Conquest Hospital and Eastbourne DGH both of which have Emergency Departments and provide care 24 hours a day. They offer a comprehensive range of surgical, medical and maternity services supported by a full range of diagnostic and therapy services.

We also provide 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 we provide 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 we jointly provide, with Adult Social Care, inpatient intermediate care services. Our community staff also provide care in the patient’s own home and from a number of clinics and health centres, GP surgeries and schools.

We are committed to providing the best possible healthcare service to patients, who come first in everything the organisation does.
Approximately 525,000 people live in East Sussex and the Trust is one of the largest organisations in the county. We employ over 7,200 dedicated staff with an annual turnover of £387 million.

Our Vision is to be:
The healthcare provider of first choice for the people of East Sussex

Crowborough War Memorial Hospital
Lewes Victoria Hospital
Rye, Winchelsea and District Hospital
During 2012/2013…

More than 119,000 patients were treated in our Emergency Departments and associated areas as emergency cases.

Our Health Visitors had more than 300,000 contacts with children and their parents.

Almost 300,000 radiological examinations and therapeutic procedures were performed.

Just under 310,000 people attended outpatient clinics at one of our Trust’s hospitals or outreach centres.

Almost 100,000 people were provided with hospital care either as inpatients or as day cases.

5.7 million pathology tests were performed.
Statement of Directors’ responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the Trust’s performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Date: 25 June 2013
Stuart Welling, Chairman

Date: 25 June 2013
Darren Grayson, Chief Executive
Our Quality Improvement Priorities for 2013/2014

The NHS identifies three fundamental areas of quality care and our 2013/2014 Quality Improvement Priorities are aligned to these.

1. Patient Safety – patients are safe and free from harm

2. Clinical Effectiveness – the treatment and care we deliver is the best available

3. Patient Experience – patients, their carers and relatives have a positive experience that meets or exceeds their expectations
How we chose our priorities for 2013/2014

Improvement priorities for 2013/2014 have been chosen following a process of listening to the views of our stakeholders and reviewing current services and developments such as the implementation of our clinical strategy.

The priorities reflect our commitment to delivering high quality care as an integrated organisation that provides care closer to home. This is reflected in our plans to increase community based services for cardiology patients and improve support for children and young people with long term conditions and disability. The introduction of the community productive series will support our local teams to learn from good practice and release time for direct patient care.

We are committed to building on our quality priorities from one year to the next, so that everyone can see whether improvements are maintained over time. This is demonstrated in the Patient Safety Thermometer priority which covers some of the themes in last year’s quality account by building on our work to reduce falls and pressure ulcers.

During November and December 2012, we held three public Quality Engagement Events (in Uckfield, Hastings and Eastbourne) to help inform the Patient Experience quality improvement priority options. The overarching theme that emerged from these events was around the need to improve our communication with patients and this has been agreed as the driving theme for our 2013-2014 Patient Experience priority. This will be supported by the implementation of our Patient Experience Strategy.
Eight clear themes have emerged, and these themes will determine and influence changes across the Trust. **What really came across at all the staff conversations was the desire of everyone to put patients at the centre of what we do each day.** Capturing feedback, responding to and learning from our patients and staff is vital to our organisation. We clearly recognise and accept that a positive patient experience for all users is only achievable if we understand and continually work towards what matters to our patients and staff. The LiA programme is about supporting staff so that they deliver the best care for our patients.

Listening into Action is a new way of working - staff from all levels of the organisation were able to get together to talk openly about the frustrations they have in their jobs, what prevents them from doing their job effectively and what we should do together to ‘unblock the way’ so we can all provide the very best care for our patients and their families.

It is about achieving a fundamental shift in the way we work and lead, putting staff at the centre of positive change for the benefit of our patients, our staff and the Trust as a whole.

The Chief Executive Darren Grayson has hosted seven ‘Big Staff Conversations’. These were a chance for a mix of staff from across all levels and roles to get together and talk openly about what really matters to them, what gets in their way, and what we should prioritise changing together for the benefit of our patients and ourselves.

The absolute focus of this, and the actions which will follow, is to support and enable staff to do the very best for our patients and their families, in a way which makes us all feel proud.
Our quality improvement priorities for the year ahead are divided into three key areas:

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2.1 Patient Safety

What is our Goal?

To ensure that safety always comes first within our organisation.

This priority will focus on achieving the following:

1. **Patient Safety Thermometer (maintaining Harm Free Care at 90% and above)**

Improving patient safety involves assessing how patients could be harmed, preventing or managing risks, reporting and analysing incidents, learning from such incidents and implementing solutions to minimise the likelihood of them happening again.

The NHS Safety Thermometer helps NHS teams in their aim to eliminate harm in patients from four common conditions: **Pressure ulcers, Falls, Urinary tract infections in patients with a catheter and Venous Thromboembolism (VTE)**

These conditions affect over 200,000 people each year in England alone, leading to avoidable suffering and additional treatment for patients and a cost to the NHS of more than £400 million. The ‘harm free’ care programme supports the NHS to eliminate these four harms through one plan within and across organisations. This builds on existing improvement work and can be implemented at local level and integrated with existing routines. It helps organisations to consider complications from the patient’s perspective, with the aim of every patient being ‘harm free’ as they move through the system. Through using the NHS Safety Thermometer during their working day, teams can measure harm and the proportion of patients that are ‘harm free’, for example at shift handover or during ward rounds.

The Safety Thermometer provides a ‘temperature check’ and can be used alongside other measures of harm to measure local and system progress - it is a national tool that was not designed to compare organisations, it requires local discussion, interpretation and implementation and should be used to drive improvement. By adopting a ‘Harm free care’ approach to patient safety, we have implemented many initiatives to promote Patient Safety. For example, Essential Care Rounds ensure that patients are approached on a regular basis and that their needs are promptly addressed.
**What does this mean for you?**

We want to build on the quality and safety processes we already have in place. It is well known that patients who suffer one harm have a higher probability of suffering further harm. It is these patients for whom the burden of dependency and cost of suffering is greatest. Data is rarely cross referenced to determine, for example, patients who have suffered a fall and also have a pressure ulcer. Understanding the overall burden of these harms across the Trust at patient level (wherever a patient is treated) is something that can be achieved via the Safety Thermometer.

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**“The very first requirement in a hospital is that it should do the sick no harm.”**  
*Florence Nightingale*

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**How will we monitor progress?**

The Safety Thermometer tool requires a baseline of 6-8 months (April - October 2013) worth of data before improvements can reliably be measured. The easy to use design enables front line staff to collect and interpret data, receive prompt feedback that is transparently displayed and acted upon to improve safety and quality of care for patients. The Trust’s Safety Thermometer is then submitted monthly to the NHS Information Centre and merged with the results from other Trusts across the country to form one National Safety Thermometer. At a local level, each team or ward receives their own Safety Thermometer information back within one week of submission; they review the results, observe the trends of harms and harm free care and implement changes if required. When enough baseline data has been collected it will be displayed on the “Knowing How We Are Doing” boards alongside Productive Series Data in patient areas across the Trust and the results used to drive improvement.

**Where will we report upon our progress and achievements?**

A robust reporting plan ensures that the immediate ward or team receive the results of their data collection in a timely manner (monthly). Senior managers receive a divisional monthly report, additionally; a quarterly report is submitted to our Trust Board. Our commissioners are informed of progress and achievements on a monthly basis. The public and our patients are able to download and observe the National Safety Thermometer from the NHS Information Centre and from October 2013 will be able to see individual Safety Thermometer results displayed across the organisation in ward / team areas. A patient safety webpage is also in development which will enable achievements to be celebrated and best practice shared.
2.2 Patient Safety

What is our Goal?

To ensure that safety always comes first within our organisation

This priority will focus on achieving the following:

1. Implementing ‘Releasing Time to Care: The Productive Community Series’

The Productive Community Series is an initiative developed by the NHS Institute for Innovation and Improvement with the ultimate aim of releasing more time for frontline staff to spend on patient care. The initiative focuses on improving processes and environments to help nurses and therapists spend more time on patient care, thereby improving safety and efficiency.

What does this mean for you?

The Productive Community Series is an organisation-wide change programme which helps systematic engagement of all front line teams in improving quality and productivity. It is a practical application of lean based techniques that will vastly increase the organisation’s capacity and capability to facilitate continuous improvement. Teams across the organisation will use the best available evidence and guidelines, policies and patient feedback to re-design core processes within their services. As care shifts away from acute settings, community services will play a crucial role in shaping a new and improved NHS – the Productive Community Series Programme is a timely opportunity to revitalise our workforce and increase the Trust’s capacity to care for patients in local settings. The Programme has the potential to:

- Increase staff to patient contact time
- Reduce inefficient work practices
- Put staff at the forefront of redesigning their services
- Improve the quality and safety of care
- Re-vitalise the workforce

Where the productive community programme has been implemented at other organisations the following achievements have been reported:

- Patient facing time increased from 21% to 35%
- Number of visits a team’s capable of increased by 25% (for a typical team that is 2100 extra visits per yr)
- Time spent managing referrals down 83%
- Time spent looking for stock items reduced by 66%
- Team morale up 93%
- Interruptions reduced by 52%
- Stock reduced by 75% (value £3000)
- Driving distances reduced by 21%

Staff across the Trust will use a variety of methods to identify how and where both the quality of care and patient safety can be improved through the redesign of systems and processes.
Why have we chosen this?

The Productive Community Series underpins the Trust’s objectives for community services, addressing not only patient safety and quality, but also the reliability of care, productivity, efficiency and staff well being.

How will we monitor progress?

The Trust will monitor progress with implementing the Productive Community Series through monthly review of a detailed project plan – identified leads and timescales will be listed to ensure the implementation of this priority remains on target throughout the year.

The Productive Community Series lead will provide on-site support and facilitation to community teams throughout the year, working with them to drive and capture progress as they implement the various programme modules - team leaders and managers will be involved in this process.

Where will we report upon our progress and achievements?

The Trust will hold monthly Productive Series Steering Group Meetings, whereby managers and staff will meet to discuss and report upon achievements and progress, celebrate success, and work together to remove any identified barriers which may affect successful achievement of this priority.

The Senior Nursing Team will also meet regularly with Matrons and team leaders at the Nursing and Midwifery Performance Review Group, whereby progress and successes will be reported, and learning will be shared across the Trust. A formal progress report will be presented to the Trust Board every quarter.
Priorities for Improvement in 2013/2014

2.3 Clinical Effectiveness

What is our Goal?

To consistently provide high quality patient care in line with identified best practice.

Cardiology – Improve the patient experience of those diagnosed with heart failure.

Our aim for 2013/2014 is to continue to improve the patient experience of those diagnosed with heart failure. We plan to increase our community based services for cardiology patients with an emphasis on heart failure and providing direct admission to cardiology services when required to ensure compliance with national standards for treatment times and have more favourable outcomes. In the past there has been a variation in the outcomes for patients with heart failure, including high death rates and re-admission rates nationally.

We have established a community heart failure service to improve the treatment and subsequent outcomes for these patients. These goals are in line with the “enhancing quality” measures of the clinician led improvement programme. We plan for all patients that have a diagnosis of heart failure to receive the appropriate investigations and treatment in a timely fashion with access to information, investigation and specialist care.

To achieve this high quality care pathway we will continue to work in collaboration with our CCG’s and GP’s for the early identification and diagnosis of this condition in order to improve the experience for our patients with heart failure.

In western populations heart failure is a common condition with a prevalence in the general population of 1% rising to more than 10% in people over 75 years. Heart failure is one of the commonest reasons for emergency medical admissions (5%), re-admissions and hospital bed days occupancy.

It has been found that 90% of heart failure admissions are as an emergency.
What does this mean for you?

We will continue to plan and provide care closer to your home and prevent re-admissions to hospital. We have appointed a specialist team of heart failure nurses to care for patients not only in hospital but also in the community – this will ensure that the patient’s care pathway is supported throughout their clinical journey. When in hospital, where clinically possible we will ensure that patients with heart failure are cared for on a Cardiology inpatient ward. Patients will also have increased review by a cardiac consultant as it was identified in the National Heart Failure Audit that patients admitted to cardiology wards were half as likely to die (6%) in hospital as those admitted to other wards (12%). Patients that for clinical reasons are not on a Cardiology ward will be consistently reviewed by our specialist teams.

Benefits for the patient include:

- Access to a named heart failure specialist nurse to reduce the chances of re-admission to hospital – improving support and relieving anxiety.
- To enable early discharge from the hospital, therefore reducing length of stay for the patient.
- Having an agreed management plan in place post discharge, ensuring a more coordinated and safe discharge.
- A greater understanding of their own condition - including when and how to raise the alarm and to promote self-management.
- Improved access to a dietician and physiotherapy specialists.
- Early monitoring of medications by the specialist nurse to stabilize the condition and improve the quality of life for the patient.
- To enable more heart failure patients to take up cardiac rehabilitation by a re-organisation of the rehabilitation service.
- End stage heart failure to be managed appropriately and effectively with palliative support.

Benefits for the Trust:

- Clinicians will have access to multi-disciplinary case conferences – allowing complex cases to be discussed to ensure best practice.
- A reduction in readmissions to the acute hospital.
- To use “telemedicine” a telecommunication and information technologies system that can provide clinical health care at a distance.
- To develop, audit and understand the use of the intravenous diuretic service (to reduce water retention) in the community.
- To create an ambulatory care facility for day case treatments.
How will we monitor progress?

The Specialist Heart Failure team meet regularly to discuss management issues within the Clinical Unit – this allows problems to be solved quickly and any issues to be escalated according; any further development needs in the acute or community settings are also reviewed. The senior management team manage the specialist team in both the acute and community settings, this is particularly positive in enabling decision making. The following audits are planned for 2012/2013:

- To audit the prescribing of appropriate medications.
- To audit the specialist heart failure input.
- To audit those offered group exercise based rehabilitation plan
- To audit the discharge management plan and community support.

Where will we report upon our progress and achievements?

The heart failure working group is a sub group of the East Sussex Cardiology Group which reports to the CCG boards and shadow boards on a regular basis with the responsibility of Heart Failure Services and development of appropriate pathways in line with delegated clinical responsibilities.

The East Sussex heart failure working group will also report to the East Sussex intermediate / integrated care network.
Priorities for Improvement in 2013/2014

2.4 Patient Experience

What is our Goal?

To improve our communication with, and listen, act upon and be responsive to the feedback we receive from our patients and their carers.

This priority will focus on achieving the following:

1. Implementation of our Patient Experience Strategy

→ Introduce Patient Experience Champions across the Trust

The aim of the Patient Experience Champion Programme is to engage with and empower staff at all levels to deliver an excellent patient experience. It will achieve this by providing a framework to enable local staff to continually listen and learn from their patient’s experiences making a real difference to patients receiving care from their ward, department or service. It will support partnership working with fellow colleagues by sharing good practice and making trust wide improvements.

→ NHS Friends and Family Test

| “How likely are you to recommend our ward / A&E department to friends and family if they need similar care or treatment?” |
| The Friends and Family Test is a simple, comparable test which, when combined with follow up questions, provides a mechanism to identify both good and bad performance and encourages staff to make improvements where services do not live up to expectations. This is our opportunity to ensure that we are truly focused on the experiences of people who use our services. We will be asking the question on the left to all adults who stay in our acute and community hospitals and who visit our emergency departments including the minor injuries units. Patients or their relatives/carers are provided with the opportunity to answer this question either using a device on the ward or department or on-line at home. All responses are confidential. Through the technology used, responses are as near to “real time” as possible and can be shared very quickly - allowing immediate actions to be taken and compliments / comments shared with staff. |
→ **On line websites such as NHS Choices and Patient Opinion**

People who use our services and members of the public can leave comments, concerns and suggestions via message boards on these websites. Our Patient Experience lead monitors these websites and will respond to all comments made. Where required they will also pass the information on to relevant people within the Trust for action or response.

→ **Increase the amount of ‘Easy Read’ Leaflets across the organisation**

Patient information is a vital element of patient care – providing our patients with essential information about our services and clinical procedures in order to allow informed treatment decisions to be made. All patient information leaflets are approved by a dedicated Steering Group before they are made available to patients and members of the public - this is to ensure that leaflets are up to date, easy to read and are based on the best available evidence. It is important that the information contained within each leaflet is understandable and accessible. For some of our patients and members of the public “easy read” leaflets are helpful. These leaflets include pictures or symbols and fewer words to help assist understanding, and are available as required in larger print, Braille and other languages. We are also reviewing our Patient Information Policy and developing a membership to ensure that where required specialist advice is available to support the development of easy read leaflets.

→ **Introduction of ‘patient diaries’**

**What are Patients Diaries?** Patient diaries provide a daily record of each day’s events written to the patient him/herself in simple, uncomplicated language. They are completed by all members of the multi-disciplinary team, families and close friends.

**Why use Patients Diaries?** Many patients have very hazy memories of their time spent in the Intensive Care Unit (ITU); some patients may even be left with Post Traumatic Stress Disorder (PTSD) type symptoms as a result of their experiences. These diaries can help to build a complete picture of what actually happened, from what may be distorted memories and hallucinations. The diaries may be used as a method of helping patients and their families regain some of this ‘lost time’ and make some sense of their experience.
Introduction of ‘Matrons Moments’

Through feedback received, the Trust is aware that patients, their relatives and carers have commented that clinical staff often appear unavailable to speak to them about care and progress. The intention of ‘Matron’s Moments’ is to provide a specific time period throughout the week when senior members of staff will be available to answer any questions or concerns – many of which staff will be able resolve quickly, the Trust wants to find a speedy solution to any problems that arise. The Trust will initially pilot Matrons Moments to determine whether or not this process can make a difference to a patient’s experience through the knowledge that that any questions can be answered at a specific time.

What does this mean for you?

The Patient Experience Champion Programme will benefit our patients by allowing them to become involved with how services are delivered and designed at ward / department level, ensuring their views are captured, heard and acted upon across all departments, and providing them with a key person in each area to take forward their views to make real differences.

Through developing initiatives such as the Patient Experience Champions, “real time” patient surveys and message boards on websites we are increasing the ways in which you can talk to us and let us know your views. This will enable us to understand and act quickly to improve where necessary, and to praise staff where services have met or exceeded your expectations.

We can provide you with the assurance that we are listening, acting and responding to your concerns and comments and that by taking the time to give us your feedback, you are helping to make a difference across the Trust.
How will we monitor progress?

The Patient Experience Champions will be supported by the Patient Experience lead and will work collaboratively through network meetings to share best practice and lessons learned across the organisation and through the Patient Experience Steering Group. Regular Patient Experience Champion awards will be issued to the individual who has made the most significant contribution to patient experience across the Trust, a certificate signed by the Chief Executive and the Director of Nursing will be presented.

The Patient Experience Champions will be supported by the Patient Experience lead and will work collaboratively through network meetings to share best practice and lessons learned across the organisation and through the Patient Experience Steering Group. Each month a Patient Experience Champion award will be issued to the individual who has made the most significant contribution to patient experience across the Trust, a certificate signed by the Chief Executive and the Director of Nursing will be presented.

The Friends and Family Test results will be available for all staff to view as required. Ward sisters and matrons will be encouraged to view their results frequently and will be trained to access the results online. Reports will be provided to the divisional managers for review, and be discussed at the Trust Board on a quarterly basis.

**Patient Diaries:** Some patients will be followed up to assess the value of these diaries during their recovery phase. Feedback from relatives and carers will also be sought through some focused collection of data.

**Matrons Moments:** The Trust will monitor the number of occasions whereby patient experience is positively commented upon, the number of complaints received which specifically refer to *staff being unavailable to speak to the patient or relative* will also be recorded throughout the year. Discussions will take place with patients, their families and their carers as to whether or not the availability of ‘Matrons Moments’ has made a difference to their experience.

Where will we report upon our progress and achievements?

Progress with achieving these Patient Experience quality improvement initiatives will be monitored on a quarterly basis by the Trust Board. The Patient Experience Steering Group is the forum for reporting all patient experience activities on a monthly basis; this Group ensures that lessons are learnt widely across the Trust.
Priorities for Improvement in 2013/2014

2.5 Patient Experience

What is our Goal?

To improve our communication with, and listen, act upon and be responsive to the feedback we receive from our patients and their carers.

2. Supporting young children and young people with long term conditions and disability to stay at home

Children in the community with long term conditions and disability will be supported to stay at home and be enabled to be discharged from hospital earlier by having a specialist team of children’s nurses available to them. If admitted to hospital they will have an identified trained nurse managing their care.

What does this mean for you?

A full consultation will take place with every child and family who lives in East Sussex with a long term condition and / or disability under our care – our aim, by the end of March 2014, is to ensure that every child / young person and their family proactively contributes to their own Care and Management Plans with the support of an interpreter as required. This will support providing care closer to home, prevention of admission and earlier discharge from hospital to optimise the patient’s recovery.

Our work will be linked to the Trust’s Age and Healthcare Steering Group’s Action Plan - the Group has identified that teenagers (aged 16/17) are currently unable to access or receive appropriate services from acute services and that the organisation needs to be more flexible in supporting their needs so we will work with our teenagers to support them better at the transition to adult care stage of their treatments.

We will refer to the Department of Health document ‘NHS at Home: Community Children’s Nursing Service March 2011’ to help support the successful implementation of this priority.

How will we monitor progress?

In April 2013, a survey will take place to assess the experience of children and families to date. The results of this exercise will be analysed between April – June and an action plan developed. The Trust will strive to successfully implement the actions between October - March of 2013/2014.

The Community Children’s Nursing Service and Clinical Service Managers will meet on a quarterly basis to review progress with completing the action plan.
Where will we report upon our progress and achievements?

A quarterly report will be presented to the Integrated Care Division’s Clinical Quality Patient Safety Group, the Clinical Management Executive and the Trust Board on the feedback received, results, identified concerns or issues, and progress with implementing the action plan.

The Children and Young Peoples Clinical Unit will keep track of any identified issues through a ‘RED’, ‘AMBER’, ‘GREEN’ rating system on the action plan, escalating concerns as they arise in a timely manner to ensure achievement of this priority remains on target.
2.6 Statement of Assurance from the Board

**Review of Services**

During 2012/2013 the East Sussex Healthcare NHS Trust provided and/or sub-contracted 74 NHS services.

The East Sussex Healthcare NHS Trust has reviewed all the data available to them on the quality of care in 74 of these NHS services.

The income generated by the NHS services reviewed in 2012/2013 represents 100% of the total income generated from the provision of NHS services by the East Sussex Healthcare NHS Trust for 2012/2013.

**Participation in clinical audits**

Clinical audit is used within East Sussex Healthcare NHS Trust to aid improvements in the delivery and quality of patient care, and should be viewed as a tool to facilitate continuous improvement.

The key component of clinical audit is that performance is reviewed to ensure that what *should* be done is *being* done, and if not it provides a framework to enable improvements to be made. It is effectively the review of clinical performance against agreed standards, and the refining of clinical practice as a result.

During 2012-13, 40 national clinical audits and 4 national confidential enquiries covered NHS services that East Sussex Healthcare NHS Trust provides. During that period East Sussex Healthcare NHS Trust participated in 98% of national clinical audits and 100% per cent of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust was eligible to participate in during 2012-13 are as follows:
<table>
<thead>
<tr>
<th>Peri and Neonatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal infant and perinatal mortality (MBRRACE-UK)</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Confidential Enquiry into Patient Outcome and Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subarachnoid Haemorrhage</td>
</tr>
<tr>
<td>Alcohol Related Liver Disease</td>
</tr>
<tr>
<td>Bariatric Surgery (Organisational Questionnaire only)</td>
</tr>
<tr>
<td>Cardiac Arrest Procedures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood epilepsy (RCPH National Epilepsy 12 Audit)</td>
</tr>
<tr>
<td>Diabetes (RCPH National Paediatric Diabetes Audit)</td>
</tr>
<tr>
<td>Child Health Review</td>
</tr>
<tr>
<td>Paediatric asthma (British Thoracic Society)</td>
</tr>
<tr>
<td>Paediatric pneumonia (British Thoracic Society)</td>
</tr>
<tr>
<td>Paediatric fever (College of Emergency Medicine)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency use of oxygen (British Thoracic Society)</td>
</tr>
<tr>
<td>Adult community acquired pneumonia (British Thoracic Society)</td>
</tr>
<tr>
<td>Non invasive ventilation - adults (British Thoracic Society)</td>
</tr>
<tr>
<td>Renal Colic (College of Emergency Medicine)</td>
</tr>
<tr>
<td>Cardiac arrest (National Cardiac Arrest Audit)</td>
</tr>
<tr>
<td>Adult critical care (ICNARC CMPD)</td>
</tr>
<tr>
<td>Potential donor audit (NHS Blood &amp; Transplant)</td>
</tr>
<tr>
<td>Asthma Deaths (NRAD)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long term conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory Bowel Disease Audit</td>
</tr>
<tr>
<td>Chronic pain (National Pain Audit)</td>
</tr>
<tr>
<td>Adult asthma (British Thoracic Society)</td>
</tr>
<tr>
<td>Bronchiectasis (British Thoracic Society)</td>
</tr>
<tr>
<td>National dementia audit (NAD)</td>
</tr>
<tr>
<td>Parkinson's disease (National Parkinson's Audit)</td>
</tr>
<tr>
<td>National Adult Diabetes Audit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elective Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip, knee and ankle replacements (National Joint Registry)</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
</tr>
<tr>
<td>Coronary angioplasty (NICOR Adult cardiac interventions audit)</td>
</tr>
<tr>
<td>Peripheral vascular surgery (VSGBI Vascular Surgery Database)</td>
</tr>
<tr>
<td>Carotid interventions (Carotid Intervention Audit)</td>
</tr>
</tbody>
</table>
Cardiovascular Disease
- Acute Coronary Syndrome / Acute Myocardial Infarction (MINAP)
- Heart failure (Heart Failure Audit)
- Sentinel Stroke National Audit Programme (SSNAP)
- Cardiac arrhythmia (HRM)

Cancer
- Lung cancer (National Lung Cancer Audit)
- Bowel cancer (National Bowel Cancer Audit Programme)
- Head & neck oncology (DAHNO)
- Oesophago-gastric cancer (National O-G Cancer Audit)

Trauma
- Hip fracture (National Hip Fracture Database)
- Fractured Neck of Femur
- Severe trauma (Trauma Audit & Research Network)

Blood Transfusion
- National Comparative Audit of Blood Transfusion:
  - 2012 Audit of Blood Sample Collection and Labeling.
  - Medical use of Red Cells (part 2)

East Sussex Healthcare NHS Trust participated in all of the above national audits during 2012/2013 with the exception of the National Adult Diabetes Audit.

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust did not participate in throughout 2012/2013 are listed below:

<table>
<thead>
<tr>
<th>National Audit Title</th>
<th>Reason for non participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric Intensive Care</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>Congenital Heart Disease</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>Intra-thoracic Transplantation</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>Adult Cardiac Surgery</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>Renal replacement Therapy</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>Renal Transplantation</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>Prescribing in Mental Health Services</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>National Audit of Psychological Therapies</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>Suicide and Homicide in Mental Health</td>
<td>Not Applicable to ESHT</td>
</tr>
<tr>
<td>National Adult Diabetes Audit</td>
<td>Please see explanation below</td>
</tr>
</tbody>
</table>
National Adults Diabetes Audit - Reason for non participation by East Sussex Healthcare NHS Trust

The Trust was unable to participate in the 2012/2013 National Adult Diabetes Audit as the required specialist data collection software is unavailable for use across the organisation. The Diabetes Consultant Lead has estimated that the cost of purchasing the required software to be around £40,000 - unfortunately funding is not currently available.

NCEPOD issued 2 reports in 2012/2013:

“Bariatric Surgery: Too Lean a Service?” was issued in October 2012
East Sussex Hospitals NHS Trust does not perform weight loss surgery and therefore the recommendations of the report are not applicable to this Trust.

“Cardiac Arrest Procedures: A Time to Intervene” was issued in June 2012
The recommendations of this report are currently being reviewed. The Trust will consider whether the current Trust processes meet the standards recommended by NCEPOD and put in place a remedial action plan if necessary.

MBRRACE-UK (formally CMACE) Mothers and Babies Reducing Risk through Audits and Confidential Enquiries
The Women’s Health unit continues to report all intra or extra uterine deaths beyond 24 weeks gestation, along with any maternal death up to 1 year after giving birth.

UKOSS UK Obstetric Surveillance System
The UK Obstetric Surveillance System is a national system established to study a range of rare disorders of pregnancy, including severe ‘near-miss’ maternal morbidity. The Women’s Health unit contributes, where possible, to their studies. The studies undertaken during the period 2012/2013 include:

- Amniotic Fluid Embolism
- Aortic dissection
- Myeloproliferative disorders
- Pituitary tumours in pregnancy
- Placenta Accreta
- Pulmonary Vascular Disease
- Obstetric Cholestasis
- Non-renal Transplant recipients
- Sickle cell disease
The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, and for which data collection was completed during 2012/2013, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Title</th>
<th>Number of Cases submitted</th>
<th>% submitted of those required (where requested)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Related Liver Disease</td>
<td>3 (out of 6 required)</td>
<td>50%</td>
</tr>
<tr>
<td>Paediatric Fever</td>
<td>11 (out of the 100 required*)</td>
<td>15% (11/73)</td>
</tr>
<tr>
<td>Emergency use of Oxygen</td>
<td>All required cases submitted</td>
<td>100%</td>
</tr>
<tr>
<td>Renal Colic</td>
<td>83 (out of the 100 required)</td>
<td>83%</td>
</tr>
<tr>
<td>Fractured Neck of Femur</td>
<td>82 (out of the 100 required)</td>
<td>82%</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td>7 (out of the 20 required)</td>
<td>35%</td>
</tr>
<tr>
<td>Asthma Deaths (NRAD)</td>
<td>All required cases submitted</td>
<td>100%</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>6 (out of the 20 required)</td>
<td>30%</td>
</tr>
<tr>
<td>Paediatric Pneumonia</td>
<td>17 (out of the 20 required)</td>
<td>85%</td>
</tr>
<tr>
<td>Paediatric Asthma</td>
<td>14 (out of the 20 required)</td>
<td>70%</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>All required cases submitted</td>
<td>100%</td>
</tr>
<tr>
<td>National Dementia Audit</td>
<td>All required cases submitted</td>
<td>100%</td>
</tr>
<tr>
<td>Parkinson’s Disease Audit</td>
<td>Data unavailable from national audit body</td>
<td></td>
</tr>
<tr>
<td>Audit of Blood Sample Collection and Labeling.</td>
<td>All required cases submitted</td>
<td>100%</td>
</tr>
<tr>
<td>Medical use of Red Cells (part 2)</td>
<td>Data not yet available from national audit body</td>
<td></td>
</tr>
</tbody>
</table>

* The Trust treated 73 primary diagnoses of Paediatric Fever in Children 0 to 16 inclusive throughout 2012/2013.

The HQIP Audit Cycle
The reports of 19 national clinical audits were reviewed by the provider in 2012/2013 and East Sussex Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Background</th>
<th>Proposed local action / outcome / recommendations</th>
</tr>
</thead>
</table>
| **Epilepsy 12 Audit** | The British Paediatric Neurology Association (BPNA) proposed a national audit of childhood epilepsies in 2007 in response to the continuing concern regarding the quality of care for children and young people with epilepsies. In 2009, the Royal College of Paediatrics and Child Health (RCPCH) was funded to establish Epilepsy12 - the UK collaborative clinical audit of health care for children and young people with suspected epileptic seizures. **Aims:** To facilitate health providers to measure and improve the quality of care for children and young people with seizures and epilepsies; *and* to contribute to the continuing improvement of outcomes for those patients. | 1. Employment of an epilepsy nurse specialist.  
2. Review of the criteria for requesting EEG’s.  
3. Ensure all patients with epilepsy have an ECG.  
4. Improve documentation neurological examination, development and school performance.  
5. Remind staff of the criteria for doing MRI Brain Scans.  
6. Review of the transition arrangements and the need for a handover clinic. |
| **Severe trauma (Trauma Audit & Research Network - TARN)** | TARN - the independent monitor of trauma care in England and Wales is committed to making a real difference to the delivery of the care of those who are injured. One of the ways they do this is by promoting improvements in care through national comparative clinical audit. The Trust submits data to TARN on the treatment of injured patients, TARN then analyses the data and publishes information about survival rates after injury in patients admitted to hospital. | The Trust’s TARN Coordinator provided an overview of local results and audit criteria to healthcare professionals at a divisional Audit Meeting - there were no identified local recommendations from the most recently published national report. |
| **Bliss Baby Charter Audit** | The Bliss Baby Charter is based on the seven key principles of Human Rights and the UN rights of the child. It evolved from the Baby Charter - a document aiming to inspire staff to continually deliver the highest quality of family-centred care that they could. The audit tool will demonstrate to families, commissioners and external reviewers the commitment to provide a service that puts the baby and the family at the centre of the service. **Aims:** By participating in the self-assessment audit tool, both the Unit and Network are displaying a commitment to delivering family-centred care. By supporting families to care for their baby, it releases time for nurses to dedicate more time to clinical duties. | 1. Purchase additional screen.  
2. Developmental Care Guideline to be ratified.  
4. Cross-site visiting policy to be developed.  
5. Development of a Neonatal Outreach Service  
6. Staff to have handling difficult conversations training.  
7. Staff to have EOLC training.  
8. Update information given to parents regarding units where we transfer babies.  
9. Inform Consultants about BLISS. |
### National Audit Background

**Cardiac Arrest Procedures: Time to Intervene? (2012) – National Confidential Enquiry into Patient Outcome and Death (NCEPOD)**

Cardiopulmonary resuscitation (CPR) can be an important, life-sustaining intervention. A high proportion of in-hospital deaths now involve CPR attempts, even when the underlying condition and general health of a patient makes success unlikely. In addition, even when there is clear evidence that cardiac arrest or death are likely, decisions about the patient’s CPR status are not always documented clearly. The result is that patients may undergo futile attempts at CPR during their dying process.

**Aims:** To describe variability and identify remediable factors in the process of care of adult patients who receive CPR in hospital, including factors which may affect the decision to initiate the CPR attempt, outcome and the quality of care following CPR.

A specific recommendation on CPR status decisions was the focus of considerable post-presentation debate, with the study’s suggestion that all decisions should be referred to senior grade doctor considered by several clinicians in the audience to be unrealistic for the consistently high patient turnover of a local general hospital; and undesirable in not supporting the development of junior doctors’ decision-making skills. The presenter agreed to communicate these opinions to the study’s authors.

### Enhancing Quality 2012

The Trust has also actively participated in the Enhancing Quality (EQ) Audit programme which is an innovative clinician-led quality improvement programme across Kent, Surrey and Sussex. By clinicians analysing where to intervene for greatest quality improvement EQ aims to improve patient outcomes and reduce variation in care, every patient, every time.

EQ works across the three domains of quality: clinical effectiveness, patient safety and patient experience.

Doctors and nurses are responsible for ensuring the clinical process measures are followed and that data is collected and outcomes monitored. This helps clinicians to identify where improvements can be made in care pathways and processes.

### Enhancing Quality 2012: Pneumonia regional audit

Areas for further improvement were noted as: Smoking cessation (advice-giving / documenting), delays to diagnosis or drug initiation in A&E; overlaps or gaps in continuity of care where chest x-ray is requested; the need for robust, definitive diagnosis of pneumonia, the precise charting of antibiotics; and the relative efficacy and economic benefits of oral versus IV antibiotic prescription (unless IV routing is specifically indicated). It was also noted that antibiotic prescribing should commence as soon as a pneumonia diagnosis is posited. These areas will be addressed in future audits.

### Enhancing Quality 2012: Acute Myocardial Infarction (AMI)

Local results were presented, the importance of the following actions were noted:

- Aspirin at arrival and discharge
- Adult smoking advice (if smoked within 12 months)
- Beta Blockers prescribed at discharge
- Primary Percutaneous coronary intervention within 90 minutes of hospital arrival
- Thrombolysis to be received within 30 minutes of hospital arrival

### Enhancing Quality 2012: Heart Failure

Local results were presented, the importance of the following actions were noted:

- Adult smoking advice (if smoker within last 12 months)
- Discharge Instructions

The new Heart Failure EQ Measures were also noted for future reference:

- Comfort Measures – Liverpool Care Pathway – importance of clear documentation of comfort measures/last days of life
- Left Ventricular Systolic Dysfunction questions to be asked
<table>
<thead>
<tr>
<th>National Audit</th>
<th>Background</th>
<th>Proposed local action / outcome / recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Cancer Patient Experience Survey 2011/12</td>
<td>The 2011/12 survey fits well with the Operating Framework (OF) for the NHS 2012/2013, which defines quality as those indicators of safety, effectiveness and patient experience that indicate that standards are being maintained or improved. The OF contains requirements to monitor and act on the outcomes of patient experience surveys. The principles and objectives of the 11/12 survey and questionnaire were overseen by the Cancer Patients’ Experience Advisory Group. The group includes representatives from NHS Trusts, academics, the third sector, and clinicians from primary and secondary care.</td>
<td>There was a 70% response rate for the Trust - higher than the national average. Results were a vast improvement on last year, with 38 questions scoring higher (compared to just 9 scoring lower). Areas for improvement have been identified and are being worked on. Financial advice was raised - some doctors do not have the knowledge to pass on to patients. Macmillan have recently launched a money advice service based in Eastbourne which would offer a solution. Staff will meet monthly with the Macmillan teams to capitalise on the support offered.</td>
</tr>
<tr>
<td>National Bowel Cancer Audit (NBOCAP)</td>
<td>NBOCAP has been in existence for more than twelve years and, in that time, has seen major changes in the management of this common disease. Multi-disciplinary teams (MDT) exist in all Trusts and their decision making process is reflected in the Audit. Surgery remains the treatment of choice and hence major changes in surgical care are likely to be reflected in improvements in outcomes of patients with colorectal cancer. The increased uptake of laparoscopic surgery seen in the last three reports reflects well, not only on surgeons’ adoption of new techniques but also the central funding made available to support the national training initiative. Other initiatives within surgery are likely to be reflected in improved outcomes, length of stay, morbidity and peri-operative mortality.</td>
<td>The issue of MRI reporting in Rectal Cancer patients was discussed in some depth at a local Colorectal Multidisciplinary Team meeting; the importance of documenting the reasons for not performing MRIs was noted – this will form the basis of a prospective audit by the team in 2013. 30 day mortality was also discussed - the MDT will maintain an ongoing review of mortality figures to monitor expected versus actual rates. The high levels of Clinical Nurse Specialist (CNS) involvement indicated in the latest NBOCAP report were noted and the CNS team were congratulated on the high levels of data capture.</td>
</tr>
</tbody>
</table>
| Paediatric Fever                                  | The purpose of this national audit is to identify current Trust practice against CEM guidelines, regarding the observation of children that present to the Emergency Department using the NICE traffic light guide. Children presenting with medical conditions should have their respiratory rate, oxygen saturation, pulse, blood pressure / capillary refill, Glasgow Coma Scale / AVPU and temperature measured and recorded as part of the routine assessment. Children with fever and without an apparent source of infection but with one or more ‘red’ features on the traffic light system should have a Full Blood Count, C-reactive protein count, blood culture analysis and urinalysis performed. | 1. Measuring Vital signs – nurses don’t always document the timing of observations, this must be improved.  
2. The Traffic light system is available from NICE and can help with clinical assessment.  
3. Staff are not documenting when a patient information leaflet has been given, this again must be improved.  
4. The Trust should participate in future rounds of this audit to monitor compliance against NICE Guideline 47. |
<table>
<thead>
<tr>
<th>National Audit</th>
<th>Background</th>
<th>Proposed local action / outcome / recommendations</th>
</tr>
</thead>
</table>
| **Fractured Neck of Femur**            | The purpose of this national audit is to identify current performance in Emergency Departments against the clinical standards of the College of Emergency Medicine (CEM) Clinical Effectiveness Committee. Fractured neck of femur is associated with significant morbidity and mortality - expediting pre-operative management minimises delay-to-surgery, which is associated with improved post-operative outcomes. | 1. Analgesia to be given at triage  
2. Decision to x-ray to be made at triage  
3. Patients should be transferred directly from x-ray to ward.  
4. Improve documentation  
5. Educational notices should be placed around the wards |
| **Myocardial Ischaemia National Audit (MINAP)** | The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. It supplies participating hospitals and ambulance services with a record of their management and compares this with nationally and internationally agreed standards. MINAP provides comparative data to help clinicians and managers monitor and improve the quality and outcomes of their local services. | National vs. Local results were reviewed at a Cardiology Governance Meeting; there were no identified local recommendations from the most recently published national report. |
| **National Heart Failure Audit**       | The National Heart Failure Audit was established in 2007 to monitor the care and treatment of patients admitted to hospital in England and Wales with heart failure. The audit reports on the clinical practice and patient outcomes of acute patients discharged from hospital with a primary diagnosis of heart failure, with a view to driving up standards by encouraging the implementation of guideline recommendations and reporting on practice statistics and outcomes. | This audit has consistently shown that specialist cardiology care and follow up is associated with better outcomes for patients with heart failure even after adjusting for age, severity and other observed differences in patient characteristics.  
There were no identified local recommendations from the most recently published national report. |
<p>| <strong>National Joint Registry (NJR)</strong>      | The National Joint Registry (NJR) was set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations and to monitor the performance of joint replacement implants. The purpose of the NJR is to collect high quality and relevant data in order to provide an early warning of issues relating to patient safety – outcomes are then reported. | The Clinical Lead for Trauma and Orthopaedics provided an overview of the local results and audit criteria to healthcare professionals at a divisional Audit Meeting - there were no identified local recommendations from the most recently published national report. |</p>
<table>
<thead>
<tr>
<th>National Audit</th>
<th>Background</th>
<th>Proposed local action / outcome / recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Hip Fracture Database (NHFD)</td>
<td>The NHFD is a joint venture of the British Geriatrics Society (BGS) and the British Orthopaedic Association (BOA), and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. It allows care to be audited against the six evidence-based standards set out by BOA / BGS on the care of patients with fragility fracture; and enables local health economies to benchmark their performance in hip fracture care against national data.</td>
<td>The Clinical Lead for Trauma and Orthopaedics provided an overview of local results and audit criteria to healthcare professionals at a divisional Audit Meeting - there were no identified local recommendations from the most recently published national report.</td>
</tr>
<tr>
<td>Severe Sepsis &amp; Septic Shock</td>
<td>The management of the septic patient has been high on the agenda of emergency physicians for many years. The sepsis group at The College of Emergency Medicine was formed to look specifically at the problems of identifying these patients and giving them the best treatment. The College established the national Severe Sepsis and Septic Shock audit for Emergency Departments in 2010. It is now apparent that it is the early detection and management of sepsis that saves lives. This means that it is the timely skills of staff in the Emergency Department that are responsible for achieving the international goal of reducing death from severe sepsis and septic shock.</td>
<td>1. Evidence that first the intravenous crystalloid fluid bolus was given should be written by a doctor and countersigned by a nurse. 2. Improvements are required with regard to the serum lactate measurement being obtained prior to leaving the Emergency Department. 3. Improve documentation with regards to antibiotics being given (ideally 1 hour) – delayed results are due to poor documentation rather than poor care.</td>
</tr>
<tr>
<td>Pain in Children</td>
<td>The aim of this audit is to analyse and monitor the treatment of children between the ages of 5 and 15 arriving at emergency departments in moderate or severe pain with a fractured elbow, forearm, wrist, ankle, tibia, fibula or femur against the clinical standards of the College of Emergency Medicine (CEM) Clinical Effectiveness Committee. This is the seventh time Pain in Children has been audited since 2003 as part of a continuing focus on quality of care for patients.</td>
<td>1. Staff are reminded of the importance of concise and full data recording. 2. Staff are reminded to re-evaluate analgesia after each observation, and review patients after analgesia is given. 3. Nurses to be made aware of Nice Guidelines, particularly, those around documentation.</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit</td>
<td>The primary aim of the National Paediatric Diabetes Audit (NPDA) is to examine the quality of care in children and young people with diabetes and their outcomes in accordance with national guidelines. It also identifies differences in care and outcomes between similar NHS organisations, and helps identify good practice and for this to be shared with other paediatric diabetes units.</td>
<td>Purchase of the new Twinkle Database (a database which will ensure more efficient data collection in future rounds of the audit).</td>
</tr>
</tbody>
</table>
The reports of 83 local clinical audits were reviewed by the provider in 2012/2013. Examples of the actions East Sussex Healthcare NHS Trust intends to take to improve the quality of healthcare provided are detailed below:

<table>
<thead>
<tr>
<th>Title / Recommendations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010 Emergency Oxygen Audit: A local re-audit</strong></td>
<td></td>
</tr>
<tr>
<td>1. A dual approach to improving oxygen use at EDGH is recommended. Drug charts should be modified to facilitate easier prescription of oxygen.</td>
<td></td>
</tr>
<tr>
<td>2. A short intensive hospital-wide education campaign for both doctors and nurses is recommended emphasising why oxygen needs to be prescribed. Staff to be trained on the new drug chart, outline the role of each member of the clinical team.</td>
<td></td>
</tr>
<tr>
<td><strong>2847 - Diarrhoea &amp; Vomiting in Children &lt;5</strong></td>
<td></td>
</tr>
<tr>
<td>1. Stool samples should only be sent where there is a clear indication.</td>
<td></td>
</tr>
<tr>
<td>2. Children with no clinical dehydration should be discharged if no other clinical concerns.</td>
<td></td>
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<tr>
<td>3. Nasogastric tubes should be implemented prior to starting IV fluids.</td>
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<tr>
<td>4. If IV fluids are commenced they should be done so to correct dehydration and replace deficits.</td>
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</tr>
<tr>
<td>5. Written and verbal advice should be given to parents on discharge.</td>
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<tr>
<td>6. A well-conducted randomised controlled trial is needed to assess the cost effectiveness, safety and acceptability of rehydration - NG tube administration vs. intravenous fluid therapy.</td>
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<tr>
<td><strong>2497 - The Timing of Surgery against NICE guidelines for fracture Neck of Femur patients</strong></td>
<td></td>
</tr>
<tr>
<td>1. Dedicated planned trauma list for fracture neck of femur patients seven days a week.</td>
<td></td>
</tr>
<tr>
<td>2. Dedicated theatre session for other trauma to take place on a regular basis.</td>
<td></td>
</tr>
<tr>
<td>3. Re-audit in six months to complete the audit loop.</td>
<td></td>
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<tr>
<td><strong>2887 - Complex Needs of older people in Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Design Complex care ward which will provide specialist care for older people with an aim of delivering comprehensive geriatric assessment to every patient by a consultant in Medicine for Older People. This recommendation was implemented with the opening of a complex care ward in August 2012. The audit was instrumental in showing the need for this ward and aided the decision making on number of beds required.</td>
<td></td>
</tr>
</tbody>
</table>
Audit 3000 - Vitamin D Deficiency in Acute Stroke Patients

This local audit was published by Heather Brown (Stroke Specialist Dietician) Dr. MJH Rahmani (Consultant Lead Stroke Physician) and Dr. A Nahhas (Consultant Physician) within the December 2012 Complete Nutrition e-Newsletter - a twice monthly national e-newsletter for Complete Nutrition Magazine.

Audit aim - In February 2012 the Department of Health released a statement to raise national awareness of vitamin D deficiency in the UK. The statement also gave guidance to health professionals regarding prescribing and recommending vitamin D supplements to those groups of the population at risk of vitamin D deficiency. We know from the National Diet and Nutrition Survey that up to a quarter of people in the UK have low levels of vitamin D in their blood, which means they are at risk of the clinical consequences of vitamin D deficiency.

The Acute Stroke Team agreed to audit vitamin D levels in acute thrombotic stroke patients admitted to the acute stroke unit at the Conquest Hospital over a six-month period (June - Nov 12). Exclusion criteria included patients diagnosed with intracranial bleed or non-stroke, and patients already on vitamin D supplements prior to admission. An audit form was developed and patient information was gathered from medical notes, blood results and patient/carer reported information. Information gathered included: stroke diagnosis, past medical history, social history, serum calcium (corrected), serum phosphate, serum 25-hydroxy vitamin D, serum parathyroid hormone, and if the patient was commenced on a vitamin D supplement after identification of a low serum level.

Results - 100 patients selected at random, were included in the study. 21 patients had a vitamin D level >50 nmol/L, meaning that 79% of patients had a vitamin D level <50 nmol/L. Of the 79% of patients with a vitamin D level <50 nmol/L, 43% were female and 57% were male. Of the 79% of patients with a vitamin D level <50 nmol/L, 85% were over 65 years of age, and 15% were under 65 years of age. East Sussex has higher proportions of people over 65 years than England overall, and proportions are expected to grow faster than England overall during the period 2010-2020. The Department of Health highlighted that people over 65 years are at risk of vitamin D deficiency, therefore, the Acute Stroke Team believe it is likely that East Sussex will have a higher prevalence of vitamin D deficiency compared to other counties in England.

Discussion - This audit has lead to interesting findings in the limited area of UK vitamin D deficiency. We recognise that the audit was carried out on a small patient group and recommend that further studies take place in the UK. The aim of the audit was achieved, and the Acute Stroke Team has raised local and national awareness of vitamin D deficiency. Audit findings were presented at the Consultant Clinical Audit Meeting at the Conquest Hospital.
Research

The number of patients receiving NHS services provided or subcontracted by East Sussex Healthcare Trust 2012-13 that were recruited during that period to participate in research approved by a research ethics committee was 413. This demonstrates a continuing increase in enabling patients to participate in research activity.

Participation in clinical research demonstrates East Sussex Healthcare’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

East Sussex Healthcare NHS Trust was involved in conducting 59 clinical research studies in Oncology, Cardiovascular, Haematology, Dermatology, Diabetes and Endocrinology, Stroke, Paediatrics, Elderly care, Rheumatology and Musculoskeletal, and Primary care, during 2012/2013.

There are a further 11 studies where expression of interest has taken place, or where studies are progressing through the R&D governance check processes, which are undertaken to ensure all is in place to grant NHS permissions to undertake the study.

There were 44 members of clinical staff participating in research approved by a research ethics committee, at East Sussex Healthcare NHS Trust, during 2012/2013. These staff participated in research covering 11 medical specialties.

As well, in the year, 28 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. These were cited within PubMed, Embase, BNI and CINAHL. The specialities include Cardiovascular, Orthopaedic, Stroke, Radiology, Histopathology, Haematology, Paediatrics, Ophthalmology. It is acknowledged that papers arising from current studies have yet to progress to publication.

Our engagement with clinical research also demonstrates East Sussex Healthcare NHS Trust’s commitment to testing and offering the latest medical treatments and techniques.

It is the intention of Research and Development to continue to increase the opportunities for patients to participate in research activities and support research active clinicians and practitioners in this aim.
Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of East Sussex Healthcare NHS Trust income in 2012/2013 was conditional on achieving quality improvement and innovation goals agreed between East Sussex Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In 2012/2013 our CQUIN schemes covered

- VTE
- Patient Experience
- Dementia
- Safety Thermometer
- Enhancing Quality and Recovery programme
- High Impact Innovations
- Reducing Unscheduled Care

It was agreed with commissioners that CQUIN funding would be dis-applied based on the final block funding position.

Details of some of the work to improve quality in these areas are already outlined in this Quality Account. Further details of the agreed goals for 2012/2013 are available electronically at http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html
What others say about East Sussex Healthcare NHS Trust ...

### Care Quality Commission

East Sussex Healthcare NHS Trust is required to register with the Care Quality Commission and our current registration status is:

<table>
<thead>
<tr>
<th>Regulated Activity:</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Arthur Blackman Clinic</td>
</tr>
<tr>
<td></td>
<td>Avenue House</td>
</tr>
<tr>
<td></td>
<td>Bexhill Hospital (inc Irvine Unit)</td>
</tr>
<tr>
<td></td>
<td>Conquest Hospital</td>
</tr>
<tr>
<td></td>
<td>Crowborough Birth Centre</td>
</tr>
<tr>
<td></td>
<td>Crowborough District General Hospital</td>
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<tr>
<td></td>
<td>Eastbourne Park Primary Care Centre</td>
</tr>
<tr>
<td></td>
<td>Eastbourne District General Hospital</td>
</tr>
<tr>
<td></td>
<td>Halsham Health Centre</td>
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<tr>
<td></td>
<td>Ian Gow Memorial Health Centre</td>
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<tr>
<td></td>
<td>Lewes Victoria Hospital</td>
</tr>
<tr>
<td></td>
<td>Orchard House</td>
</tr>
<tr>
<td></td>
<td>Peacehaven Health Centre</td>
</tr>
<tr>
<td></td>
<td>Rye Memorial Hospital</td>
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<tr>
<td></td>
<td>Seaford Health Centre</td>
</tr>
<tr>
<td></td>
<td>St Anne’s House</td>
</tr>
<tr>
<td></td>
<td>Stanton Plaza Health Centre</td>
</tr>
<tr>
<td></td>
<td>Sturton Place Dental Clinic</td>
</tr>
<tr>
<td></td>
<td>Uckfield Community Hospital</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
</tr>
<tr>
<td>Diagnostic &amp; screening procedures</td>
<td></td>
</tr>
<tr>
<td>Maternity &amp; midwifery services</td>
<td></td>
</tr>
<tr>
<td>Termination of pregnancies</td>
<td></td>
</tr>
<tr>
<td>Family Planning Services</td>
<td></td>
</tr>
<tr>
<td>Assessment / medical treatment of persons detained under the Mental Health Act</td>
<td>Arthur Blackman Clinic, Avenue House, Bexhill Hospital (inc Irvine Unit), Conquest Hospital, Crowborough Birth Centre, Crowborough District General Hospital, Eastbourne Park Primary Care Centre, Eastbourne District General Hospital, Halsham Health Centre, Ian Gow Memorial Health Centre, Lewes Victoria Hospital, Orchard House, Peacehaven Health Centre, Rye Memorial Hospital, Seaford Health Centre, St Anne’s House, Stanton Plaza Health Centre, Sturton Place Dental Clinic, Uckfield Community Hospital</td>
</tr>
<tr>
<td>Management of supply of blood and blood derived products</td>
<td>Arthur Blackman Clinic, Avenue House, Bexhill Hospital (inc Irvine Unit), Conquest Hospital, Crowborough Birth Centre, Crowborough District General Hospital, Eastbourne Park Primary Care Centre, Eastbourne District General Hospital, Halsham Health Centre, Ian Gow Memorial Health Centre, Lewes Victoria Hospital, Orchard House, Peacehaven Health Centre, Rye Memorial Hospital, Seaford Health Centre, Stanton Plaza Health Centre, Sturton Place Dental Clinic, Uckfield Community Hospital</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Arthur Blackman Clinic, Avenue House, Bexhill Hospital (inc Irvine Unit), Conquest Hospital, Crowborough Birth Centre, Crowborough District General Hospital, Eastbourne Park Primary Care Centre, Eastbourne District General Hospital, Halsham Health Centre, Ian Gow Memorial Health Centre, Lewes Victoria Hospital, Orchard House, Peacehaven Health Centre, Rye Memorial Hospital, Seaford Health Centre, Stanton Plaza Health Centre, Sturton Place Dental Clinic, Uckfield Community Hospital</td>
</tr>
</tbody>
</table>
Following unannounced inspections at both Eastbourne DGH and the Conquest Hospital in January 2013 they found both sites had continued to make substantial improvements where previously areas of non-compliance had been identified. Both sites were found to be fully compliant with all the outcomes assessed.

The CQC have made several unannounced visits to various sites across the Trust during 2012/2013 and found the majority to be fully compliant with the essential standards of quality and safety.

Full copies of all the reports can be accessed at http://www.cqc.org.uk/directory/RXC.

East Sussex Healthcare NHS Trust has not participated in any special reviews or investigations by the CQC, and they have not taken enforcement action against the Trust during 2012/2013.

Staff Survey 2012

The NHS Staff Survey has been completed by NHS organisations annually since 2003; its purpose is to collect staff views about working in their local NHS Trust. The CQC uses the staff survey to provide information on national performance measures and as part of the ongoing monitoring of registration compliance.

For the Trust, the survey helps to assess the effectiveness and application of policies and strategies on for example, training, flexible working policies, and safety at work, and helps to inform future developments in these areas. The survey also monitors performance against the four staff pledges of the NHS Constitution: these pledges clarify what the NHS expects from its staff and what staff can expect from the NHS as an employer.

The survey was conducted during the autumn of 2012; the results were published in February 2013, and an analysis of them has now been undertaken. Individual Divisional reports have been shared so that Divisional Leads can take forward actions specific to their Divisions and Clinical Units. 415 staff at East Sussex Healthcare NHS Trust took part in this survey.
This is a response rate of 51% which is average for acute trusts in England, and compares with a response rate of 53% for the Trust in the 2011 survey. At the time of sampling, 6679 staff were eligible to receive the survey. Questionnaires were sent to a random sample of 815 staff. This includes only staff employed directly by the Trust (i.e. excluding staff working for external contractors and bank staff unless they are employed directly elsewhere in the Trust).

*There are two ways of scoring responses to questions:*
1. % scores which indicate the percentage of staff giving a particular response to a question or a series of questions.
2. Scale summary scores which convert staff responses to questions into scores, with the minimum being 1 and the maximum being 5.

**The tables below summarise the Trust’s top and bottom ranking scores:**

<table>
<thead>
<tr>
<th>Top 5 Ranking Scores</th>
<th>ESHT 2012</th>
<th>Average Acute Trusts 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF14 - Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>KF17 - Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>KF13 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>31%</td>
<td>34%</td>
</tr>
<tr>
<td>KF19 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>23%</td>
<td>24%</td>
</tr>
<tr>
<td>KF16 - Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>14%</td>
<td>15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bottom 5 Ranking Scores</th>
<th>ESHT 2012</th>
<th>Average Acute Trusts 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF15 - Fairness and effectiveness of incident reporting procedures</td>
<td>3.35</td>
<td>3.5</td>
</tr>
<tr>
<td>KF6 - Percentage of staff receiving job-relevant training, learning or development in last 12 months</td>
<td>76%</td>
<td>81%</td>
</tr>
<tr>
<td>KF23 - Staff job satisfaction</td>
<td>3.49</td>
<td>3.58</td>
</tr>
<tr>
<td>KF9 - Support from immediate managers</td>
<td>3.51</td>
<td>3.61</td>
</tr>
<tr>
<td>KF4 - Effective team working</td>
<td>3.64</td>
<td>3.72</td>
</tr>
</tbody>
</table>
The five key findings where staff experiences have improved at East Sussex Healthcare NHS Trust since the 2011 survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>ESHT 2012</th>
<th>ESHT 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF23 - Staff job satisfaction</td>
<td>3.49</td>
<td>3.38</td>
</tr>
<tr>
<td>KF7 - Percentage of staff appraised in last 12 months</td>
<td>79%</td>
<td>72%</td>
</tr>
<tr>
<td>KF24 - Staff recommendation of the trust as a place to work or receive treatment</td>
<td>3.41</td>
<td>3.21</td>
</tr>
<tr>
<td>KF15 - Fairness and effectiveness of incident reporting procedures</td>
<td>3.35</td>
<td>3.28</td>
</tr>
<tr>
<td>KF26 - Percentage of staff having equality and diversity training in last 12 months</td>
<td>51%</td>
<td>41%</td>
</tr>
</tbody>
</table>

The two key findings where staff experiences have deteriorated at East Sussex Healthcare NHS Trust since the 2011 survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>ESHT 2012</th>
<th>ESHT 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF10 - Percentage of staff receiving health and safety training in last 12 months</td>
<td>70%</td>
<td>84%</td>
</tr>
<tr>
<td>KF12 - Percentage of staff saying hand washing materials are always available</td>
<td>53%</td>
<td>65%</td>
</tr>
</tbody>
</table>

This following section presents each of the 28 Key Findings, using data from the Trust's 2012 survey, and compares these to other acute Trusts in England and to the Trust's performance in the 2011 survey. The findings are arranged under six headings – the four staff pledges from the NHS Constitution, and the two additional themes of staff satisfaction and equality and diversity. Positive findings are indicated with a green arrow (e.g. where the 2012 Trust score has improved since 2011), negative findings are highlighted with a red arrow (e.g. where the 2012 Trust score has deteriorated since 2011) - where comparisons are possible.
<table>
<thead>
<tr>
<th>Key Finding</th>
<th>ESHT 2012 (▲/▼ against ESHT 2011 score)</th>
<th>ESHT 2011</th>
<th>Average Acute Trust 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Pledge 2 – To provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF6 - % of staff receiving job-relevant training or development in the last 12 months</td>
<td>76% ▼</td>
<td>-</td>
<td>81%</td>
</tr>
<tr>
<td>KF7 - % of staff appraised in last 12 months</td>
<td>79% ▲</td>
<td>72%</td>
<td>84%</td>
</tr>
<tr>
<td>KF8 - % of staff having well structured appraisals in the last 12 months</td>
<td>32% ▲</td>
<td>28%</td>
<td>36%</td>
</tr>
<tr>
<td>KF9 – Support from immediate managers</td>
<td>3.51 ▼</td>
<td>3.58</td>
<td>3.61</td>
</tr>
<tr>
<td><strong>Staff Pledge 3 – To provide support and opportunities for staff to maintain their health, well-being, and safety.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF10 - % of staff receiving health and safety training in the last 12 months</td>
<td>70% ▼</td>
<td>84%</td>
<td>74%</td>
</tr>
<tr>
<td>KF11 - % of staff suffering work related stress in the last 12 months</td>
<td>36% ▼</td>
<td>32%</td>
<td>37%</td>
</tr>
<tr>
<td>KF12 - % of staff saying hand washing materials are always available</td>
<td>53% ▼</td>
<td>65%</td>
<td>60%</td>
</tr>
<tr>
<td>KF13 - % of staff witnessing potentially harmful errors, near misses or incidents in the last month</td>
<td>31% ▲</td>
<td>32%</td>
<td>34%</td>
</tr>
<tr>
<td>KF14 - % of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>94% ▲</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>KF15 – Fairness and effectiveness of incident reporting</td>
<td>3.35 ▲</td>
<td>3.28</td>
<td>3.50</td>
</tr>
<tr>
<td>KF16 - % of staff experiencing physical violence from patients, relatives or the public in the last 12 months</td>
<td>14% ▼</td>
<td>-</td>
<td>15%</td>
</tr>
<tr>
<td>KF17 - % of staff experiencing physical violence from staff in the last 12 months</td>
<td>2% ▼</td>
<td>-</td>
<td>3%</td>
</tr>
<tr>
<td>KF18 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>32% ▼</td>
<td>-</td>
<td>30%</td>
</tr>
<tr>
<td>KF19 - % of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>23% ▼</td>
<td>-</td>
<td>24%</td>
</tr>
<tr>
<td>KF20 - % of staff feeling pressure in the last 3 months to attend work when feeling unwell</td>
<td>29% ▼</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Staff Pledge 4 – To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF21 - % of staff reporting good communication between senior management and staff.</td>
<td>21% ▼</td>
<td>-</td>
<td>27%</td>
</tr>
<tr>
<td>KF22 - % of staff able to contribute to improvements at work.</td>
<td>63% ▲</td>
<td>56%</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Additional Theme – Staff satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF23 – Staff job satisfaction</td>
<td>3.49 ▲</td>
<td>3.38</td>
<td>3.58</td>
</tr>
<tr>
<td>KF24 – Staff recommendation of the Trust as a place to work or receive treatment</td>
<td>3.41 ▲</td>
<td>3.21</td>
<td>3.57</td>
</tr>
<tr>
<td>KF25 – Staff motivation at work</td>
<td>3.77 ▲</td>
<td>3.68</td>
<td>3.84</td>
</tr>
</tbody>
</table>
Key Finding | ESHT 2012 (▲/▼ against ESHT 2011 score) | ESHT 2011 | Average Acute Trust 2012
---|---|---|---
**Additional Theme – Equality and Diversity**
KF26 - % of staff having equality and diversity training in last 12 months | 51% ▲ | 41% | 55%
KF27 - % of staff believing the Trust provides equal opportunities for career progression or promotion | 89% ▲ | 84% | 88%
KF28 - % of staff experiencing discrimination at work in the last 12 months | 11% ▲ | 15% | 11%

Staff Survey Comments from our Chief Executive

“It is extremely pleasing to note that there are a number of areas where the Trust has made improvements since last year. These include the % of staff who would recommend the Trust as a place to work or receive treatment, the number of staff who have had an appraisal in the last 12 months, job satisfaction amongst staff and a reduction in staff working extra hours. In addition, our results for the number of staff reporting errors, near misses or incidents in the last month and experiencing physical violence from staff in the last 12 months put us in the top 20% of Trusts nationally.

As you would expect, alongside the positives there are areas where we need to make improvements. These include support from immediate managers, effective team working, staff receiving job relevant training, learning or development in the last 12 months and fairness and effectiveness of incident reporting procedures. Of particular concern is the reduction in the number of staff who say that hand washing materials are always available (down from 65% in 2011 to 53%) and the number of staff receiving health and safety training in the last 12 months (down from 84% to 70%). As always, the Trust’s scores have been compared with those of other Trusts nationally, and in this respect there is further work to do. However, we are still being compared with other acute Trusts when as an integrated acute and community Trust, a third of our staff do not deliver acute services. This is not particularly helpful and is an issue we have raised with the CQC. This aside, we know there are a number of areas where we still need to make improvements, and work to identify the areas we need to focus on is now underway. We will be working with managers throughout the organisation to ensure that the improvements we identify are then implemented.

However, I do not want to lose sight of the fact that this year’s results show improvements in some key areas and I think this is further evidence of the progress we are making as an organisation. As I have said before, the changes we needed to make could not happen overnight, and this year’s staff survey results give me confidence that, as an organisation, we are moving in the right direction.”
East Sussex Healthcare NHS Trust will be taking the following action to maintain and improve data quality:

- Implementation of any recommendations following an external review of the department
- Participation in both internal & external audits of clinical coding quality
- A re-audit of completeness of NHS Numbers to ensure continued progress
- Validate correct attribution on the Patient Administration System of GP Practice through the national register (SPINE)
- Launch the updated Data Quality Policy with clearly defined responsibilities and ownership for the delivery of Data Quality
- Ensure those working in Data Quality are appropriately trained
- Participate in the validation of data held on systems against the data documented in the health records
- Greater liaison with the Clinical Units
- Provide regular Data Quality reports with proposed action plans for improvement
- Introduce processes for data validation within the Divisions prior to data being submitted externally, this will ensure that data accurately reflects practice

**NHS Number and General Medical Practice Code Validity**

East Sussex Healthcare NHS Trust submitted records during April 2012 – March 2013 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- **Which included the patient’s valid NHS number was:**
  99.6% for admitted patient care;
  99.7% for out patient care; and
  97.9% for accident and emergency care.

- **Which included the patient’s valid General Medical Practice Code was:**
  100% for admitted patient care;
  100% for out patient care; and
  100% for accident and emergency care.
Information Governance Toolkit attainment levels

As a key part of the Information Governance agenda, the Department of Health and the NHS Connecting for Health (CfH) jointly produced an Information Governance Toolkit. This web-based tool was launched in late 2003, and represents DH policy on issues relating to safe and effective information governance.

The Toolkit has been made available to assist organisations to achieve the aims of Information Governance, and currently encompasses:

- Information Governance Management
- The Confidentiality NHS Code of Practice
- Data Protection Act 1998
- Information Security
- Information Quality
- Records Management
- Freedom of Information Act 2000

East Sussex Healthcare NHS Trust’s Information Governance Assessment Report score overall score for 2012/2013 was 69% and was graded ‘green’ or ‘satisfactory’.

Clinical coding error rate

East Sussex Healthcare NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect 5.75%
- Secondary Diagnoses Incorrect 0.9%
- Primary Procedures Incorrect 5.25%

Note: This is the overall error rate percentage based on the PbR audit of Inpatient Orthopaedic and Inpatient Stroke patients combined, but does not include the Outpatient Dermatology element of the PbR audit (procedure codes only)
Part 3

1. Review of quality performance in 2012/2013
2. Statements from our key stakeholders

This section of the report details our progress in delivering our improvement areas identified in last year’s Quality Account, and our quality performance throughout 2012/2013.

Key to Quality Improvement Priority Achievements:

- Goal achieved
- Goal not fully achieved but improvements made
- Improvements not demonstrated

In last year’s Quality Account seven areas for improvement were identified:

<table>
<thead>
<tr>
<th>Patient Safety</th>
</tr>
</thead>
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<tr>
<td>Patients are safe and free from harm:</td>
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1. **Essence of Care (Falls and resulting harm / Pressure Ulcers)**

- Reducing the number of patient falls by at least 10% and ensuring that a minimum of 95% of adult inpatients have a falls risk assessment completed upon admission.

- Evidencing a reduction in the number of inpatient hospital acquired pressure ulcers of grade 3 and 4 by 25%.

2. **Consent and Mental Capacity**

- Ensuring that as a minimum, 95% of patients admitted to hospital have evidence that their mental capacity was reviewed during the admission process, and where indicated, the appropriate care plan for adults lacking capacity would be implemented to ensure the delivery of appropriate personalised care to the patient.
Clinical Effectiveness

Caring for vulnerable patients:

1. **End of Life Care**
   - Continue to improve the quality of end of life care for patients by ensuring that 80% of patients who have an expected death in 2012/2013 are placed on the Liverpool Care Pathway (as appropriate).
   - Evidencing a 10% reduction in the number of complaints received relating to End of Life Care.

2. **Dementia and Delirium Care**
   - Ensuring that 90% of patients aged 75+ have a dementia screening assessment and dementia risk assessment.
   - Ensuring that 90% of patients identified as at risk of having dementia have a referral to an appropriate specialist diagnosis.

3. **Stroke Care**
   - Ensuring that the care delivered for stroke patients follows best practice guidance. We will strive to ensure compliance with NICE quality statements, in line with the NICE Quality Standard for Stroke Care...
   - 100% of stroke patients are swallowing screened by a trained nurse/Health Care Assistant within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and that they have an ongoing management plan for the provision of adequate nutrition.
   - 100% of stroke patients are assessed and managed by stroke nursing staff and a referral is made to least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.
   - We will aim two to ensure that 100% of stroke patients are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week at a level that enables the patient to meet their rehab goals.
Patient Experience

Providing personalised, dignified, respectful and compassionate care:

1. **Patient Centred Care Planning**
   
   Ensuring that 90% of patient centred care plans are responsive to individual patient preferences, needs and values.

2. **Patient Engagement**

   Ensuring that patients are fully engaged in their care and understand the reasons why a particular treatment or course of action is being proposed. Specifically that at least 95% of the patients surveyed attending an outpatient consultation throughout 2012/2013 leave the clinic feeling fully informed, and understand reasons for suggested courses of action or treatment.
3.1 Patient Safety

Patients are safe and free from harm:

1. **Essence of Care** (Falls and resulting harm / Pressure Ulcers)

   - Reducing the number of patient falls by at least 10% and ensuring that a minimum of 95% of adult inpatients have a falls risk assessment completed upon admission.

   - Evidencing a reduction in the number of inpatient hospital acquired pressure ulcers of grade 3 and 4 by 25%.

☑ Falls and resulting harm

A patient fall with injury may be defined as:

> *An unplanned / unintentional descent to the floor, with injury, regardless of cause (slip, trip, fall from a bed/chair or other, whether assisted or unassisted fall). Patients ‘found on the floor’ should be assumed as a fall unless confirmed as intentional acts*.

Why we chose this priority...

The NHS National Patient Safety Agency (NPSA) has identified that there were 257,679 falls reported nationally in the year ending March 2009 and estimate that about 1,000 patient falls a year result in a fracture(s). A significant number of falls result in death or severe / moderate injury, at an estimated cost of £15m per annum for immediate healthcare treatment alone. One UK study has estimated that the cost associated with a patient fall that had resulted in a fractured neck of femur to be £11,452, with an extra cost per day of £234 for geriatric and rehabilitation care, and additional orthopaedic and theatre costs of £584 per day. This equates to around £92,000 per year per NHS Trust.

Reducing patient falls and any resulting harm was a high priority for East Sussex Healthcare NHS Trust in 2012/2013 and will continue to be a focus throughout 2013/2014 as a Commissioning for Quality and Innovation (CQUIN) target through the Patient Safety Thermometer.

What we were aiming to achieve in 2012/2013:

Our goal was to reduce the number of patient falls by at least 10% across the Trust (against baseline data from 2011/2012), and, to evidence that 95% of adult inpatients (as a minimum) undergo a falls risk assessment upon admission.
2012/2013 Results:
The Trust merged with Community Services in April 2011 but did not use our software system “Datix” for incident reporting until October 2011; therefore between April and September 2011, the statistics for falls is unavailable on Datix for analysis and comparison.

Communication has taken place throughout the year to increase the awareness of the requirement to report falls on our datix system. This has led to an increase in the number of falls reported and is a contributory factor in the Trust not fully meeting the target set during 2012/2013 (a 10% reduction in the total number of falls). We will continue with our work on falls avoidance as outlined in this section.

We are able to demonstrate that we have achieved the second part of this quality improvement priority - 96%* of our 2012/2013 adult inpatients underwent a falls risk assessment upon admission (our target was to achieve 95%).

*96% is a rolling average of a 76% admission rate sample size and calculated from our weekly audit results, 6 patients selected at random per ward / area are audited per week.

Total number of falls recorded on datix during 2011/2012 and 2012/2013
Improvements delivered in 2012/2013:

- A falls action plan has been developed and agreed by both the Trust’s Patient Safety and Clinical Improvements Group and the PCT’s Clinical Quality Review Group. The plan includes a focus on identifying whether or specific groups of patients are more at risk of falls and outlines future work that will be undertaken with dementia patients and those whom may require special observations.

- A Falls Action Group is being set up to build on the existing engagement of medical, therapy and nursing staff and look at the impact of falls across both the community and the acute area. Part of the group’s work will be to review any falls that result in harm ensuring lessons are learnt and actions are taken that can be shown to result in improvements in care.

- All falls are now recorded on a web-based system called DatixWeb, allowing for more dynamic reporting and informing rapid action.

- Trust policy is for falls risk assessments to be undertaken on all patients. Weekly ward-level audits of documentation take place across the Trust - these audits include measuring the completion of falls risk assessments for all patients. Performance against this key indicator is discussed with the ward matron at monthly ward performance reviews.

- Significant progress has been made in the education, training and clinical support of staff who deliver care, including the development of an e-learning training package. The Trust has an organisational plan in place to support the delivery of both improved clinical documentation as well as educational programmes. Workshops have been set up across the Trust to include both community and acute staff.

- Weekly ward-level audits of documentation take place across the Trust - these audits include measuring the completion of falls risk assessments for all patients.

Continuous improvement and planned monitoring in the 2013-2014:

- Pilot the use of a system of colour coding mobility aids, such as walking frames and crutches
- Development of a Falls Prevention Team.
- Ensure compliance with NICE Clinical Guideline 21 (Falls: The Assessment and Prevention of Falls in Older People).
- Complete a systematic review of all falls which result in moderate or major harm.
Pressure Ulcers

Pressure ulcers develop when a large amount of pressure is applied to an area of skin over a short period of time. Or, they can occur when less force is applied but over a longer period of time.

Why we chose this priority...

Our staff work with some of the most vulnerable people in the community who often have complex health and social care needs. Care is delivered in both acute and community settings (including within a patient’s home and within the Community Hospitals). The development of a pressure ulcer can have a physical, social and financial impact on a patient’s life, the resulting consequence for our services can also be considerable in terms of the time and the resources required to facilitate healing.

Despite considerable efforts to raise awareness of pressure ulcer management and avoidance, a number of pressure ulcers are still reported each quarter, therefore like falls, reducing pressure ulcers will remain a key focus for the Trust in the year ahead as part of Patient Safety Thermometer improvement priority.

What we were aiming to achieve in 2012/2013:

Our goal was to reduce the number of inpatient hospital acquired pressure ulcers of grade 3 and 4 by 25% (against baseline data from 2011/2012).

2012/2013 Results:

Merger with Community Services took place in April 2011 but the Trust did not use Datix for incident reporting until October 2011; therefore between April and September 2011, Pressure Ulcer statistics are unavailable on Datix for analysis and comparison.

Across the organisation the Trust has raised awareness of reporting requirements for pressure ulcers and we believe the subsequent increased reporting is a significant contributory factor in the Trust not fully meeting the target set during 2012/2013 (a 25% reduction in the total number of inpatient hospital acquired pressure ulcers of grade 3 and 4).
Total number of Grade 3 – 4 Pressure Ulcers recorded on Datix during 2011/2012 and 2012/2013

<table>
<thead>
<tr>
<th>Month</th>
<th>2011 – 2012</th>
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<tr>
<td>April</td>
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**Improvements delivered in 2012/2013:**

- A training package is being delivered across the organisation with a current focus on the grading of pressure ulcers.
- An integrated policy between the community and acute areas has been agreed on pressure ulcer management.
- East Sussex Healthcare is part of the new Sussex wide Tissue Viability Network. One of the main aims of this group is to ensure that all providers within the region are reporting uniformly and consistently, but also measures the differences in organisations i.e. the Trust has both an acute and community arm, which means there is not a comparator organisation within Sussex.
- The clinical areas collect pressure ulcer data locally and the clinical matrons are measured on this indicator through the ward performance reviews which occur monthly. At this point they discuss the issues and the impact on the patients, along with necessary actions.
- All grade 3 and 4 pressure ulcers are reported as Serious Incidents and also have a Safeguarding Adult Alert raised. As part of this the organisation then reviews through the Serious Incident process the subsequent Root Cause Analysis and actions.
- The Trust has developed a generic action plan for pressure ulcers; this has been agreed by both the Trust’s Patient Safety and Clinical Improvements Group (PSCIG) and the PCT’s Clinical Quality Review Group.
Monitored use of the pressure ulcer risk assessment tool every month with data reported to PSCIG and the Nursing and Midwifery Quality reviews.
Provision of core care plans for Pressure Ulcer prevention and a revised Pressure Ulcer Prevention and Treatment Policy.

**Continuous improvement and planned monitoring in the 2013-2014:**
- Monitor Trust compliance with using the new Pressure Ulcer risk assessment tool.
- Education of staff with regards to the new policy.
- Continue to improve the robustness and organisational transparency of the investigation of all grade 3 & 4 Pressure Ulcers.
- Continue to report trend data to the Trust’s monthly PSCIG.
- Continue to verify data of all grade 3 & 4 ulcers by the Tissue Viability Team.
- Undertake a bed and mattress audit and formal replacement programme.
- Deliver care compassionately and consistently.
- Rapid programme of change driven by clinicians – supported by the executive.
Consent and Mental Capacity

Consent is the principle that a person must give their permission before they receive any type of medical treatment. It is required from a patient regardless of the type of treatment being undertaken, from a blood test to an organ donation.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. One main exception is if a person does not have the mental capacity (the ability to understand and use information) to make a decision about their treatment. In this case, the healthcare professionals can go ahead and give treatment if they believe that it is in the person’s best interests.

The Mental Capacity Act (MCA) is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. This could be due to a mental health condition, a severe learning difficulty, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident.

Why we chose this priority
The Trust included Consent and Mental Capacity as a 2012/2013 priority in order to establish adherence to the principle of best practice and best interest, ensuring that all clinical decisions made are patient centred and within the legal framework of the Mental Capacity Act.
What we were aiming to achieve in 2012/2013:
Our goal was to ensure that as a minimum, 95% of patients admitted to hospital have evidence that their mental capacity was reviewed during the admission process, and where indicated, the appropriate care plan for adults lacking capacity would be implemented to ensure the delivery of appropriate personalised care to the patient.

What we did:
The Trust has, through a number of methods, undertaken an education and performance monitoring programme to ensure all staff in responsible for the care of patients are aware of the requirements to consider and where necessary fully assess an individual's mental capacity in terms of seeking consent for care, treatment and procedures.

2012/2013 Results:
Each inpatient ward completes a weekly measurement of quality performance indicators on 6 patient records. One indicator that is monitored is evidence of mental capacity, and associated factors being considered and recorded. This is measured through the completion of a specific section within the integrated patient document. The monitoring process is supported by 'real time' intervention and resolution of any issues identified and monthly review by the senior nursing team.

The monitoring tool was amended to incorporate the collection of this data in April 2012 and over a period of time was rolled out to all areas. All areas were using the monitoring tool in the second quarter of the year and the table below shows the performance of the organisation (from April 2012 to 21st March 2013) in relation to the consideration of mental capacity during the admission / assessment period.
The monitoring process should have captured information for 13,092 patients. Due to the evolving nature of the reporting systems this has been difficult to achieve and information is only available for 53% of the anticipated patients i.e. 7,000. Of those 7,000 patients it was demonstrated that 93% had their mental capacity considered at the time of admission/assessment.

Conclusions:

Within the limits of the data provided there is evidence of a progressive improvement in this target which was reported at under 10% in April 2012, and 65% in September 2012.

The data does not provide complete assurance nor have we met the target that was established at the beginning of the year. There has however been significant progress and this does provide confidence, along with ongoing education that mental capacity has a much stronger profile within the assessment of patients and delivery of care.

Improvements delivered in 2012/2013:

There are a number of initiatives that will continue to support the care of those who lack capacity both at a national and local level, including:

1. An ongoing and developing education programme within the Trust.
2. Initiatives regarding the care of those living with dementia, learning disabilities and other conditions that may affect mental capacity.
3. Scrutiny of concerns and issues both within the organisation and externally through mechanism such as Safeguarding alerts, Consent and Clinical Ethics Committee and Serious Incident investigation.

A Patient’s Story…

Often we use figures as a method of demonstrating performance. Probably what is more valuable is identifying how care is affected by education and development of staff. To that end the following patient story provides evidence of best practice.

Mr X is a twenty seven year old man with a severe learning disability who can present with significant challenging behaviour in the form of self injurious behaviour and physical aggression to others (biting, kicking, punching). Due to the degree of his learning disability and associated behaviours Mr X had not been able to participate in dental examination for several years and his father was becoming increasingly worried about his dental health.
Approximately seven years previously (and before the advent of the MCA) an attempt had been made to anaesthetise Mr X at another hospital. There had been no prior exploration of need related to his learning disability, no planning meeting and subsequently no provision for reasonable adjustments to be made. This resulted, according to Mr X’s Father, in seven staff members ‘holding’ Mr X down in order that he was anaesthetised. This is reported to have been very traumatic for both Mr X and his father.

The community learning disability nurse attempted to support Mr X to understand the concept of dental examination / treatment, via the use of various accessible information systems but following a mental capacity assessment it was evident that he did not have the capacity to consent to any form of dental intervention. As such a best interest meeting was convened to include the following individuals:

- Mr X’s Father
- Anaesthetist
- Specialist Dentist
- Dental Nurses
- Operating Department Practitioner
- Community Learning Disability Nurse
- Hospital Acute Liaison Nurse Learning Disabilities

The discussion included the other examinations that Mr X was required to have - including obtaining bloods and an examination of his foot due to a possible bone deformity as a result of self injurious behaviour. The meeting addressed Mr X’s needs and it was agreed by all that he would be admitted as a day surgery patient in order that dental exam and treatment, taking of bloods and an examination of his foot could occur. Referrals were made to the relevant professionals with a request for all interventions to be conducted under the same General Anaesthetic.

It was clear that this was going to be a difficult time for Mr X and discussions identified the specific issues which were likely to make the situation even more problematic for him (triggers to challenging behaviour, identification of early warning signs to challenging behaviour and intervention which could reduce likelihood of their occurrence).

A risk assessment was undertaken and due to the potential extent of risk of injury to staff members it was necessary to purchase bite resistant protective arm sleeves. Staff members had previously received training in the safe use of physical intervention should it be required as a last resort.
The risk assessment identified the triggers to, and early warning signs for, the challenging behaviour and informed the formulation of the subsequent care plan and identification of required reasonable adjustments as follows:

- Mr X would be a single patient list.
- Mr X’s father would drive Mr X to the ambulance bay outside A&E as it was the closest entry to day surgery. A&E were advised and agreed.
- Noise had to be kept to a minimum as it could be a trigger to challenging behaviour. Discussion occurred with the construction crew who agreed to ‘down tools’ for 15-20 minutes to allow Mr X the opportunity to access the Day Surgery Unit (DSU).
- The DSU was cleared of personnel not relevant to procedure as unfamiliar people can trigger challenging behaviour.
- Sedation was taken in Mr X’s favourite cup, which we had obtained from his father, to the car and Mr X drank his favourite drink containing the sedation.
- Contingency plans had been devised in the event that the sedation was not sufficient.
- Mr X was supported into the DSU with his father – sedation had been adequate and no increase was necessary.
- Father accompanied Mr X into the anaesthetic room and remained with him whilst inducted.
- Mr X was supported to be anaesthetised without issue.

All relevant procedures were undertaken by each specialist under the same General Anaesthetic. Mr. X’s father was visually present for Mr X as soon as he was safely recovered. No injury was sustained by any staff member and Mr X did not attempt to hurt himself. Mr X was discharged home when safe and suffered no adverse effect from the day or procedures. Mr X’s father advised that the comparison between the approaches undertaken previously and on this occasion were polar opposites and he was very relieved that his son had received the necessary interventions.

Without this degree of multi-disciplinary involvement and planning, and without the subsequent reasonable adjustments being made it is extremely unlikely that any treatment intervention would have been possible.
### 3.2 Clinical Effectiveness

#### Caring for vulnerable patients:

<table>
<thead>
<tr>
<th>1. <strong>End of Life Care</strong></th>
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<tr>
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**End of Life Care**

End of Life Care (EOLC) refers to the care delivered to patients approaching death or in the final year of their lives. It is the responsibility of all healthcare organisations and clinicians to ensure that they have the skills, knowledge and resources to provide high quality EOLC. EOLC has become increasingly important nationally in the face of an aging population and locally, where we have a larger than average elderly population. It is anticipated that patients will be less able to rely on family support to remain at home and more patients in the future will rely on the health care system for their EOLC.

Good EOLC should enable the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. High quality EOLC implies that patients reaching the end of their lives have the right to be:

◆ Treated as an individual, with dignity and respect;
◆ In familiar surroundings and in the company of close family and/or friends;
◆ Without pain and other symptoms.

The Liverpool Care Pathway (LCP) is a major initiative to improve the care of the dying within healthcare. It aims to improve the knowledge related to the process of dying and improve the quality of care in the last hours or days of life. It is a means to transfer the best quality care for the dying from the hospice movement into other clinical areas, so that wherever the person is dying there can be an equitable model of care. It is recommended as a best practice model by the Department of Health. The LCP has been rolled out across all clinical areas within East Sussex Healthcare Trust.
Why we chose this priority...
Ensuring the delivery of high quality palliative care for all patients reaching the end of their life is of particular relevance to the Trust when our growing elderly population is considered - East Sussex has the highest percentage of very elderly residents of any county in England (those aged over 85).

The Trust is committed to ensuring that any queries or concerns raised by patients or their representatives are addressed as quickly as possible. Unfortunately, a high number of complaints were received across the organisation in 2011/2012 in relation to bereavement experiences and this is something the Trust aims to reduce.

What we were aiming to achieve in 2012/2013:

❖ Continue to improve the quality of end of life care for patients by ensuring that 80% of patients who have an expected death in 2012/2013 are placed on the Liverpool Care Pathway (as appropriate).
❖ Evidencing a 10% reduction in the number of complaints received relating to End of Life Care.

2012/2013 Results:
Based on the current figures available, approximately 50% of patients who had an expected death during 2012/2013 where placed on the Liverpool Care Pathway. This has been a particularly challenging target as adverse news reporting during the late summer and autumn resulted in many patients and families not wishing to use the Liverpool Care Pathway. A programme of education is being put in place to help advise patients on the benefits of the pathway.

A national review of the Liverpool Care Pathway was launched in January 2013. This will be led by Baroness Julia Neuberger.

The review will examine various elements of the LCP, including:

- the experience and opinions of patients and families
- the experience and opinions of health professionals
- hospital complaints
- local payments made to hospitals in respect of the LCP
- the literature about benefits and limitations of the Liverpool Care Pathway.

Following this work, the review will make recommendations about what, if any, changes are needed to improve care, to ensure that patients are always treated with dignity and that, wherever possible, they are involved in decisions about their care, and that carers and families are always involved in the decision-making process.

It is anticipated that the review will report to ministers and to the NHS Commissioning Board in the summer.

Whilst work continues within the Trust to ensure that all end of life care patients are given the appropriate care.
One of the Quality Account indicators for 2012/2013 related to the number of complaints concerning end of life care. The trust had set a target reduction of 10%.

The overall figure for 2012/2013 was 62 which was the same total as for the previous year and therefore this target was not met.

The increased profile of End of Life care within the national press has contributed to the ability to meet the target however further sustained effort is required to improve the processes and experiences of patients and carers in relation to this area.
End of Life Care Improvements delivered in 2012/2013:

The Trust continues to work closely with our local hospices to develop continuity of care through collaborative working, there is a commitment to build on areas of good practice and explore ways of improving care in end of life care for all people.

An End of Life Care (EOLC) Group chaired by the Medical Director has been set up. In addition we have introduced a new Morbidity and Mortality policy (with a grading system for deaths looking specifically at avoidable mortality) and a Death Notification Policy. Key Performance Indicator (KPI) dashboards have been established for all divisions and clinical units – End of Life Care is a KPI on each dashboard.

The lead for this priority has spent time speaking to and educating the divisions and specialties to increase understanding and awareness of EOLC across the Trust. Task and finish groups have been established to ensure that all parts of the EOLC programme are focussed and deliver their objectives over the coming months. These groups report into the Trust’s Programme Board.

We have improved our bereavement counselling and there is access to chaplaincy and pastoral services to support families and carers.

Work will continue in 2013/2014 to embed EOLC improvements across all relevant areas of care in the Trust. Two EOLC Facilitators have been recruited who will ensure this work is prioritised. The Facilitators are in the process of reinstating the LCP Link Groups across both acute and community sites and are auditing the reasons why some patients / carers are not taking up the Liverpool Care Pathway as a care process.

Further training is being delivered to ensure that more acute and community nurses are able to verify expected deaths – this is being organised by an appointed Consultant Nurse.
## Clinical Effectiveness

### Caring for vulnerable patients:

<table>
<thead>
<tr>
<th>2. Dementia and Delirium Care</th>
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<tr>
<td>◆ Ensuring that 90% of patients aged 75+ have a dementia screening assessment and dementia risk assessment.</td>
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<td>◆ Ensuring that 90% of patients identified as at risk of having dementia have a referral to an appropriate specialist diagnosis.</td>
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### Dementia and Delirium Care

The term ‘dementia’ describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer's disease and damage caused by a series of small strokes. Dementia is progressive, which means the symptoms will gradually get worse. How fast dementia progresses will depend on the individual person and what type of dementia they have. Each person is unique and will experience dementia in their own way. The Royal College of Physicians has identified through the National Audit of Dementia that up to 70% of acute hospital beds are currently occupied by older people and up to one half of these may be people with cognitive impairment, including those with dementia and delirium. The National Audit Office has estimated the excess cost to be more than £6 million per year to an average general hospital.

Why we chose this priority...

In view of East Sussex's large elderly population, it is essential that our patient care follows the best practice guidelines, as specified within the National Dementia Strategy and the NICE Quality Standard for Dementia care. Nationally, it is generally noted that:

◆ Admission to a general hospital ward is a time of high risk for people with dementia.
◆ Admission can lead to worsening of the condition and poor outcomes in general.
◆ There is a need for better consistency in standards of care on general hospital wards.
◆ People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.

What we were aiming to achieve in 2012/2013:

Our goal was to ensure that...

◆ 90% of patients aged 75+ have a dementia screening assessment and dementia risk assessment.
◆ 90% of patients identified as at risk of having dementia have a referral to an appropriate specialist diagnosis.
2012/2013 Results:
The profile of dementia screening has been raised across the organisation. However, capture of electronic data sets was not possible until December 2012. The data capture process is hindered somewhat by a two stepped process, whereby the Doctors undertake the screening and ward clerks input onto the Patient Administration System. This has resulted in early screening compliance for the over 75’s of 18.9% in January and 21.1% in February 2013. Figures have not yet been returned by the PCT’s or Clinical Commissioning Groups of the uptake of onward referral by the hospital to GPs for comprehensive assessment by the newly commissioned Memory Assessment Services.

Memory assessment services ensure an integrated approach to the care of people with dementia and the support of their carers. Delivered in partnership with local healthcare, social care and voluntary organisations, they have been shown to significantly improve the quality of life of carers and people with dementia.

Improvements delivered in 2012/2013:

New dementia pathways
The Trust is currently undertaking a range of projects in order to enhance the quality of care for people with dementia in acute and community settings. The key objective is to introduce new dementia pathways that provide timely, comprehensive and multidisciplinary care and increase quality. The delivery of these pathways will be supported by re-focusing learning and development programmes, and by working with key partners to ensure that all aspects of the pathway are fully integrated and cost effective. Work is ongoing to engage relevant staff groups, share best practice and make any necessary environmental changes.

Environment and care
There is a wealth of evidence highlighting the impact of the hospital setting in increasing disorientation and distress for people with dementia. Work-streams are in place to address this, and work is already underway or completed in several areas.
One ward, MacDonald at the Conquest Hospital is becoming an exemplar, practice development unit with expertise on improving the care environment for people with dementia. A ‘Bus Stop’ has been created on the ward to aid with the care of patients with dementia and minimise their disorientation. The bus stop is part of pioneering treatment for Alzheimer's disease and Dementia. It was first used at a centre in Dusseldorf, Germany and is now being used widely in this country. Patients often say that they want to go home and nothing can distract them. Now, when they say they are looking for their husband, wife or parents, they can go and wait on a bench at the bus stop. It can ease their frustration, knowing that there is somewhere they can go. After a few minutes, they have often forgotten why they are there and focus on going somewhere else.
Early evidence of improvements has been seen on MacDonald - such as a reduction in falls, the Trust will continue to assess the impact of these environmental changes in the year ahead.

A second ward has been redesigned and repainted in contrasting colours that support those with dementia with their orientation and depth perception. Other small scale but significant advances, such as the introduction of memory or rummage boxes have enabled people to undertake occupational activities or reminiscence whilst they are in hospital. People with dementia can often remember the distant past more easily than recent events. The rummage box can be made of a shoe box, a biscuit tin, a drawer or even a whole room filled with familiar objects is a means of tapping into memories from the past and helps people with dementia feel empowered and secure in a familiar environment.

**Dementia Care Champions**
70 multi-professional Trust staff have completed a 6 day university module to become dementia care champions within wards and service departments, increasing their knowledge and skills for delivering person centred dementia care. Some of the work produced has been acknowledged by the Department of Health, and is being entered for poster competitions at the Royal College of Psychiatrists’ July 2013 National Audit of Dementia conference in London.

Monica Golding, Ward Matron on MacDonald Ward said: “Patients living with dementia can become disorientated at times due to the deterioration of their short-term memory, but because their long-term memory is still active they are aware that the bus stop sign is a means to get them where they need to go. The idea is that during periods of confusion they are able to wait at the bus stop in the safety of our own ward. Alzheimer's disease and Dementia is distressing for patients and their loves ones. Our aim is to become a "ward of excellence" in the care of patients suffering from Alzheimer's disease and Dementia.
ESHT - 1 day ‘Older Peoples Workshop’
54 attendees in 2011 and 166 attendees in 2012.
Formal teaching sessions are delivered on both acute sites to junior doctors and GP practitioners by geriatric consultant staff in addition to their ad-hoc clinical ward based training. Information regarding holistic care and the dementia care pathway is also delivered by the Dementia Care Pathway Lead to all levels of clinical and managerial staff at Trust Induction, divisional, clinical unit, audit and governance meetings.

Reduction in anti-psychotic medication
Initiatives such as the monitoring of anti-psychotic drugs and the introduction of screening for the over 75s will be included in the overall framework of the new care pathways - the participation of key professionals will play a crucial role in the success of this programme. Underpinning our focus on improving care will be practice development which will aim to transform the culture and context of care for people with dementia and their supporters within the hospital and community setting.

East Sussex Healthcare NHS Trust Antipsychotic and Benzodiazepine Transactions
166 per month January 2011/2012 Annual expenditure £21,696
56 per month to October 2012 - £6,606 -projected for full year 2012 £7,927

Information resources
An ‘Information resource for people with dementia, their carers and relatives’, has been written and reviewed – this will be available on the Trust’s website shortly alongside other resources such as our ‘Anxiety and Depression’ leaflet. Staff additionally have access to numerous other tools and resources on the Trust’s internal extranet site.
## 3.2 Clinical Effectiveness

### Caring for vulnerable patients:

3. **Stroke Care**

   Ensuring that the care delivered for stroke patients follows best practice guidance. We will strive to ensure compliance with NICE quality statements, in line with the NICE Quality Standard for Stroke Care.

- 100% of stroke patients are swallowing screened by a trained nurse / Health Care Assistant within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and that they have an ongoing management plan for the provision of adequate nutrition.

- 100% of stroke patients are assessed and managed by stroke nursing staff and a referral is made to least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.

- We will investigate the feasibility of what is required in order to ensure that 100% of stroke patients are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week at a level that enables the patient to meet their rehab goals.

---

### Stroke Care

For the brain to function, it needs a constant blood supply, which provides vital nutrients and oxygen to the brain cells. A stroke happens when the blood supply to part of the brain is cut off and brain cells are damaged or die. There is also a related condition known as a ‘transient ischaemic attack’ (TIA), where the supply of blood to the brain is temporarily interrupted, causing a ‘mini-stroke’.

Nationally, every year, approximately 110,000 people have a stroke and around 150,000 people have a suspected TIA. Of those who have a stroke, a quarter of people will die immediately or within a few days.

Stroke is also the single largest cause of adult disability: there are over 900,000 stroke survivors living in England, and 300,000 people live with moderate to severe disability as a result of stroke.
In 2007, the Department of Health published a National Stroke Strategy which set out a framework of 20 quality markers for raising the quality of stroke prevention, treatment, care and support over the next decade. This strategy has given stroke national priority and it is supported by a public awareness campaign which began in February 2009.

Local NHS organisations are expected to work towards implementing these quality markers in the context of local strategies and services.

**Why we chose this priority…**

The Trust is dedicated to ensuring that the care delivered for Stroke patients follows best practice guidance – identified from the NICE Quality Standard for Stroke Care and the National Stroke strategy. NICE Quality Standards are central to supporting the Government's vision for an NHS focussed on delivering the best possible outcomes for patients. The Health and Social Care Bill (2011) makes it clear that the Secretary of State in discharging their duty to improve the quality of health services “must have regard to the quality standards prepared by NICE”.

**What we were aiming to achieve in 2012/2013:**

Our goal is to ensure that the care delivered for stroke patients follows best practice guidance. We will strive to ensure compliance with NICE quality statements, in line with the NICE Quality Standard for Stroke Care, specifically with consideration of the following targets -

- 100% of stroke patients are swallowing screened by a trained nurse / Health Care Assistant within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and that they have an ongoing management plan for the provision of adequate nutrition.

- 100% of stroke patients are assessed and managed by stroke nursing staff and a referral is made to least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.

- The Trust will investigate the feasibility of what is required in order to ensure that 100% of stroke patients are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week at a level that enables the patient to meet their rehab goals.
2012/2013 Results:

**Target 1** - A programme of dysphagia (swallowing problems) training was set up for nurses to access throughout the year. Due to staffing difficulties within the Speech and Language Therapy service, this programme has not yet become a rolling programme as initially planned, however, with the implementation of the Clinical Strategy for Stroke (increasing staffing levels); a rolling programme of dysphagia training for all trained nurses in place should be available shortly.

*Patients assessed within 4 hours of admission to hospital* – this data will eventually be available via the Sentinel Stroke National Audit Programme (SSNAP), unfortunately the Trust does not yet have access to this information since the audit is still in its infancy.

**Target 2** – The Trust participates in SSNAP and data is captured on a national database. Unfortunately the Trust has been unable to meet this target due to staff capacity stemming from a difficulty in recruiting stroke therapy staff when vacancies occur. Currently, we have sufficient therapy staff to provide care 5 days per week – this target should be achievable in the future in accordance with the business case specified as part of the Trust’s Clinical Strategy for Stroke which consolidates staff on one site enabling them to provide care for 7 days a week.

Stroke patients are assessed on admission by an appropriately trained stroke nurse; this nurse has extended assessment skills and is able to request CT scans for patients with stroke symptoms. The stroke pathway has ensured that all patients with stroke symptoms are promptly reviewed and transferred to a stroke unit.

The stroke specialist nurse also visits the inpatient wards to provide assessments for patients who have developed new stroke symptoms during their in-patient episode. All stroke patients are referred to the specialist rehabilitation team, however for patients admitted over the weekend, the rehabilitation assessment will be accepted on the next working day. All patients are assessed by the specialist rehabilitation team within 72hrs.

**Target 3** - The Trust has investigated the feasibility of providing 45 minutes of each therapy and this is pivotal to the introduction of the new Stroke Model of Care which will be adopted within the planned single site stroke unit.

**Improvements delivered in 2012/2013**
Swallow screening - 23 nurses have been trained to perform swallow assessments for stroke patients. Following an intense training programme, it is aimed to have a least 1 swallow trained nurse on duty to ensure swallow screening is completed for all stroke patients within 4 hours of admission.
Dietetic Posters on the Stroke Units - As part of their training, two dietetic students have developed posters to give advice on dietary changes (reducing salt and saturated fat consumption) to reduce stroke risk factors.

Salt and Stroke

- High blood pressure (hypertension) is the biggest cause of stroke.
- A stroke is when part of the brain stops receiving oxygen so the brain gets cut off.
- A high salt diet increases your blood pressure and therefore could increase your risk of stroke.

Simple dietary changes, such as reducing the amount of salt in your diet can help to reduce blood pressure and therefore lower your risk of stroke or protect you from having another stroke.

The aim is to have less than 6g salt a day; that’s about only 1 teaspoon.

- Cornflakes: 1g salt
- Pasta: 2.5g salt
- Cheese & potato chips: 3.2g salt
- Baked or salted chips: 6g salt

Tips to reduce your salt intake

- Avoid adding more salt when cooking or at the table
- Taste your food first before adding salt, if it needs more flavour, try using different seasoning such as paprika, lemon juice, herb and spices
- Use less sauce (ketchup, barbeque, mayonnaise, etc.)
- Compare food labels and go for lower salt options
- Foods may taste bland at first, but it will only take a couple of weeks for your taste buds to adjust
- Sea and rock salts are just as bad for you
- Low salt alternatives can interact with some medications so it best just to cut back on salt without using these

Other lifestyle changes:

- Be more active
- Become a healthy weight
- Try to aim for 5 portions of fruit and vegetables a day
- Reduce foods high in fat and sugar

Understanding Food Labels
Salt content can vary widely in products which you eat daily. Compare brands per 100g and choose lower salt options.

- High - more than 1.5g salt per 100g
- Medium - 0.3-1.5g per 100g
- Low - less than 0.3g salt per 100g

Don’t mistake sodium for salt – to convert sodium to salt multiply by 2.5

For more information: www.action_salt.org.uk, www.stroke.org.uk
A group of stroke therapists, supported by Darren Grayson, are taking part in the LIA process and have so far developed a mission statement and gone on to identify areas where we can make “quick wins” to improve services.

**Our Mission Statement**

*To provide a seamless, sustainable, high quality, person centred service for people who have had a stroke and the families in East Sussex in line with best practice and local and national guidelines.*

**Quick Wins:**
- Routine blood tests for Stroke patients at admission to include cholesterol and INR.
- A copy of the 2012 RCP Stroke guidelines available to each team.
- Improving availability of specialist seating in nursing homes for patients in need after a Speech and Language Therapist assessment.
- Access to a shared stroke drive online to allow efficient information sharing.
- Instigating a process to allow a company representative to visit a patient to trial specialist seating prior to going to a funding panel, if equipment is deemed suitable.
- Allow direct referrals by therapists into mental health services when a need has been identified.
- Instigation of a quarterly Stroke News Letter.

**Learning from Patients: Experiential accounts of transient ischaemic attack (TIA)** – Dr. Margaret Hewett, Clinical Specialist Physiotherapist in Neurology presented a poster about her doctoral research findings at the UK Stroke Forum Conference in Harrogate in December 2012; and the abstract was published in the International Journal of Stroke in December 2012 (vol 7, 2). The emphasis was upon the importance of patient engagement, to include acknowledging and embracing patient expertise. These were some of the findings from her thesis ‘Patient Experiences of Transient Ischaemic Attack’. She had previously presented at the World Confederation of Physical Therapy Congress in Amsterdam in 2011 and at Physiotherapy UK 2012.

Dr. Margaret Hewett, Clinical Specialist Physiotherapist, presenting at the UK Stroke Forum Conference in Harrogate in December 2012.
Achievements for Eastbourne Community Stroke Rehabilitation Service 2012

Early Supported Discharge (ESD) describes pathways of care for people transferred from an inpatient environment to a primary care setting to continue a period of rehabilitation, reablement and recuperation at a similar level of intensity and delivered by staff with the same level of expertise as they would have received in the inpatient setting. Service provision is focused around time specific patient goals and embraces the needs and ability of their carers.

Early discharge services for stroke:
- allow stroke patients to return home early and
- improve their long-term recovery
- are provided by teams of therapists, nurses and doctors
- aim to allow stroke patients to return home from hospital earlier than usual and receive more rehabilitation at home

Patients who receive these services return home earlier, and are more likely to remain at home in the long term and to regain independence in daily activities.

Our achievements:
- The Eastbourne Community Stroke Rehabilitation Service initiated ESD at beginning of February 2012, and now provides a 7 day service, 365 days a year.
- Recruitment of new team members has taken place to support the provision of the ESD service.
- Since the start of ESD, the provision of in-house, inter-disciplinary training for all team members has taken place. There is a plan to continue this training throughout 2013.
- The “Friends of the Eastbourne Hospital” have very kindly funded the team with equipment to support the ESD service - this includes scales, a bladder scanner, and a pulse oximetry.

What else have we achieved to improve Clinical Effectiveness in 2012/2013?

Neighbourhood Support Teams (NSTs)

NSTs are being set up across East Sussex with the aim of delivering health and social care support to help patients and their carers manage their own care and look after themselves better. Introduced in phases, NSTs will ultimately bring together adult social care, community NHS and mental health services into a single generic service, provided by 12 locality based teams. There will be a single point of access for all community services, with multidisciplinary meetings to discuss key worker arrangements and shared care plans and documentation.
Through Phase 1 of developing Neighbourhood Support Teams (NSTs) we have joined together our community rehabilitation services with the Living at Home (LAHS) service in Adult Social Care to create a joint community rehab (JCR) service.

In October 2012, the second phase brought together district nursing services, integrated night services, Social Worker practitioners, Advanced Community Nurse practitioners (previously known as Community Matrons) and Psychiatric Nurses to join with the Joint Community Rehab services that came together in Phase 1. The last 2 phases will include the community intermediate care beds and specialist community nursing services.

The NSTs aim to:

- Deliver health, social and mental health assessment, care and support for those in need in patients’ local communities
- From a single referral, the NST will ensure that the right professionals are involved in developing a care plan, and providing timely intervention
- Reduce unnecessary acute setting admissions and attendances to Emergency Departments
- Reduce delays and duplication, increase capacity and ensure a more timely and joined-up approach to health and social care, benefiting both referrers and clients
- Provide a Key Worker for patients identified as at high risk of admission
- Conduct regularly multi-disciplinary reviews for complex patients and those considered at high risk of admission

How the NSTs will work:

1. **Collaborative working:** Referrals will be responded to on the basis of the urgency and type of intervention. Once the referral has been received by the most appropriate professional a care plan will be developed. The NST team members will be able to request support from their NST members in a timely manner without the need of a referral. It is anticipated that this will result in a timely intervention and prevent admissions to the acute setting.

2. **Multi-disciplinary meetings:** The NST locality team will meet on a monthly basis to discuss patients identified as having complex needs or being of high risk of admission. It would be highly beneficial to GPs to be involved in these discussions.

3. **Key worker:** Patients identified as having complex needs or being of high risk of admission will have a Key Worker. This individual will be responsible for ensuring care is being provided in accordance with the Care Plan. The Key Worker can be of any discipline and should be the professional who has the most contact with the patient. The Key Worker can change if necessary, depending on patients’ needs.
Patient Centred Care Planning

Developed collaboratively between the patient and healthcare provider, personalised patient-centred care plans are recognised to have numerous recognised benefits, these include:

- Highlighting the specific care needs and goals of the individual patient.
- Details a programme of care based on best practice guidance.
- Encourages and empowers the patient to have a greater involvement in managing their own condition.

It is also important to note that the need for personalised care planning threads through a number of the NICE Quality Standards.

Learning first hand how it feels to be a patient at one of our hospitals or a user of our services in the community is invaluable. Modern healthcare must be responsive which is why we need to listen to our patients and act upon what they tell us.

Why we chose this priority...

We are committed to putting the patient and their experience at the heart of quality improvement. This measure is about making sure that inpatients understand what the plans are for their care - it is important that we ensure that care planning is explained to patients in a way that they can understand and, where possible, that the plans are co-designed with patient. This is then personalised to their needs with their individual preferences and values taken into account and documented within the patient’s records.
What we were aiming to achieve in 2012/2013:
Our goal was to ensure that 90% (as a minimum) of patient centred care plans were responsive to individual patient preferences, needs and values.

2012/2013 Results:
Through the Trust’s weekly audit results (a sub set of all admissions*) we are able to demonstrate that we have achieved this quality improvement priority - 98% of patient centred care plans were responsive to individual patient preferences, needs and values (our target was to achieve 90%).
*98% is a rolling average - calculated from our weekly audit results, 6 patients selected at random per ward / area are audited per week.

Improvements delivered in 2012/2013:
Over the past twelve months considerable developments have been made with respect to the personalisation of care across the organisation, implemented methods include: observations of care, Divisional Challenge sessions, Quality initiatives and the Quality Turnaround Group. Additional focus is being given to support staff in delivering person centred care and how they document the care they have provided. A training package with prompts for care plans has been introduced along with supervision for staff in clinical areas to review their record keeping.

‘At a Glance’ care plans have been developed and are now part of the process of documenting care within the records of patients. To support staff in delivering person centred care and in documenting the care they have provided, a training package with prompts for care plans has been introduced along with supervision for staff in clinical areas to review their record keeping.

This person centred approach is also being used with patients whom have dementia and a programme has been set up to look at how we work with this patient group and the first cohort are working through this.

The Integrated Patient Document is nearing its first draft and this has involved staff at all levels of the organisation and the need to treat the patient in a person centred way is a central theme running throughout the document.
### Patient Engagement

East Sussex Healthcare NHS Trust sees over 300,000 outpatients each year. When patients are seen in clinic, they have the right to be involved in discussions and decisions about their healthcare and to be given information to enable them to do this (The NHS Constitution 2009).

We value the feedback from our patients, their families and carers and use this information to help shape the services we offer.

**Why we chose this priority…**

In the recent National Outpatient Survey 2011 published by the CQC, the Trust was slightly within the bottom 20% of trusts when asked:

> “Did the doctor explain any reasons or action in a way that you could understand?”

We therefore decided to focus on improving our performance in this area.

**What we were aiming to achieve in 2012/2013:**

Our goal was to ensure that at least 95% of the patients surveyed attending an outpatient consultation throughout 2012/2013 leave the clinic feeling fully informed, and understand reasons for suggested courses of action or treatment.
2012/2013 Results:
During 2012/2013 the Trust developed a survey which would be used to determine whether patients left their outpatient appointment feeling fully informed, and understood the reasons for any suggested courses of action or treatment. We piloted this survey in the stroke clinic at the Conquest hospital. During the pilot stage, 100% of patients who responded to the survey reported that they fully understood any reasons for treatment and/or action (with one patient indicating “no need”). Furthermore, 100% of patients who completed the survey reported that if they had any questions, answers were provided in a way they could understand (with 4 patients indicating “no need”).

As it was felt that the pilot had been a success, the survey was then rolled out to further outpatient clinics across the Trust. The percentage of patients who responded “Yes definitely” to the survey question “did the doctor explain the reasons for any treatment/action in a way that you could understand?” was 99.5%

In summary we can conclude that at least 99% of patients surveyed stated that they felt fully informed and understood any reasons for treatment and/or action.

Improvements delivered in 2012/2013:
We have implemented a new way of gathering patient experience across the Trust…
From March 2013, all adult ward areas and A&E departments will have an electronic device that patients, or their relatives and carers, can use to give us their feedback. There are also patient feedback points in the main reception areas of the Conquest and Eastbourne District General Hospitals. These electronic devices will enable us to be more responsive to feedback and concerns. The feedback will be available to the ward and service area almost immediately, it is also a very useful way to provide feedback to staff where praise and compliments have been given.

This new system will be used to ask the Friends and Family Test. This is a simple question which everyone over the age of 18 who has either been admitted to hospital or attended one of our emergency departments will be given the opportunity to complete…

“How likely are you to recommend our (ward or A&E department) to friends and family if they needed similar care or treatment?”

The Department of Health is requesting that all hospitals across the country ask this question, results will then be provided directly to the public in the form of a league table. East Sussex Healthcare NHS Trust started to pilot the Friends and Family Test in July 2012, on average our net promoter score has been a very encouraging 84 - although this is not a direct percentage the nearer to ‘100’ the better the score is.
*This is calculated by deducting the percentage detractors (scores of 1-6) from the percentage of promoters (scores of 9-10).
We are hoping to improve on this score throughout 2013/2014 and using this electronic system will enable us to ask more people if they would recommend us.

The comments that patients, relatives and carers provide as part of their surveys are vital for us to learn from, share across our services and praise staff for their good work. Here is a selection of comments received in March 2013:

“I would like to thank all the wonderful nurses on my ward who made an unbearable situation more bearable each and everyone of them were helpful, kind and brilliant at their jobs. Thank you so much”.

“The nursing staff which I received was excellent...The cleaners worked very hard the housekeeping staff we had didn’t stop working and would go out of their way to help. The ward I was in I could not complain about any of the staff from the bottom to top. The doctor’s rounds could be more private.”

“I would like to thank all the staff on the *** ward, but especially ** who made my stay so much more comfortable with her help and friendliness thank you”.

The Trust has also participated in two national surveys reported on by the Care Quality Commission. The Accident and Emergency Survey achieved an overall response rate of 43.5%. National results indicate that we perform “about the same” as other trusts in 39 of the 44 questions.
There are areas which we need to improve upon and these are linked to waiting times and having enough time to discuss concerns with the Doctor. From March 2013 we will be continually surveying our patients in A&E to help us to gather up to date information in order to make whatever improvements are deemed necessary.

The National inpatient survey has not yet been published by the CQC, though our initial findings are more positive than those found in 2011 and we are hopeful that the hard work and commitment of our staff will be reflected in the CQC report when it is published in spring 2013.

As well as the National surveys we have also been surveying our patients locally across our services, these surveys have included:

- patients who have been an inpatient,
- patients with a diagnosis of heart failure,
- patients who have undergone surgery for hips or knees,
- patients under the care of community nursing,
- carers of patients in critical care,
- Maternity survey
- Patients undergoing a bronchoscopy
- Patients admitted to the respiratory department

Feedback from these surveys is reviewed, learning shared and actions implemented as required.
3.4 Review of our Performance Indicators in 2012/2013

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Thresholds</th>
<th>MONTH 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Performing</td>
<td>Under-performing</td>
</tr>
<tr>
<td>Total time in A&amp;E - 95% of patients should be seen within four hours</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>MRSA</td>
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<td>&gt;1SD</td>
</tr>
<tr>
<td>C Diff</td>
<td>50</td>
<td>&gt;1SD</td>
</tr>
<tr>
<td>RTT - admitted - 90% in 18 weeks</td>
<td>90%</td>
<td>85%</td>
</tr>
<tr>
<td>RTT - non-admitted - 95% in 18 weeks</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>RTT - incomplete 92% in 18 weeks</td>
<td>92%</td>
<td>87%</td>
</tr>
<tr>
<td>RTT delivery in all specialties</td>
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<td>&gt;20</td>
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<tr>
<td>Diagnostic Test Waiting Times</td>
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</tr>
<tr>
<td>Cancer 2 Week Wait</td>
<td>93%</td>
<td>88%</td>
</tr>
<tr>
<td>Cancer 2 week wait - Breast</td>
<td>93%</td>
<td>88%</td>
</tr>
<tr>
<td>Cancer 31 day - Subsequent Surgery</td>
<td>94%</td>
<td>89%</td>
</tr>
<tr>
<td>Cancer 31 day - Subsequent Chemo</td>
<td>98%</td>
<td>93%</td>
</tr>
<tr>
<td>Cancer 31 day - Diagnosis to Treatment.</td>
<td>96%</td>
<td>91%</td>
</tr>
<tr>
<td>Cancer 62 Day Screening Service</td>
<td>90%</td>
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<td>Cancer 62 Day Urgent Referral</td>
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<td>80%</td>
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<tr>
<td>Delayed transfers of care</td>
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<td>5.0%</td>
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<td>Mixed Sex Accommodation Breaches</td>
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<tr>
<td>VTE Risk Assessment</td>
<td>90.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

Further details on actions in respect of CDiff are outlined on page 92.

In respect of cancer metrics - breaches relate to a very small number of patients and the Trust is working with colleagues in primary care and other Trusts to ensure that patients are seen as quickly as possible.
The National Quality Board has requested that all NHS Trusts report upon the following set of core quality indicators to help readers understand the comparative performances of Trusts across the country.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework domain</th>
<th>Indicator</th>
</tr>
</thead>
</table>
| Domain 1: Preventing people from dying prematurely | → **Summary Hospital-Level Mortality (SHMI)**
  ◊ SHMI value and banding
  ◊ Percentage of admitted patients whose treatment included palliative care; and
  ◊ Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (Context indicator) |

**Results**

The most recent SHMI value published for East Sussex Healthcare NHS Trust is 1.05. This is for the data period October 2011 to October 2012. The associated banding for this value by the NHS Information Centre is ‘2’ – within expected range along with 114 other Trusts. In the same period of time, 18 Trusts were categorised at lower than expected and 10 trusts in England were categorised as higher than expected. The next SHMI publication will be in July 2013.

The Trust position of 1.05 is marginally above the national average of 1 and published by the NHS Information Centre for Health and Social Care as within the expected range. The Trust closely monitors the indicator in addition to other mortality indicators and undertakes reviews of patient notes to provide assurance that the care provided is safe and effective.

The Trust faces some difficulties with the interpretation of these results as East Sussex Healthcare NHS Trust is one of a few Integrated Acute and Community Trusts which has multiple community hospital sites - patients are often admitted from other acute hospital providers. Although this indicator is an Acute hospital indicator, patient data for community hospitals have been included and therefore direct comparisons are difficult to achieve. The Trust continues to work towards unravelling these complexities and actively seeks to fully understand the indicator as part of a range of quality indicators.

◊ The percentage of admitted patients whose treatment included palliative care for East Sussex Healthcare NHS Trust is 1.1% compared to national rate for the same period of approximately 1%. The range across all Trusts included with the indicator is 0% to 3.3%.

◊ The percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care for East Sussex Healthcare NHS Trust is 13.5% compared to the national rate of approximately 18.4% for the same data period. The range across all the Trusts included within the indicator is 0.3% to 46.3%.
Domain 3: Helping people to recover from episodes of ill health or following injury

→ Patient reported outcome scores / measures (PROMS) for:
  • Groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery.

Results

All NHS patients having hip or knee replacements, varicose vein surgery, or groin hernia surgery are invited to fill in a ‘PROMs’ questionnaire. The NHS is asking patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards - this will help the Trust to measure and improve the quality of its care based upon the outcomes of surgical interventions. Questionnaires are issued to patients undergoing hip and knee replacements, groin hernia repairs and varicose vein surgery at the pre-assessment clinic and then either three or six months after surgery.

**East Sussex Healthcare NHS Trust data**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Percentage Improving</th>
<th>Measure</th>
<th>Condition Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EQ-5D Index</td>
<td>EQ-VAS</td>
<td></td>
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<tr>
<td>Groin Hernia</td>
<td>48.1%</td>
<td>36.7%</td>
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</tr>
<tr>
<td>Hip Replacement</td>
<td>90.0%</td>
<td>22.2%</td>
<td>84.6%</td>
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<tr>
<td>Knee Replacement</td>
<td>71.4%</td>
<td>57.1%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Varicose Vein</td>
<td>*</td>
<td>No data</td>
<td>No data</td>
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</table>

**National data**

<table>
<thead>
<tr>
<th>Procedure</th>
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<th>Measure</th>
<th>Condition Specific</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>EQ-5D Index</td>
<td>EQ-VAS</td>
<td></td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>51.4%</td>
<td>38.9%</td>
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<tr>
<td>Hip Replacement</td>
<td>89.8%</td>
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<tr>
<td>Knee Replacement</td>
<td>79.4%</td>
<td>55.0%</td>
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<tr>
<td>Varicose Vein</td>
<td>51.7%</td>
<td>41.6%</td>
<td>83.4%</td>
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</tbody>
</table>

In summary, the data in these tables show that:

**EQ-5D Index is a combination of five key criteria concerning general health**

- 48.1% of groin hernia respondents recorded an improvement in their general health following their operation, against 51.4% nationally.
- 90.0% of hip replacements respondents recorded an improvement in their general health following their operation, against 89.8% nationally.
- 71.4% of knee replacement respondents recorded an improvement in their general health following their operation, against 79.4% nationally.
- The number of varicose vein questionnaires submitted were too low to provide data analysis. This is due to the low level of surgery undertaken by the Trust in this area.
EQ-VAS assesses the patients’ general health based upon a visual analogue scale

- 36.7% of groin hernia respondents recorded an improvement in their general health following their operation, against 38.9% nationally.
- 22.2% of hip replacement respondents recorded an improvement in their general health following their operation, against 65.2% nationally.
- 57.1% of knee replacement respondents recorded an improvement in their general health following their operation, against 55.0% nationally.
- The number of varicose vein questionnaires submitted were too low to provide data analysis. This is due to the low level of surgery undertaken by the Trust in this area.

Condition Specific Measures

- 84.6% of hip replacement respondents recorded joint related improvements following their operation as measured by their response to a series of questions about their condition (Oxford Hip Score), against 96.3% nationally.
- 75.0% of knee replacement respondents recorded joint related improvements following their operation as measured by their response to a series of questions about their condition (Oxford Knee Score), against 92.4% nationally.

No groin hernia completed questionnaires were returned by East Sussex Healthcare NHS Trust patients for this measure.

Although the Trust scores favourably by patients utilising our services, we are focussing on improving the number of completed responses submitted to Quality Health, the PROMs provider for the Organisation. A meeting took place in January 2013 with the Managing Director of Quality Health, and subsequently a number of local meetings have taken place with pre-assessment clinic lead staff to ensure that the processes in place facilitate the return of completed questionnaires. The Trust has little control over the follow up questionnaire, as this is sent directly to the patient’s home address six months after surgery. Local internet training is also being arranged for pre-assessment staff to re-familiarise themselves with the requirements and principles behind the PROMs data collection. Monitoring of PROMs data has also been incorporated into the clinical strategy document and related monitoring once the re-configuration has taken place.
NHS Outcomes Framework domain | Indicator
--- | ---
**Domain 3:** Helping people to recover from episodes of ill health or following injury | → Emergency readmissions to hospital within 28 days of discharge

**Results**

The percentage of patients of all ages and genders who were readmitted to hospital within the trust within 28 days of being discharged is shown below.

### 2012/2013 Emergency Re-Admissions

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>0-14</th>
<th>15+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges in 2012/2013 *</td>
<td>9,648</td>
<td>36,108</td>
<td>45,756</td>
</tr>
<tr>
<td>Emergency readmission within 0-27 days of the precious discharge **</td>
<td>265</td>
<td>4,515</td>
<td>4,780</td>
</tr>
</tbody>
</table>

This is calculated using the specified technical advice exclusions usually applied to readmissions:

* Day cases and discharges due to death, maternity spells or cancer are excluded from these figures;

** Obstetric and cancer readmissions are excluded from these figures.

The national average for patients 16+ is 11%; East Sussex Healthcare is just above this benchmark, with a current figure of 12.5% for patients in the 15+ age group.

‘Readmission’ is an area for continued focus within the Trust - currently work is being undertaken within Trauma and Orthopaedics and Chronic Obstructive Pulmonary Disease (COPD) will be a focus for reducing readmissions during 2013/2014.

---

NHS Outcomes Framework domain | Indicator
--- | ---
**Domain 4:** Ensuring that people have a positive experience of care | → Responsiveness to inpatients’ personal needs

**Results**

The NHS Outcomes Framework for 2012/2013 includes an organisation’s responsiveness to patients needs as a key indication of the quality of patient experience. This score is based on the average of answers to five questions in the CQC national inpatient survey:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

The score for the Trust calculated from the CQC national inpatient survey 2012 is 67.7.

The National Average score is 67, therefore the Trust performed slightly better than the national average.

East Sussex Healthcare NHS Trust is currently ranked 73 out of 161 NHS Trusts. The Trust will continue to monitor performance through regular surveying, the results of which are reviewed through the Patient Experience Steering Group (PESG) where divisional action plans are monitored.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework domain</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 4: Ensuring that people have a positive</td>
<td>→ % of staff who would recommend the provider to friends or family needing</td>
</tr>
<tr>
<td>experience of care</td>
<td>care</td>
</tr>
</tbody>
</table>

Results

The results of Key Finding 24: ‘Staff recommendation of the Trust as a place to work or receive treatment’, are displayed as a ‘scale summary score’ (the higher the score the better - the minimum score is always 1 and the maximum score is 5):

The above score demonstrates that we are still adrift from the national average for Acute Trusts. However, it is encouraging to note that our score has improved since the 2011 survey which indicates that we are moving in the right direction, and that our staff engagement initiatives (including our Listening into Action initiative), are beginning to have an impact. We will be continuing with and building upon the Listening into Action programme throughout 2013/2014, actively engaging and encouraging staff to identify and implement changes and improvements to enhance their delivery of quality care.
### Results

Domain 5 of the NHS Outcomes Framework for 2012/2013 includes incidence of VTE as an important indicator of improvement in protecting patients from avoidable harm, and the NHS Operating Framework for 2012/2013 sets out an expectation that patients will be risk assessed for hospital-related VTE. The VTE Risk Assessment compliance percentages as submitted to Department of Health via UNIFY at East Sussex Healthcare Trust for 2012/2013 are shown below.

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>May</td>
</tr>
<tr>
<td>92.1%</td>
<td>92.7%</td>
</tr>
<tr>
<td>ESHT Q1 average = 92.3%</td>
<td>ESHT Q2 average = 93.1%</td>
</tr>
<tr>
<td>National Q1 average = 93.4%</td>
<td>National Q2 average = 93.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
<td>Nov</td>
</tr>
<tr>
<td>95.5%</td>
<td>94.8%</td>
</tr>
<tr>
<td>ESHT Q3 average = 94.6%</td>
<td>ESHT Q4 average = 93.1%</td>
</tr>
<tr>
<td>National Q3 average = 94.1%</td>
<td>National Q4 average = 94.2%</td>
</tr>
</tbody>
</table>

The CQUIN Goal for April 2012-March 2013 was set at 90% compliance. This has been reported each month via UNIFY and the goal was met consistently despite the Trust falling slightly below the national average in quarters 1-2. The CQUIN Goal for April 2013-March 2014 will be 95% compliance.

Trust recommended actions to improve compliance in 2013-2014:

- To ensure that individual VTE risk assessments are undertaken, and that the Trust meets the national requirement of 95% compliance, a robust feedback process to the Divisions and Clinical Units must be developed in order to highlight underperforming areas.
- A robust process for capturing Hospital Acquired Thrombosis (HATS) must be agreed: it is recommended that a variety of data sources should be used.
- Establish and implement a Root Cause Analysis (RCA) process for all HATs including time frames for review. It is recommended that the VTE Nurse and Consultant Lead for VTE perform and report the RCAs with consultation and mandatory feedback from individual consultants within a specified timeframe to avoid non compliance with this requirement.
- Action is required to improve compliance with NICE guidelines. There is a need to identify responsibility at Clinical Unit level to support the changes in clinical practice including implementing regular audit.
<table>
<thead>
<tr>
<th>NHS Outcomes Framework domain</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 5:</strong> Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>→ Rate of C. Difficile</td>
</tr>
</tbody>
</table>

## Results

Domain 5 of the NHS Outcomes Framework for 2012/2013 includes incidences of C. Difficile (CDiff) as an important indicator of improvement in protecting patients from avoidable harm, as does the NHS Operating Framework for 2012/2013, which sets out a “zero tolerance” approach to infections acquired in healthcare settings. The Trust’s rate of CDiff compared to the national average are given below.

<table>
<thead>
<tr>
<th>Financial Year 2012/2013</th>
<th>17.14</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rate of CDiff infections per 100,000 bed days amongst patients aged two years and over apportioned to the Trust (ESHT)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4 of Calendar Year 2012</th>
<th>17.37*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rate of CDiff infections per 100,000 bed days amongst patients aged two years and over (national average)</td>
<td></td>
</tr>
</tbody>
</table>

*data source: Quarterly Epidemiological Commentary: Mandatory MRSA, MSSA and E. coli bacteraemia, and CDiff infection data (up to October–December 2012), HPA, 14th March 2013.

In 2012/2013 the Trust reported 51 cases of CDiff against an objective of 50. The Trust’s Infection Control Group held focussed meetings to develop and oversee a CDiff action plan for 2013/2014. Actions include:

- A new process for undertaking root cause analysis of all CDiff cases within 14 calendar days
- Formation of a new Infection Control Steering Group to be held fortnightly chaired by the Deputy CEO. Clinical teams will present their cases to this group within agreed timeframes.
- Frequency of the Trust Infection Control Group meetings is to increase to monthly and attendance by Divisional leads will be mandatory.
- The development of an action plan by the Lead Antimicrobial Pharmacist regarding monitoring and control of antimicrobial prescribing
- Revised housekeeping service level agreements to be agreed and monitored by the Trust National Cleaning Standards Group and reported to the Trust Infection Control Group.

The annual objective for the reduction of CDiff in 2013/2014 is to report no more than 25 cases.
Domain 5 of the NHS Operating Framework for 2012/2013 includes the rate of patient safety incidents reported and the proportion of these resulting in severe harm or death, as a measure of the willingness to report incidents and learn from them, and therefore reduce the number of incidents that cause serious harm. The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, whilst the numbers of incidents resulting in severe harm or death should reduce.

The rate of patient safety incidents they have reported per 100 admissions
The rate of patient safety incidents reported to the National Patient Safety Agency for 2012/2013 is 6.9 per 100 admissions. (6,898 patient safety incidents sent to the NRLS / 99,477 admissions)
It should be noted that an admission is defined as 'to a bed on a ward in a hospital' and therefore does not include other admissions for example to a community nursing caseload. However the patient safety data provided covers the whole spectrum of services provided by East Sussex Healthcare Trust.

The proportion of patient safety incidents they have reported that resulted in severe harm or death
The proportion of patient safety incidents which resulted in severe harm or death for 2012/2013 was 1.1%. This is calculated by dividing the number of grade 4 (major) and 5 (catastrophic) patient safety incidents reported by East Sussex Healthcare Trust (79 in the year) by the total number of patient safety incidents reported to the National Patient Safety Agency (6898).

The latest report from the National Reporting and Learning System (NRLS) which was published in March 2013 and covering the period of 01.04.12 to 30.09.12 provided a reporting rate of 7.5 incidents reported per 100 admissions for East Sussex Healthcare Trust. This placed the Trust within the middle 50% of reporters (although towards the top). The previous report covering the period of 01.10.11 to 31.03.12 provided East Sussex Healthcare NHS Trust with a reporting rate of 7.6 incidents per 100 admissions placing the Trust in the highest 25% of reporters.

The March 2013 report from the NRLS provided East Sussex Healthcare NHS Trust with a reporting rate of 1.1% of incidents leading to severe harm and death. The reporting rate of ‘all large acute organisations’ in the same report was 0.7%.

East Sussex Healthcare Trust is categorised as a large acute organisation for the purposes of the NRLS reports; the Trust is an integrated organisation providing both acute and community services and there are very few comparator organisations. In addition, not all organisations apply the national coding of degree of harm in a consistent way which can make comparison of harm profiles of organisations difficult.

Serious Incidents are investigated via Root Cause Analysis and reports are presented to the Trust Serious Incident Review Group. At these meetings the severity risk score is reviewed to ensure it is appropriate for the incident. In addition, the central Datix Team review all incidents reported on Datixweb prior to ‘approving’ them for closure and the severity risk score is reviewed as part of this process.
3.5 Statements from Key Stakeholders

Statement from Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and High Weald Lewes Havens CCG

The CCGs have reviewed the document and agree that overall the Quality Account provides an accurate record of achievement against national and local priorities in 2012/2013. We acknowledge that there is a lot of good work described in the account and look forward to seeing further developments and sustained quality improvements in 2013/2014.

The Quality Account is aligned to the three pillars of quality: patient safety, clinical effectiveness and patient experience. These headings are used to set out 2013/2014 quality priorities and what this means for the people who use these services. We will monitor progress of the improvement areas at the monthly Clinical Quality Review Group, via quality assurance modules at the Quality and Governance Committee and Contract and Performance meetings.

We also noted the significant improvements assessed by the Care Quality Commission resulting in full compliance with all essential standards reviewed in 2012/2013.

For the 2013/2014 we particularly want to see improvement in:

Safety

- Patient Safety Thermometer - to provide Harm Free Care for more than 90% of patients. The CCGs expect to see a substantial reduction in pressure ulcers.

- Quality and productivity information about community teams and services. The planned introduction of the Productive Community Series is welcomed and we would be looking to see systematic engagement of all from these teams.

- CDI infection control - remains a significant challenge and we are pleased to see the Trust making use of the resources from the NTDA to facilitate further improvement.

- Changes to clinical practice and services as a result of lessons learnt from serious incidents. The Francis report mandated that organisations must be open and transparent about the services they provide, and be able to demonstrate where improvements have occurred when things went wrong. We note that there is transparency between the Trust and the CCGs in this area.

Effectiveness

- End of Life Care (EOLC) achieving the plan outlined in CQUIN.

- Dementia Care - To replicate the success of ward teams such as MacDonald Ward throughout the integrated trust achieving the CQUIN.
• Stroke - We are mindful of the disparity between the Trust’s evaluations of the quality of stroke services and the CCGs. There has been some improvement to stroke services, however there needs to be significant and sustained increase in the number of patients who spend most of their time in a dedicated stroke bed.

Patient Experience

• Implementation of the Patient Experience Strategy - There is a strong focus on patient experience as the key theme throughout the account. The patients’ stories and what this means for you sections clearly state what patients can expect and it would be good to see an audit of whether these measures are achieved in 2013/2014.

The CCGs look forward to working collaboratively with ESHT on the quality agenda and are confident that they can continue to rise to the challenge of providing localised information relating to quality to evidence that the services commissioned are delivered safely, effectively and with improved patient experience.
Statement from East Sussex Health Overview and Scrutiny Committee

East Sussex Health Overview and Scrutiny Committee (HOSC) is made up of elected local councillors from East Sussex County Council and District and Borough Councils in the county, together with representatives from the local voluntary sector. The Committee has reviewed the Trust’s Quality Account 2012/2013 and makes the following statement of comments:

Patient and public involvement

HOSC is pleased to note the Trust’s efforts to engage with patients, staff, and volunteers in the development of the Quality Account, including the stakeholder events introduced this year. The Trust’s increased focus on patient experience over the past year, including the development of a patient experience strategy, is also welcome.

Quality priorities for 2012/2013

The selection of priorities for 2012/2013 does reflect issues of importance to patients in the areas of safety, clinical effectiveness and patient experience. The emphasis on responsiveness to patient feedback should yield benefits across a range of issues which matter to patients, and contribute to ongoing cultural change within the organisation.

HOSC particularly welcomes the focus on community based services. The Committee has consistently highlighted the need for these services to be developed alongside the redesign and reconfiguration of acute services. The opportunities presented by an integrated acute and community Trust have yet to be exploited.

Other observations based on HOSC’s work

HOSC has devoted considerable time during 2012/2013 to scrutinising the Trust’s proposals for reconfiguration of stroke, orthopaedic and general surgery services, ultimately agreeing these plans. The implementation of these changes successfully during 2013/2014 will be critical and HOSC will be ensuring that recommendations attached to the Committee’s support are honoured. Alongside the management of these and other significant changes, it will be critically important to maintain focus on improvements to quality of care and patient outcomes in a challenging financial climate.

HOSC has previously scrutinised the Trust’s response to CQC inspections in 2011 which required improvements to be made in order to meet required standards of care. The Committee was pleased to note that CQC declared the Trust compliant with all essential standards earlier in 2013. This reflects progress which has been made in a range of areas over the past year or more and continued focus will be required to sustain this.

Following a Committee review in 2009/10 HOSC has continued to monitor the Trust’s progress on patient nutrition and hydration and this was extended to wider issues of dignity in care during 2012/2013. The Committee noted that significant progress has been made, for example in nutritional screening and the introduction of essential care rounds, but also that further work is needed to fully embed some relatively new initiatives and ensure these are applied consistently for all patients.
Statement from East Sussex Community Voice – delivering Healthwatch in East Sussex

East Sussex Local Involvement Network continued to participate in activities with East Sussex Healthcare NHS Trust around Patient Engagement during their final year 2012 – 2013. These activities included:

- Contributing to the Patient Experience Strategy and attending the first Patient Experience Conference
- Participating in the NHS Sussex and East Sussex Healthcare NHS Trust (ESHT) public consultation called *Shaping our Future*.
- Regular attendance at the Community Redesign Group meetings

Healthwatch East Sussex is looking forward to building on the good relationships established by the LINk, so it too can continue to work with the Trust in improving services on behalf of patients and public.
3.6 Independent auditor’s limited assurance report

INDEPENDENT AUDITOR’S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF EAST SUSSEX HEALTHCARE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of East Sussex Healthcare NHS Trust’s Quality Account for the year ended 31 March 2013 (“the Quality Account”) and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (“the Act”). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death;
- Percentage of patients readmitted within 28 days.

I refer to these two indicators collectively as “the indicators”.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not consistent with the requirements set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on April 2013 ("the Guidance").

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any inconsistencies.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from relevant Clinical Commissioning Groups;
- feedback from Healthwatch East Sussex;
- feedback from East Sussex Health Overview and Scrutiny Committee;
- the trust’s complaints report to be published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated May 2013;
- the latest national patient survey dated February 2012 for outpatients and April 2013 for inpatients;
- the latest national staff survey dated 2012;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 17 April 2013;
- the annual governance statement dated 6 June 2013;
- Care Quality Commission quality and risk profiles dated June 2013; and
- Results of the Payments by Results coding review dated May 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of East Sussex Healthcare NHS Trusts in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East Sussex Healthcare NHS Trusts.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:
- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Leigh Lloyd-Thomas
for and on behalf of BDO LLP
London, UK
26 June 2013
### 3.7 Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
| **Abuse** | Abuse is defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as:  
- Sexual abuse  
- Physical or psychological ill-treatment  
- Theft, misuse or misappropriation of money or property, or  
- Neglect and acts of omission which cause harm / place at risk of harm. |
<p>| <strong>Avoidable Death</strong> | Deaths that could have been avoided given a different course of action |
| <strong>Avoidable Harm</strong> | Harm of patients that could have been avoided given a different course of action |
| <strong>Cardiology</strong> | Cardiology is a medical specialty dealing with disorders of the human heart. The field includes medical diagnosis and treatment of congenital heart defects, coronary artery disease, heart failure, valvular heart disease and electrophysiology. Physicians who specialize in this field of medicine are called cardiologists. |
| <strong>Care Quality Commission</strong> | The Care Quality Commission (CQC) replaced the Healthcare Commission and Mental Health Act Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: <a href="http://www.cqc.org.uk">www.cqc.org.uk</a> |
| <strong>Care Pathway</strong> | This is an anticipated care plan that a patient will follow, in an anticipated time frame and is agreed by a multi-discipline team (i.e. a team made up of individuals responsible for different aspects of a patient’s care). |
| <strong>Clinical Audit</strong> | Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary. |
| <strong>Clinical Coding</strong> | Clinical Coding Officers are responsible for assigning ‘codes’ to all inpatient and day case episodes. They use special classifications which are assigned to and reflect the full range of diagnosis (diagnostic coding) and procedures (procedural coding) carried out by providers and enter these codes onto the Patient Administration System. The coding process enables patient information to be easily sorted for statistical analysis. When complete, codes represent an accurate translation of the statements or terminology used by the clinician and provides a complete picture of the patient’s care. |
| <strong>Clinical Division</strong> | East Sussex Healthcare NHS Trust’s clinical services are organised into three clinical divisions: Planned Care, Urgent Care and Integrated Care. Each division is led by a Divisional Director. |
| <strong>Clinical Management Executive</strong> | The Clinical Management Executive (CME) exists to ensure that the organisation is able to plan and undertake the actions required to effectively deliver its strategic objectives. It ensures the business of the organization is run effectively, efficiently and in accordance with relevant statutory obligations. It makes decisions relating to planning and delivery across all aspects of the organisations functions within the strategic framework provided by the Board. |
| <strong>Clostridium difficile or C. Difficile / C.Diff</strong> | Clostridium Difficile also known as ‘C.Difficle’ or ‘C. diff’, is a gram positive bacteria that causes diarrhoea and other intestinal disease when competing bacteria in a patient or persons gut are wiped out by antibiotics. C. Difficile infection can range in severity from asymptomatic to severe and life-threatening, especially among the elderly. People are most often nosocomially infected in hospitals, nursing homes, or other institutions, although C. Difficile infection in the community and outpatient setting is increasing. |
| <strong>Commissioners of services</strong> | Organisations that buy services on behalf of the people living in the area that they cover. This may be for a population as a whole, or for individuals who need specific care, treatment and support. For the NHS, this is done by Clinical Commissioning Groups (CCGs) and for social care by local authorities. |
| <strong>Commissioning for Quality and Innovation</strong> | High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Visit: <a href="http://www.dh.gov.uk/en/">www.dh.gov.uk/en/</a> |
| <strong>Culture</strong> | Learned attitudes, beliefs and values that define a group or groups of people. |
| <strong>Data Quality</strong> | Ensuring that the data used by the organisation is accurate, timely and informative |
| <strong>DatixWeb</strong> | On 1st January 2013 East Sussex Healthcare NHS Trust introduced an electronic incident reporting software known as DatixWeb. Incidents are reported directly onto the system by any employee of the organisation, about incidents or near missing occurring to patients, employees, contractors, members of the public. The data provided by DatixWeb assists the organisation to trend the types of incidents that occur, for learning lessons as to why they occur and to ensure that these risks are minimised or even eliminated by the action plans that we put in place. DatixWeb is also used to comply with national and local reporting requirements. |
| <strong>Department of Health</strong> | The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS. |
| <strong>Deteriorating Patient</strong> | A patient whose observations indicate that their condition is getting worse |
| <strong>Dignity</strong> | Dignity is concerned with how people feel, think and behave in relation to the worth or value that they place on themselves and others. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual views and beliefs. |
| <strong>Discharge</strong> | The point at which a patient leaves hospital to return home or be transferred to another service or, the formal conclusion of a service provided to a person who uses services. |
| <strong>Enforcement action</strong> | Action taken to cancel, prevent or control the way a service is delivered using the range of statutory powers available to the Care Quality Commission. It can include action taken in respect of services that should be, but are not, registered. |
| <strong>Essential Care Rounds</strong> | Health professionals undertake hourly rounds to ask patients how they are feeling, make sure that they are comfortable, address their concerns and see if they require pain management. The approach can helps nurses to focus on clear, measurable aims and expected outcomes and frontline teams to organise workload and provide consistent care. Essential care rounding can reduce adverse events, improve patients' experience of care and also provide comfort and reassurance. |
| <strong>Friends and Family Test</strong> | An NHS ‘friends and family’ test to improve patient care and identify the best performing hospitals in England has been announced by Prime Minister David Cameron. From April 2013, patients will be asked a simple question: whether they would recommend hospital wards, accident and emergency units to a friend or relative based on their treatment. Publishing the answers will allow the public to compare healthcare services and clearly identify the best performers in the eyes of patients – and drive others to take steps to raise their standards. |
| <strong>Healthcare- associated infection</strong> | An avoidable infection that occurs as a result of the healthcare that a person receives. |
| <strong>Hospital Episode Statistics</strong> | Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. |
| <strong>Hospital Standardised Mortality Ratio</strong> | Hospital Standardised Mortality Ratio (HSMR) is an indicator of whether death rates are higher or lower than would be expected. |
| <strong>Key Performance Indicators (KPIs)</strong> | Key Performance Indicators, also known as KPI help an organisation define and measure progress toward organisational goals. Once an organisation has analyzed its mission, identified all its stakeholders, and defined its goals, it needs a way to measure progress toward those goals. Key Performance Indicators are those measurements. Performance measures such as, length of stay, mortality rates, readmission rates and day case rates can be analysed. |
| <strong>Multidisciplinary</strong> | Multidisciplinary describes something that combines multiple medical disciplines. For example a ‘Multidisciplinary Team’ is a group of professionals from one or more clinical disciplines who together make decisions regarding the recommended treatment of individual patients. |
| <strong>MRSA</strong> | Methicillin-Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is, by definition, any strain of Staphylococcus aureus bacteria that has developed resistance to antibiotics including the penicillins and the cephalosporins. MRSA is especially troublesome in hospitals, where patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public. |
| <strong>Malnutrition Universal Screening Tool (MUST)</strong> | ‘MUST’ is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. |
| <strong>Multidisciplinary</strong> | Multidisciplinary describes something that combines multiple medical disciplines. For example a ‘Multidisciplinary Team’ is a group of professionals from one or more clinical disciplines who together make decisions regarding the recommended treatment of individual patients. |
| <strong>National Confidential Enquiry into Patient Outcome and Death – NCEPOD</strong> | The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews clinical practice and identifies potentially remediable factors in the practice of anaesthesia and surgical and medical treatment. Its purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public. It does this by reviewing the management of patients and undertaking confidential surveys and research, the results of which are then published. Clinicians at East Sussex Healthcare NHS Trust participate in national enquiries and review the published reports to make sure any recommendations are put in place. |
| <strong>National Institute for Health and Clinical excellence</strong> | The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: <a href="http://www.nice.org.uk">www.nice.org.uk</a> |</p>
<table>
<thead>
<tr>
<th><strong>Never Event</strong></th>
<th>A Never Event is a type of SUI. These are defined as ‘serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers’.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Palliative Care</strong></td>
<td>Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.</td>
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<tr>
<td><strong>Patient Experience Champions</strong></td>
<td>Patient Experience Champions have been identified across the organisation and will work to raise awareness and facilitate improvements to the patient experience of patients on their wards / in their departments.</td>
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<tr>
<td><strong>Patient Safety Thermometer</strong></td>
<td>The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE (venous thromboembolism - deep vein thrombosis and pulmonary embolism). It provides a quick and simple method for surveying patient harms and analysing results so that we can measure and monitor local improvement and harm free care.</td>
</tr>
<tr>
<td><strong>Periodic reviews</strong></td>
<td>Periodic reviews are reviews of health services carried out by the Care Quality Commission (CQC). The term ‘review’ refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services.</td>
</tr>
<tr>
<td><strong>Pressure Ulcers</strong></td>
<td>Pressure ulcers develop when a large amount of pressure is applied to an area of skin over a short period of time, or, they can occur when less force is applied but over a longer period of time.</td>
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<tr>
<td><strong>Privacy and dignity</strong></td>
<td>To respect a person’s privacy is to recognise when they wish and need to be alone (or with family or friends), and protected from others looking at them or overhearing conversations that they might be having. It also means respecting their confidentiality and personal information. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual beliefs.</td>
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<tr>
<td><strong>Patient Reported Outcome Measures (PROMs)</strong></td>
<td>Assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre and post-operative surveys.</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td>Providers are the organisations that provide NHS services, e.g. NHS trusts + their private or voluntary sector equivalents.</td>
</tr>
<tr>
<td><strong>Registration</strong></td>
<td>From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC).</td>
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<tr>
<td><strong>Releasing time to care – the productive community series</strong></td>
<td>The NHS Institute for Innovation and Improvement has been working with nurses and therapists to develop ways to increase the amount of direct care time given to patients in community hospitals. The Productive Community Hospital programme is designed to help achieve this by improving the effectiveness, safety and reliability of inpatients, day hospitals and minor injuries units.</td>
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<tr>
<td><strong>Research</strong></td>
<td>Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.</td>
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<tr>
<td><strong>Root Cause Analysis (RCA)</strong></td>
<td>RCA is a method of problem solving that tries to identify the root causes of faults or problems that cause operating events. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing correction on root causes, problem recurrence can be prevented.</td>
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<td><strong>Safeguarding</strong></td>
<td>Ensuring that people live free from harm, abuse and neglect, and in doing so, protecting their health, wellbeing and human rights. Children, and adults in vulnerable situations, need to be safeguarded. For children, safeguarding work focuses more on care and development; for adults, on independence and choice.</td>
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<tr>
<td><strong>Serious Incident (SI)</strong></td>
<td>A Serious Incident is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death on hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern.</td>
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<tr>
<td><strong>Summary hospital-level mortality indicator (SHMI)</strong></td>
<td>SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a trust over a period of time divided by the expected number given the characteristics of patients treated by that trust (where 1.0 represents the national average). Depending on the SHMI value, trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.</td>
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<tr>
<td><strong>Trust Board</strong></td>
<td>The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the community.</td>
</tr>
<tr>
<td><strong>Waterlow</strong></td>
<td>The 'Waterlow' score (or scale) gives an estimated risk of a patient developing a pressure sore.</td>
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<tr>
<td><strong>Venous Thromboembolism (VTE)</strong></td>
<td>Your blood has a mechanism that normally forms a ‘plug’ or clot to stop the bleeding when you are injured, for example when you have a cut to your skin. Sometimes the blood’s clotting mechanism goes wrong and forms a blood clot when there has been no injury. When this happens inside a blood vessel, the blood clot is called a thrombus. When the blood clot is deep inside one of the veins in your body, most commonly in the leg, it is called deep vein thrombosis (DVT). If the blood clot comes loose it can travel through your bloodstream to your lungs. This is called pulmonary embolism and it can be fatal. DVT and pulmonary embolism together are known as venous thromboembolism.</td>
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3.8 Feedback

Feedback on this document is welcome…

Please email us at:
enquiries@esht.nhs.uk

Or write to us at:
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Eastbourne DGH
Kings Drive
Eastbourne
BN21 2UD

Follow us on Twitter @ eshealthcarenhs

Follow us on Facebook @ eshtnhs

Accessibility

The Trust can provide information in other languages when the need arises. Furthermore, to assist any patient with a visual impairment, literature can be made available in Braille or on audio tape.

For patients who are deaf or hard of hearing a loop system is available around our hospitals and a British Sign Language service can be arranged. Information on these services can be obtained via the Patient Advice and Liaison Service (PALS).