Quality Account

2015 - 2016
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Part 1 Introduction

Statement on Quality from the Chief Executive

I am delighted to introduce the Quality Account for East Sussex Healthcare NHS Trust (ESHT). The Account summarises the Trust's quality achievements and successes during 2015/16, it also identifies areas for further improvement and sets out our quality priorities for the coming year.

In 2015/16 ESHT faced significant challenges. In September 2015 the Care Quality Commission found the Trust wanting in a number of areas – although it noted that people across the organisation were compassionate and caring in the way they delivered their services. The Trust was placed under Special Measures. The Trust fully acknowledges that it has not met the standards the people in East Sussex rightly expect and to which we aspire. We are determined to learn the lessons from this challenging time and restore the standards and reputation of the organisation. We have begun that programme of work which has already resulted in some quantifiable successes. In the meantime, patients and carers have continued to write regularly to compliment the Trust on the quality of care provided by people across the organisation.

The Trust is one part of a system of health and social care across East Sussex. We will work closely with colleagues in the Clinical Commissioning Groups, Primary Care, Social Services, and the Voluntary Sector to ensure the optimum arrangement of care for our patients. The ‘East Sussex Better Together’ programme provides an important context for the development of services that focus on early intervention, management of long term conditions in the community, and the full involvement of patients and those close to them in their care.

ESHT remains committed to the provision of high quality services for patients of all ages both in the community and at our hospital sites. The Trust will continue to develop its services and premises to ensure that we meet this commitment.

This report is a testament to the continued hard work, commitment and compassion of staff across ESHT.

Dr Adrian Bull MD
Chief Executive
East Sussex Healthcare NHS Trust employs around 6,500 committed, skilled, caring and professional staff who deliver healthcare to a population of approximately 525,000 people living within the communities of East Sussex.

Our population is spread across urban, rural and semi-rural areas which are demographically diverse, with areas of significant deprivation, health inequalities and chronic disease.

We are an integrated Trust which provides healthcare within acute and community hospitals, including various clinics from health centres, children’s centres and GP surgeries. We also provide community nursing and therapy services within patients’ own homes.

Our hospitals and the services provided from these are:

- **Eastbourne District General Hospital**
  - Emergency and Urgent Care, Diagnostics and Clinical Support, Critical Care, Specialist Medicine, Surgery, Outpatients, midwifery led birthing service and short stay children’s Assessment Unit

- **Conquest Hospital**
  - Emergency and Urgent Care, Diagnostics and Clinical Support, Critical Care, Specialist Medicine, Surgery, Outpatients, acute child and maternity services

- **Bexhill Hospital**
  - Outpatients, Day surgery, Rehabilitation and Intermediate Care and Radiology

- **Crowborough War Memorial Hospital**
  - Minor Injury Unit, Radiology, Rehabilitation and Inpatient Intermediate Care Services (until 31 October 2015) and the Midwifery Led Birthing Service until 31st March 2016

- **Lewes Victoria Hospital**
  - Minor Injury unit, Inpatient Intermediate Care services and Radiology (until 31 October 2015) and continue to provide Day Surgery services

- **Uckfield Community Hospital**
  - Minor Injury Unit, Radiology, Rehabilitation and Inpatient Intermediate Care services (until 31 October 2015) and continue to provide Outpatients and Day Surgery

- **Rye, Winchelsea and District Memorial Hospital**
  - Outpatients and inpatient intermediate care services

- **Firwood House**
  - Inpatient Intermediate Care services jointly run with Adult Social Care (East Sussex County Council)
**Our Vision and Values**

Our **vision** as a Trust is to be the healthcare provider of first choice for the people of East Sussex. Our mission is to provide a wide range of safe and high quality healthcare, delivered by a skilled and caring workforce, committed to putting people first and striving for excellence.

Our Trust values were developed by staff and launched in August 2014, they are -

**Respect and compassion**

We care about acting with kindness. We want our staff, patients and local people to have a positive experience of us.

**Engagement and involvement**

We care about involving people in our planning and decision-making. We want patients, staff and the public to help us to shape the delivery of high quality and safe care.

**Improvement and development**

We care about striving to be the best. We want to continue to improve our services and make the best use of our people and resources for the benefit of our patients.

**Working together**

We care about building on everyone’s strengths. We develop strong teams and partnerships to benefit local people.

During 15/16 we have worked to embed the values in a number of ways. For existing staff our Director of Human Resources and Chairman wrote to all staff reminding them how and why our values have been developed and why they are important to us. The values have been incorporated into our appraisal process so all staff have the opportunity to formally reflect on how they demonstrate the values in their everyday working life. Reminders of the values are embedded in documents across the Trust.

We have introduced bespoke programmes for leaders to support them in embedding the values in their teams. We have worked with specific teams to understand what the values mean to them as a group, and how they can demonstrate the values in their interactions with colleagues and the people who use our services.
For new or prospective staff we have reviewed the way we advertise our vacancies to include reference to the values. Many departments now use a values based recruitment process.

In the latest staff survey results 90% of respondents said they were aware of our values.

During 16/17 we will continue our mission to embed the values and bring them to life. Building on work undertaken in the previous year, there will be clearer links between the overall mission of the Trust, our strategic objectives and our values. To support this, we are undertaking a cultural review which links to the Trust values. This review will provide a powerful insight from our staff and help us to understand what steps need to be taken to achieve our mission.

Events such as our International Nursing Day, Dignity Day and our Trust Annual Awards will continue to encourage staff to think about how they live the values and we will promote and share this information to other staff through our existing communication methods.
Staff Achievements and Successes

We celebrate the work of our staff in a number of ways:

- Each month we have a staff/team award for staff who have achieved something over and above their duties
- Our Trust Annual Awards celebrate a range of achievements of our staff. We had over 258 nominations from a range of services last year
- This year we have introduced a People’s Choice Award where the public can nominate an individual staff member/team
- Our Unsung Hero event in October celebrated the work of our support staff, and highlighted the contribution they make to the people who use our services
- Several of our staff were award winners or finalists at the Kent, Surrey and Sussex Unsung Heroes’ Awards
- Our ‘Community First’ celebration event in February shared the progress our Out of Hospitals Clinical Unit has made in transforming services as part of the Better Together programme
- All staff received a small token of thanks from the Trust Board for the work they have done during the year
- The Trust had two finalists in the Health Education, Kent, Surrey and Sussex Leadership Awards
- A team in the Out of Hospitals Clinical Unit arranged the first ever Sussex Trauma Conference
- We received over 1842 letters and cards complimenting the services we provide
- Two of our Senior Nurses were awarded Florence Nightingale Scholarships
- Our Medical Education team have worked diligently to improve our GMC Survey results for doctors in training. This resulted in a reduction from 35 to 19 red flags across all clinical specialty areas in 2015. There were also no red flags overall for the Trust. Junior Doctor Conversation’s meetings took place on each site in September and October 2015 to take this work forward.
- We celebrated the achievements of our Project Search interns and many have found employment as a result of participating in this project
Our Improvement Journey

**ESHT 2020** is the name we have given to our Trust Quality Improvement Programme. The programme sets out the journey we are taking and the tasks we need to complete to deliver our Quality Improvement Plan. Our plan addresses the challenges and issues highlighted in the Care Quality Commission reports for ESHT of March and September 2015. The Care Quality Commission highlighted a significant number of areas of concern and issues that we need to address. These areas for improvement are detailed in the reports and in our plan, and include how we will approach, organise and deliver improvement.

We know that our task is three-fold. We need to:

- Set the ambition for excellence and appropriate delivery standards for our work in each of the areas identified
- Work together to identify what we need to do; what we need to put in place; and where we may need support from others; to make sure we can **consistently** deliver to these standards and make them ‘how we do things around here’
- Make sure we can measure our progress and embed continuous learning and improvement as part of our approach

It is important that our staff take ownership of the services that they deliver to ensure that patients get the best experience they can.

During 16/17 we will further develop and publish a Quality Strategy which includes Patient Safety Improvements, to ensure we align improvements required following the Care Quality Commission (CQC) inspection with other trust improvement plans such as the Quality Account Priorities.

This strategy will detail the various projects and work streams and the outcome measures to assure the organisation of their effectiveness. It will also detail the process by which they will be monitored and reported internally, and to external stakeholders requiring assurance.

We will establish a system to further improve engagement and involvement of staff with improvement projects, as this was a required focus following our 2015/16 staff survey results. We will continue to monitor patient safety, patient experience and clinical effectiveness schemes across the organisation to identify and build on success, and to address areas requiring improvement.

It is also important to ensure that those who use our services are listened to, and their contribution valued. As a result of this our patient experience and engagement work will be further developed and strengthened in the coming year.
Purpose of a Quality Account

The Quality Account is an annual public report to share information on the quality and standards of the care and services we provide. It enables us to demonstrate the achievements we have made, and identify what our key priorities for improvement are in the forthcoming year.

Since 2010 all NHS Trusts are required to produce a Quality Account. The report incorporates mandatory statements and sections which cover areas such as our participation in research, clinical audits, a review of our quality performance indicators and what our regulator says about the services and care we provide.

How the report was produced

In addition to the mandatory elements of the Quality Account we have engaged with staff, patients, public, our commissioners and other stakeholders to ensure that the account gives an insight into the organisation and reflects the improvement priorities which are important and matter to us all.
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 Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 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 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; 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

30th June 2016

Chairman

30th June 2016

Chief Executive
Part 2 Priorities for Improvement and Statement of Assurance from the Board

Our Quality Improvement Priorities for 2016/17

We are developing a new Quality Strategy to detail the programme of work for quality improvement and measurement for the next three years. This will also describe systems for continuous improvement and engagement with staff in identifying and undertaking new improvement projects. Quality improvement is a constant process within the organisation and there are a vast number of improvement schemes both large and small across the trust. These can originate through learning following an incident or identification of a risk or from national or local audit or guidance. The following describes a sample of continuous improvement priorities and details the key priorities we will report on within 2016/17 Quality Account to demonstrate our commitment to enhance the care our patients receive.

Continuous Improvement Priorities:

Although this account identifies new priorities detailed below there are a number of on-going quality measures the organisation will continue to address. These are as follows:

- **Harm free Care**

  The Trust has a system in place for staff to report and investigate clinical incidents; information is then analysed and reported to the Board to identify trends, themes and reporting numbers. Examples of an incident would be a patient fall resulting in an injury. In addition the NHS Patient Safety Thermometer is used where 1 day every month a trust wide audit is undertaken on all patients on each ward to identify if they have suffered one or more harms from:
  
  - Hospital acquired pressure ulcers
  - Catheter associated urinary tract infections
  - Avoidable venous thromboembolism (VTE)

  It distinguishes between harms that have occurred prior to admission and those that have occurred since admission, known as ‘new harms’. The Safety Thermometer audit during 2015/16 found 94% of our patients received harm free care.

  **Our Goal:** Our ultimate aim is to provide 100% harm free care to all our patients, our target towards achieving this for 2016/17 NHS Patient Safety Thermometer is 96% harm free care.

- **Reducing mortality**

  We will continue to monitor our mortality data and ensure through our review of deaths we identify and act on
trends or themes in care provision. To ensure we provide safe and effective care that also relates to mortality we will continue to progress with care bundles such as Stroke, Sepsis and Acute Kidney Injury to ensure the pathway is robust and measured effectively for compliance.

Currently our statistical mortality data for the organisation is outside the normal range.

Our Goal: To be within the national range for Summary Hospital Mortality Indicator (SHMI)

➢ Improving patient experience

Understanding and acting on patient feedback is essential for the organisation to identify areas to improve care. We have systems in place to capture patient experience information however we can increase the quantity of feedback internally through the Friends and Family Test and inpatient questionnaires.

Our Goal: To increase patient feedback response rates for Accident and Emergency, In-patient and Out-patient areas. To increase the % of patients who would recommend ESHT.

➢ Duty of Candour

Saying sorry when things go wrong is important for the patient, their family and carers as well as supporting the trust to learn from and improve patient safety. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm.

The trust is committed to being open and transparent when things go wrong and during 2015/16 we have established a system to ensure this is adhered to. We will continue to audit and improve this process during 2016/17.

Our Goal: To ensure we are open and transparent for all incidents where our poor care resulted in moderate or severe harm.

➢ Sign up to Safety Campaign

Whilst developing our Quality Strategy we will review our current pledges within the Sign up to Safety Campaign to ensure they are aligned with our overall priorities and goals.

In addition to our continuous improvements the following six initiatives have been determined as the key Quality Improvement Priorities (QIP) for 2016/17 which are aligned to the overarching objectives of Improving Patient Experience, Patient Safety and Clinical Effectiveness.
Patient Experience

- Improve the availability and timeliness of outpatient appointments
- Improve end of life care
- Understand the scale of the transport issues between sites experienced by our patients and staff

Clinical Effectiveness

- Improve the recognition and treatment of Sepsis

Patient Safety

- Improve medicine management
- Reduce the transfer of patients for non-clinical reasons between our wards
Priority 1:

Improving the availability and timeliness of outpatient appointments

Why we have chosen this priority

A priority for the Trust is to ensure patients are seen in a timely manner. Our patients have raised concerns regarding the quality and timeliness of appointment letters. Some patients are also keen to use alternative media for example, texts/email to manage their outpatient appointment(s).

Effective communication with our patients regarding their outpatient appointment(s) is paramount to ensure they are able to attend and have adequate notice. This in turn enables the Trust to maximise utilisation of clinics and reduce Did Not Attend (DNA) rates, reducing the waiting time to receive care and treatment.

What we are going to do

- Outpatient Appointment Letters: Revise these letters sent to patients in order that the Trust provides consistent and clear information relevant to the appointment. This will be achieved through a working group, which will include patient representatives.

- Reminder Service: Continue to develop our call reminder service at seven days and 24 hours prior to the appointment, including personal phone call reminders for patients over 70. This will provide patients with a reminder of their forthcoming appointment. Current feedback suggests this is useful to patients and there is good evidence that DNA rates are reducing.

- Electronic Referral: The national Electronic Referral Service (ERS) is being phased into use across East Sussex GP practices and hospitals. The facility allows for electronic transfer of information and provides patients and their GPs with accurate information regarding the waiting times. In addition patients can select the most convenient appointment date and time within the available clinics.
What will success look like?

- There will be no complaints regarding the quality of outpatient letters following the review
- The Trust DNA rate will reduce by at least 1%, increasing the number of appointments actually used
- Alternative media will be available to patients to manage their outpatient booking

How will we monitor progress?

The weekly clinical administration performance dashboard will monitor DNA rates and patient complaints. The Clinical Administration group will monitor the rollout and utilisation of this service.

There will be a lead assigned for each priority and where required an existing or new working group or committee established to manage and monitor the work. A progress report will be provided quarterly to the Quality and Standards Committee.

Priority 2:

Improving End of Life Care

Why we have chosen this priority?

There is only one chance for ESHT services to provide the best care for a person and those most important to them at the end stage of their life. End of life can be described as being the last 12 months of a person’s life, however in the last days and hours of life it is even more crucial that we “get it right”. There were a number of key publications in 2015, the recommendations of which will form the basis of our overarching end of life care strategy. In addition to our own CQC report and the NICE guidelines, there is a national framework for local action called *Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020*. Success can be measured by linking outcomes to these ambitions.

For our quality improvement work for 2016/2017 we have chosen to focus on care in the last days and hours of life so that we can be sure that the patient’s symptoms will be controlled and that those most important to them are also supported and cared for. We also want to ensure that every person is treated with privacy, dignity and compassion.
What we are going to do?

The improvements that we hope to make in the year 2016/2017 will be linked to some of the 6 ambitions for palliative and end of life care.

- Set up a process for identification of patients who are in the last days or hours of life in both the community and acute settings
- Develop an easily identifiable document that can be individualised to encompass the patient’s wishes
- Review the training programme for end of life care to ensure that the right staff receive the right training that will enable them to deliver the right care
- Monitor delivery of that training so that there is measurable progress throughout the year
- Develop key quality indicators for end of life care and monitor compliance on a monthly basis

Develop a process for understanding the patients’ experience of end of life care.

What will success look like?

- We will know who is in the last days or hours of life so that support and care can be given (related to Ambition 4)
- 100% individuals who are in the last days or hours of life will have a clearly identifiable individualised plan of care (related to Ambitions 1 and 3)
- 80% of ESHT staff will have received training in the key aspects of good end of life care (related to Ambition 5)
- Understand peoples’ views in relation to their experience of ESHT services

How will we monitor progress?

We will monitor progress of our planned improvements and measures of success through monthly End of Life Care team meetings. This will be monitored quarterly by the Quality and Standards Committee which reports progress to the Trust Board. In addition to this QIP we will also be implementing and monitoring actions and outcomes as part of the wider end of life strategy which includes working with key stakeholders across East Sussex.
Specifically we will monitor:

- End of Life Care training compliance
- Compliance with completion of individualised care plans
- Compliance with quality indicators for end of life care
- Feedback from relatives and carers in relation to end of life care

**Priority 3:**

*Understand the scale of the transport issues between sites experienced by our patients and staff*

**Why we have chosen this priority**

The lack of available transport between sites has been raised by patients and staff at a number of forums and through letters to the Chief Executive, therefore the trust has committed to scope the scale of the problem to enable future planning and decision making.

**What we are going to do?**

We will develop a set of actions following a series of travel surveys which were undertaken in October 2015 where 2,428 patients/visitors were interviewed, which may include further work with our patients and staff.

We will work with our commissioners, local transport providers and volunteer’s services to improve access to the hospitals.

**What will success look like?**

- A completed report detailing the above information with analysis of findings presented to board.
- Development of a healthy transport improvement plan
How will we monitor progress?

There will be a lead assigned for each priority and where required an existing or new working group or committee established to manage and monitor the work. A progress report will be provided quarterly to the Quality and Standards Committee.

Priority 4:

Improving medicines management

Why we have chosen this priority?

Medicines Management within the organisation was highlighted by the CQC as a cause of concern. Much work has been undertaken to improve this with strengthened governance processes around medicines management at a ward or department level and a more integrated pharmacy service. Key Performance Indicators and a medicines optimisation dashboard are under development by the Medicines Management Committee to provide oversight of this work. As part of this work three key areas have been identified within patient safety that can have a positive impact on improving patient outcomes and experience.

These are:

- A focus on reducing omitted or delayed doses of medicines
- Improving the extent of Medicines Reconciliation on admission into hospital
- Improving the accuracy of information provided about medicines during transfers of care to another provider (at discharge)

Omitted and delayed doses of medicines can occur for a number of reasons. Some of these are legitimate clinical reasons; however there are two, potentially three markers which may indicate poor care these are:

- Doses that are not signed for (undocumented), which could lead to overdose or omission of a critical medicine
- Doses that are not administered due to medicine unavailability
- Potentially doses that are not administered because a patient is absent or route not available
Obtaining an accurate medication history and undertaking **Medicines Reconciliation** on a patient’s admission to hospital is an important step in their care. It underpins ongoing treatment and ensures accurate information is provided during transfers between care settings for example the reasons for medicines being stopped. Additionally NICE recommends that a pharmacist is involved in medicines reconciliation as soon as possible after admission.

During an admission to hospital medicines may change as a result of review by clinicians in the context of their care. It is therefore essential that if the benefits of the changes are to be seen by the patient, **accurate information about medicine changes at the transfer of care** must be given to the new provider (GP or other care settings). Having pharmacist involvement during the transfer of care ensures the information is safe, accurate and a true reflection of the current medication record.

**What we are going to do?**

1) Reduce the number of doses of critical medicines either undocumented or not administered due to supply issues by:

- Measurement, challenge and escalation of undocumented or repeated non-administration of medicines
- Reviewing ward or department stock lists
- Improving the ordering and supply process of medicines through increased adoption of electronic cabinets and a review of pharmacy distribution
- Providing an effective medicines supply service through a review of current pharmacy service provision over 5.5 days and looking to move to a future 7-day service model.
• Ensuring medicines can be effectively obtained outside of pharmacy opening hours through remote dispensing and improved access to the on-call pharmacist

2) Improve the extent of pharmacy led medication history taking and medicines reconciliation on admission to hospital by:

• Restructuring within pharmacy to provide an integrated clinical team
• Reviewing service specifications to wards and ensuring admission areas have a sustainable and comprehensive clinical pharmacy service

3) Increase the number of electronic discharge summaries authorised by clinical pharmacists by:

• Increasing the uptake of the ICE discharge system and adoption of the ‘submit to pharmacy’ button

What will success look like?

1) Not more than 2% of doses of critical medicines are either undocumented or not administered due to supply issues in the population sample

2) 75% of patients have their medicines reconciled by pharmacy within 24 hours in the population sample

3) All discharge letters from acute medical wards via the ICE discharge summary system are submitted to pharmacy for review and are checked for safety and accuracy by a pharmacist prior to discharge.

How will we monitor progress?

Omitted and delayed doses of critical medicines and medicines reconciliation are measured through the Medication Safety Thermometer. The Medication Safety Thermometer is an audit of 5 patients on each ward area every month. Pharmacist involvement in discharge summary approval is a metric that can be reported with adoption of a bespoke report organised through the ICE discharge team. These metrics will form part of the medicines optimisation dashboard that is generated by the medicines management committee and will be escalated through the quality and standards committee for inclusion into a board level report.
Priority 5:

Reduce the transfer of patients for non-clinical reasons between our wards

Why we have chosen this priority

Ward moves can have an adverse impact on patient experience and a change of environment for patients can lead to confusion and an increased risk of falls.

What we are going to do?

- Comprehensive review of current practice is required to ensure that ward moves are minimised
- Introduction of standard procedures for transfers
- Monitoring ward moves between 10pm and 7am

Review themes and hot spots and implement actions
What will success look like?

- Reduction in monthly ward moves
- Reduction in patient safety incidents related to transfer

How will we monitor progress?

There will be a lead assigned for each priority and where required an existing or new working group or committee established to manage and monitor the work. A progress report will be provided quarterly to the Quality and Standards Committee.

Priority 6:

Improving the recognition and treatment of sepsis

Why we have chosen this priority

Sepsis is a common and potentially life threatening condition triggered by an infection. If affects patients of all ages, but is most common in the elderly and very young. In 2014 approximately 123,000 people in England suffered from Sepsis with an estimate of around 37,000 deaths per year associated with it.

When a patient has sepsis the body’s immune system goes into overdrive, setting off a series of widespread inflammation, swelling and blood clotting which can lead to decreased blood pressure, and therefore reduced blood supply to vital organs starving them of oxygen. If not recognised and treated quickly sepsis can lead to multiple organ failure and death.

We have undertaken actions to improve Sepsis recognition and treatment at ESHT however we know we can do more to improve the outcomes for our patients.

What we are going to do?

- Unify and continue to drive screening for sepsis in our acute hospitals
- Implement and embed a sepsis care bundle and develop supporting protocols and policies
- Develop robust monitoring of measurement
- Develop an educational programme and tools for Junior doctors and Nurses
What will success look like?

- Effective screening process across the organisation
- The Sepsis Care bundle is followed for all identified sepsis cases
- Monitoring process in place to provide assurance on compliance to the above measures and feedback to our staff

How will we monitor progress?

There will be a lead assigned for each priority and where required an existing or new working group or committee established to manage and monitor the work. A progress report will be provided quarterly to the Quality and Standards Committee.
Statement of assurance from the board

Review of Services
During 2015/16 the East Sussex Healthcare NHS Trust provided and/or sub-contracted 65 NHS services.
The East Sussex Healthcare NHS Trust has reviewed all the data available to them on the quality of care in 65 of these NHS services.
The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by the East Sussex Healthcare NHS Trust for 2015/16

National Clinical Audit and National Confidential Enquiries
The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust was eligible to participate in during 2015/16 are as follows:

### National Confidential Enquiries (NCE)

<table>
<thead>
<tr>
<th>National Confidential Enquiries</th>
<th>ESHT Eligible</th>
<th>ESHT Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Maternal infant and perinatal mortality (MBRRACE-UK)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>2 Acute Pancreatitis (NCEPOD)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>3 Physical and Mental Healthcare (NCEPOD)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>4 Non-invasive Ventilation (NCEPOD)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>5 Young Peoples Mental Health (NCEPOD)</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

- The Trust participated in all 5 (100%) of applicable National Confidential Enquiries in 2015-2016
## National Clinical Audit

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>ESHT Eligible</th>
<th>ESHT Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Neonatal Intensive and Special Care (NNAP)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>2 Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD) and National Inpatient Falls Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>3 Adult Critical Care Audit (Case mix programme - ICNARC)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>4 National Joint Registry (NJR)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>5 National Bowel Cancer Audit Programme (NBOCAP)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>6 Major Trauma</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>7 Coronary Angioplasty (BCIS) (Adult Cardiac Interventions)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>8 Cardiac Rhythm Management (CRM) (PPM, ICD and EPS National Audits)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>9 National Heart Failure Audit (HF)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>10 Acute Coronary Syndrome / Acute MI Audit (MINAP)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>11 Cardiac Arrest Audit (NCAA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>12 National Inflammatory Bowel Disease Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>13 National Prostate Cancer Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>14 Rheumatoid &amp; Early Inflammatory Arthritis National Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>15 National Vascular Registry (NVR)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>16 National Emergency Laparotomy Audit (NELA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>17 National Paediatric Diabetes Audit (NPDA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>18 National Pregnancy in Diabetes (NPID) Audit</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>19 National Inpatient Diabetes Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>20 National Diabetes Foot Care Audit (NDFA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>21 National Audit of Intermediate Care</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>22 Stroke National Audit (SSNAP)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>23 National Lung Cancer Audit (NLCA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>24 National Oesophago-Gastric Cancer Audit (NOGCA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>25 VTE risk in lower limb immobilisation (CEM)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>26 Elective Surgery (National PROMs Programme)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>27 National Diabetes Adult Audit</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>28 Paediatric Asthma Audit (BTS)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>29 Procedural Sedation in Adults (CEM)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>No.</td>
<td>Audit Description</td>
<td>Participation Status</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>30</td>
<td>Vital signs in children (CEM)</td>
<td>Y</td>
</tr>
<tr>
<td>31</td>
<td>National Comparative Audit of Blood Transfusion: Use of blood in haematology</td>
<td>Y</td>
</tr>
<tr>
<td>32</td>
<td>National comparative audit of blood transfusion: Audit of patient blood management in scheduled surgery</td>
<td>Y</td>
</tr>
<tr>
<td>33</td>
<td>Audit of the use of blood in Lower GI bleeding</td>
<td>Y, N</td>
</tr>
<tr>
<td>34</td>
<td>Chronic Obstructive Pulmonary Disease (BTS / RCP)</td>
<td>Y</td>
</tr>
<tr>
<td>35</td>
<td>Emergency use of Oxygen (BTS)</td>
<td>Y</td>
</tr>
<tr>
<td>36</td>
<td>National Complicated Diverticulitis Audit (CAD)</td>
<td>Y</td>
</tr>
<tr>
<td>37</td>
<td>National Ophthalmology Audit</td>
<td>Y</td>
</tr>
<tr>
<td>38</td>
<td>UK Parkinson’s Disease Audit</td>
<td>Y</td>
</tr>
</tbody>
</table>

The Trust participated in 35 (92%) of all applicable National Clinical Audits in 2015-2016

- **National Adults Diabetes Audit - Reason for non-participation by ESHT**

  The Trust was unable to participate in the 2015-2016 National Adult Diabetes Audit as the required specialist data collection software is currently unavailable for use across the organisation. Two software programmes have been identified; discussions are taking place within the Cardio Vascular Clinical Unit to identify which would be the most suitable option for ESHT to purchase.

- **National Pregnancy in Diabetes Audit - Reason for non-participation by ESHT**

  The Trust did not participate in the 2015/2016 round of the audit as the project lead was unable to secure the resources required (time, administrative support). The Trust is however participating in the 2016/17 round of the audit. Progress with this national audit will be closely monitored and any concerns will be flagged up immediately to the Associate Medical Director (Quality) via the Clinical Effectiveness Overview Group (CEOG). The deadline for data submission for 2016 will be early 2017.
Audit of the use of blood in Lower GI bleeding - Reason for non-participation by ESHT

The Trust did not participate in this audit as the project lead was unable to secure the resources required (time, administrative support).

NCEPOD issued two reports in 2015/2016:

‘Gastrointestinal Haemorrhage: Time to Get Control?’ was published in July 2015.
21 recommendations were made by NCEPOD; the Trust is in the process of reviewing these recommendations against current process to assess compliance. Remedial action plans will be developed where non-compliance has been identified.

Sepsis: Just Say Sepsis!’ was published in November 2015.
18 recommendations were made by NCEPOD; the Trust is in the process of reviewing these recommendations against current process to assess compliance. Remedial action plans will be developed where non-compliance has been identified.

MBRRACE-UK: Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (the current definitions are as follows)

The Women’s Health unit continues to report:

- All late fetal losses between 22+0-23+6 weeks gestation.
- Terminations of pregnancy – resulting in a pregnancy outcome from 22+0 weeks gestation onwards.
- Stillbirths - the baby is delivered showing no signs of life after 24+0 of pregnancy
- Neonatal deaths - death of a live born baby (born at 20 weeks gestation of pregnancy or later OR 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after 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 2015-16 include:

- Amniotic Fluid Embolism (0 cases reported)
- Anaphylaxis in pregnancy (1 case reported)
- Aspiration in Pregnancy (0 cases reported)
- Breast Cancer in Pregnancy (new Q3) (1 case reported)
- Cystic fibrosis in pregnancy (new Q1) (0 cases reported)
- Epidural Haematoma or Abscess Study (0 cases reported)
- Epilepsy in pregnancy (new Q3) (0 cases reported)
- Gastric Bypass Surgery in Pregnancy (0 cases reported)
- Pulmonary Embolism in Pregnancy (1 case reported)
- Vasa Praevia (1 case reported)
The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, and for which data collection was completed during 2015-16, 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>National inpatient Diabetes Audit</td>
<td>45 cases CONQ 57 cases EDGH</td>
<td>A minimum case number was not specified for submission</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (Pulmonary Rehab)</td>
<td>210 cases ESHT</td>
<td>A minimum case number was not specified for submission</td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td>176 cases across the Trust</td>
<td>100% - All required information submitted (all patients who met the criteria were included)</td>
</tr>
<tr>
<td>Emergency use of Oxygen (BTS)</td>
<td>7 cases CONQ 15 cases EDGH</td>
<td>A minimum case number was not specified for submission</td>
</tr>
<tr>
<td>Paediatric Asthma (BTS)</td>
<td>30 cases CONQ</td>
<td>100% CONQ (20 cases requested)</td>
</tr>
<tr>
<td>National Inpatient Falls Audit</td>
<td>24 cases CONQ 30 cases EDGH</td>
<td>80% CONQ 100% EDGH (30 cases requested per site)</td>
</tr>
<tr>
<td>UK Parkinson’s Disease Audit</td>
<td>11 cases OT, 11 cases SALT 36 cases Physiotherapy 22 cases EDGH Elderly / Neurology 0 cases CONQ Elderly / Neurology</td>
<td>100% OT, 100% SALT 100% Physiotherapy 10 cases requested 100% EDGH Elderly / Neurology 0% CONQ Elderly / Neurology 20 cases requested</td>
</tr>
<tr>
<td>Procedural Sedation in Adults (CEM)</td>
<td>83 cases CONQ 34 cases EDGH</td>
<td>100% - All required information submitted (all patients who met the criteria were included)</td>
</tr>
</tbody>
</table>
Audit report(s) from 39 national audit teams were published in 2015/16. The results of 100% of national clinical audits were reviewed by the provider in 2015-16. Three of these national clinical audits/confidential enquiries are detailed below with the associated actions that East Sussex Healthcare NHS Trust intends to take to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>CONQ Cases</th>
<th>EDGH Cases</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs in Children (CEM)</td>
<td>100</td>
<td>100</td>
<td>100% CONQ 100% EDGH (100 cases requested per site)</td>
</tr>
<tr>
<td>VTE risk in lower limb immobilisation (CEM)</td>
<td>89</td>
<td>100</td>
<td>100% All required information submitted (all patients who met the criteria were included)</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion: Audit of patient blood management in scheduled surgery</td>
<td>22</td>
<td>12</td>
<td>49% CONQ 27% EDGH (45 cases requested per site)</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion: Use of blood in haematology</td>
<td>25</td>
<td>33</td>
<td>63% CONQ 83% EDGH (40 cases requested per site)</td>
</tr>
<tr>
<td>Acute Pancreatitis – NCEPOD</td>
<td>5 Clinical Questionnaires 9 Case Notes 2 Organisational Questionnaires</td>
<td></td>
<td>9 cases selected: 56% Clinical Questionnaires 100% Case Notes 100% Organisational Questionnaires</td>
</tr>
<tr>
<td>Sepsis – NCEPOD</td>
<td>7 Clinical Questionnaires 7 Case Notes 7 Organisational Questionnaires</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Gastrointestinal Haemorrhage – NCEPOD</td>
<td>9 Clinical Questionnaires 9 Case Notes 4 Organisational Questionnaires</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>
Sepsis – Just say Sepsis (NCEPOD – published November 2015)

This NCEPOD study addresses a huge subject, which sets it aside from those of our reports that have focused on Cinderella topics, parts of the NHS that have been previously overlooked. Sepsis, by which we mean the systemic inflammatory response to microbial infection, causing damage to organs then shock and ultimately death is a common problem: the international prevalence is estimated at 300 per 100,000, suggesting that there are around 200,000 cases a year in the UK alone. To put this into the context of our recent studies, there are around 5,500 lower limb amputations, a similar number of subarachnoid haemorrhages, 8,000 or so aortic aneurysms, 9,000 deaths from alcohol-related liver disease, 10,000 tracheostomies and 11,600 bariatric procedures performed per year. Sepsis eclipses even the 90,000 patients treated for gastrointestinal bleeding. Sepsis is important because it is a major cause of avoidable death in our hospitals.

A number of the identified recommendations and actions are listed below:
1. A Trust Sepsis screening tool has been compiled and is in print - this will be placed in the inpatient documentation to be completed for all patients attending the Trust for treatment. This also forms part of the CQUIN audit - notes are being audited weekly.
2. A Clinical Lead for sepsis has been appointed at the Conquest, vacant post at the EDGH – plan to fill this post by the end of June 2016.
3. Trusts/Health Boards should use a standardised sepsis proforma to aid the identification, coding, treatment and ongoing management of patients with sepsis – the Trust proforma has been designed and we are currently waiting for the integrated proforma to be ratified, this should be completed by the end of June 2016.
4. On arrival in the Emergency Department a full set of vital signs (as stated in the Royal College of Emergency Medicine standards for sepsis and septic shock) should be undertaken - A sepsis screening tool is in use in the Emergency Departments already. SECAMB also have a screening tool which they use.
5. A clinical audit is required to ensure that all acutely ill patients are seen by a Consultant within 14 hours of admission, available 24/7, to identify compliance levels and initiate any necessary improvement – June 2016.

National Audit for End of Life Care; Dying in Hospital (published March 2016)

ESHT participated in both National End of Life Care Audits undertaken in 2013 and 2015. This latest report was published on the 31st March 2016. The changes since 2013 included the phasing out of the Liverpool Care Pathway, this was recommended by the 2013 Neuberger review in its report More care, less pathway. There was significant concern in some sections of the palliative care community that the gap left after the Liverpool Care Pathway’s withdrawal could result in a degradation of services to people in the last days and hours of life. This report demonstrates that, far from deterioration, comparing the 2013 and 2015 audits, there have been broad improvements in nearly all aspects of care of the dying in hospitals within those Trusts who participated.
A number of the identified recommendations and actions are listed below:

1. There is now senior nurse corporate leadership allocated to assist in the co-ordination, facilitation and implementation of the Trust End of Life Care Action Plan.

2. Progress against the Trust Quality Improvement Plan regarding End of Life Care will now be reported on weekly through the Quality Improvement Group.

3. A Planning Together policy has now been developed to support shared decision making between the clinician, the patient and those most important to them.

4. Monthly End of Life Care Team meetings to occur to ensure that service developments and implementation of the Trust End of Life Care Action Plan continue at pace whilst continuing to support the Specialist Palliative Care Team until they are fully established.

5. The recommendations from the National End of Life Care Audit – Dying in Hospital to be incorporated into the Trust’s End of Life Care Action Plan.

6. Ensure that proper and complete information about patients is available to all those involved in their end of life care by taking account of the different paper and electronic systems in use - A process has been agreed whereby plans of care for patients at the end of life stage are kept as a hard copy in the patient's home so that other agencies e.g. hospice services are communicated with. Preferred Priorities of Care documents are now being uploaded onto SECAMB's 'IBIS' electronic system. Read only access to Somerset has been offered to the community nursing teams so that continuity of information is ensured, this will now be implemented. Further work has been done with both of the local hospices to ensure that care plans are available to all in the patient's home.

7. Individual ward areas have utilised space to create facilities for privacy, the Bereavement office also have a newly decorated room for bereaved families to meet with the team. A scoping exercise has taken place to determine additional space requirement and refurbishment of accommodation has been completed so that carers may stay overnight. Funding was provided from Charitable Funds. Funding has also been secured for “Comfort Packs” for relatives and friends of patients who are dying in the acute Trust but do not want to leave the bedside – this recommendation has not yet been implemented and progress will be monitored by the Trust’s Action Plan.

**National Heart Failure Audit / Cardiac Rhythm Management**

- 50/50 nurses have been recruited - these are nurses whose role covers both an inpatient and community patient caseload so there is better pathway flow for patients in the first two weeks post discharge from an acute setting.

- Heart failure devices specialist nurse at the EDGH – we have two members of staff whose remit includes devices. This is a quality improvement; to ensure that a heart failure patient’s pre-device insertion and post device insertion has excellent continuation of care.

- Currently there is a one year contract for additional administrative support for Cardiac Rehabilitation and Heart Failure teams to help save time so that their clinical workload is priority.
Local Clinical Audit

Local clinical audits are undertaken by teams and specialities in response to issues at a local level, they are generally related to a service, patient pathway, procedure or operation or equipment.

56 local clinical audit reports were reviewed by the provider in 2015-16. Five of these local clinical audits are detailed below with the associated actions that East Sussex Healthcare NHS Trust intends to take to improve the quality of healthcare provided:

Examples of Improvement resulting from local clinical audit

Audit 3507 - An audit of the quality of child protection referrals to East Sussex Children’s Social Care (CSC) for children identified to be at risk of significant harm by health service staff.

Background / Aims: The aim of this audit was to critically analyse the quality of referrals made to the Children’s Social Care (CSC) department by ESHT staff. If the quality of referrals is consistently high there is the potential to maximise the likelihood of children at risk of significant harm getting the response necessary to safeguard them, increase practitioner skills in this area, increase practitioner satisfaction and reduce the time spent by ESHT staff in seeking additional information to inform judgements.

Lessons Learnt and recommendations made
- The departments concerned, with the support of the Safeguarding team, must ensure that only the current documentation is available to staff.
- Where possible staff should see it as their responsibility to seek out all the information asked for on the form unless to do so puts a child or young person at greater risk.
- It should be an expectation that referrals are typewritten to aid the reader.
- Training, particularly for staff working directly with children, needs to include the use of the Continuum of Need (CoN) language to describe and assess risk.
- Further consideration should be given to formalising the role of the safeguarding teams as a ‘sounding board’ prior to referrals being made. For those assessed at level 1 & 2 on the CoN it would seem likely that they were inappropriate referrals.
- Further work should be undertaken in partnership with East Sussex Social Care to understand the relationship between the telephone discussion and the submission of a Statement of Referral. In this small study just under a third resulted in assessment or intervention.

Audit 3559 - Traumatic Ankle Pain Radiograph Requests Adequacy of clinical information with reference to the Ottawa ankle rules

Background / Aims: To review the necessity of ankle radiographs, measuring compliance against the Ottawa Ankle rules in the Eastbourne Hospital A&E department. The original study reported that Ottawa ankle rules are 100% sensitive
and reduced the number of ankle x-rays by 36%.

The Ottawa ankle rules state that ankle radiographs are only required if there is malleolar pain and bone tenderness of the posterior distal tibia/medial malleolus tip, the posterior distal fibula/lateral malleolus tip or an inability to weight bear both immediately and in the Emergency Department for four steps.

The aim of this audit is to reduce the number of unnecessary radiographs, reducing patient exposure to radiation and cost saving. If found that unnecessary radiographs are performed, education of the requestors will be initiated to reduce these numbers.

**Lessons Learnt and recommendations made**

Continuous reminders to clinical teams of the Ottawa ankle rules is necessary as improved knowledge will reduce the amount of inappropriately requested traumatic ankle X-Rays, without incurring any unnecessary harm to the patients by missing fracture (a good knowledge of the Rules can provide clinicians with the confidence to make good assessments).

Improved compliance to the Ottawa Rules will save the Trust money and clinical time.

- Further awareness of the Ottawa ankle rules is required for the A&E department - cyclical teaching and reminders to be introduced in keeping with rotation of A&E doctors.
- Further audit cycles to be conducted to ensure and monitor compliance, re-audits will be placed on the Trust’s Clinical Audit Forward Plan and progress monitored by the Clinical Effectiveness team.

**Audit 3650 - Re-audit of liver biopsy adequacy and Audit of post-procedure complications following non-targeted liver biopsy.**

**Background / Aims:** Audit of Liver Biopsy Adequacy (Audit 3200), showed that successful use of Temno needle systems to achieve adequate percutaneous liver biopsy was operator dependent, whereas the Biopince needle system reliably yielded adequate liver biopsies for all operators. It was recommended that Biopince needles were to be used routinely and that routine reporting of needle type and gauge should be recorded on the Picture Archiving and Communication System (PACS). Concern was raised at the Radiology Audit meeting that taking larger liver biopsies may result in an increase in complication rates.

The aim was to re-audit the uptake of the recommendation to routinely use Biopince needles for percutaneous liver biopsy. All non-targeted medical liver biopsies taken over a 6 month period would be assessed for adequacy and identification of post procedure complications.
Lessons Learnt and recommendations made
The routine reporting of the number of portal tracts identified in liver core biopsies in addition to core length acts as an important feedback to interventional radiologists. Where portal tracts are disrupted by disease processes, special stains can be used to provide an estimated number.
Adequate liver biopsy may be ensured through the routine use of percutaneous liver biopsy needle systems such as Biopince. The sustained improvement in liver biopsy adequacy has not led to increased procedure related complications.

1. Routine reporting of portal tract number as part of assessment of liver biopsy adequacy.
2. Routine use of Interventional Radiology Care Pathway for inpatient and outpatient procedures.
3. Ongoing monitoring for procedure related complications.
4. Consideration of re-audit of liver biopsy adequacy and procedure related complications.

Audit 3703 - Removal of wisdom teeth, compliance with NICE guidelines

Background / Aims: An external audit performed in 1995 indicated that between 22% and 44% of surgical cases involved the prophylactic removal of pathology free third molars. NICE concluded that there was no reliable research evidence to support a health benefit to patients from prophylactic removal of wisdom teeth.
Every surgical removal of an impacted 3rd molar carries a risk to the patient, including temporary or permanent nerve damage, alveolar osteitis, infection and haemorrhage as well as temporary local swelling, pain and restricted mouth opening. Considering all these factors, NICE published new guidance on the topic in 2000.
The aim of this audit was to assess department compliance of lower wisdom teeth extractions against the NICE guideline.

Lessons Learnt and recommendations made
This audit identified a 98.6% compliance rate to the NICE guidance.
- To ensure thorough documentation in case notes – specifying clear reasons for extraction.
- To ensure all radiographs are reported.
- To undertake a re-audit in 2016/2017 – this will be placed on the Trust’s Clinical Audit Forward Plan and progress monitored by the Clinical Effectiveness team.

Audit 3762 - Audit of compliance with the Trust MRSA policy for the management of emergency admissions with a known history of MRSA

Background / Aims: Post Infection Reviews (PIRs) of recent cases of Meticillin resistant staphylococcus aureus (MRSA) bacteraemia (blood stream infection) identified non-compliances with the Trust MRSA policy when managing patients with
a known previous history of MRSA. The aim of this audit was to seek assurance of improved compliance with the management of patients with a known history of MRSA by measuring compliance against the following elements within the Trust MRSA policy.

<table>
<thead>
<tr>
<th>Lessons Learnt and recommendations made</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is limited evidence to demonstrate compliance with the Trust policy for the management of patients with a known history of MRSA (i.e. those most at risk of developing harm from MRSA whilst receiving healthcare).</td>
</tr>
<tr>
<td>Highest compliance was achieved with element 1 - 90% of the patients were screened within 24hrs of admission.</td>
</tr>
<tr>
<td>Lowest compliance was achieved with element 5 – 2.5% (1 patient) was found to have documented evidence of daily body washes.</td>
</tr>
<tr>
<td>1. Significant improvement is required to demonstrate compliance with the Trust’s MRSA policy. Until this is achieved there is a risk of patient harm due to further cases of MRSA bacteraemia (blood stream infection) amongst patients with a history of MRSA.</td>
</tr>
<tr>
<td>2. Audit results and recommendations to be cascaded widely across the acute Clinical Units for action.</td>
</tr>
<tr>
<td>3. The processes and procedures for rapidly identifying patients with a history of MRSA to clinical staff require review and improvement.</td>
</tr>
<tr>
<td>4. Evidence of improved compliance is required to demonstrate assurance and reduce risk of patient harm.</td>
</tr>
<tr>
<td>5. A standardised sticker for the treatment with topical Naseptin as an alternative to Mupirocin is required to promote compliance when there are supply issues with Mupirocin (first line treatment).</td>
</tr>
</tbody>
</table>

The Trust policy for the Control of MRSA in hospital requires revision to clarify the importance of screening all potential sites rather than just the essential nasal swab.
Commissioning for Quality and Innovation (CQUIN)

East Sussex Healthcare in addition to all NHS Trusts are required to make a proportion of their income conditional on achieving quality improvement and innovation goals, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The baseline value for CQUIN is 2.5% of contract values which is approximately £7.1 million. If milestones and goals are not fully achieved a proportion of CQUIN monies would be withheld.

During 2015/16 East Sussex Healthcare NHS Trust undertook four national schemes, nine locally agreed schemes with commissioners and eight specialised service schemes agreed with NHS England.

Further details of the agreed goals for these schemes for 15/16 and the following 12 month period are available on request from the Trust.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Value</th>
<th>Milestones Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National CQUIN</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Physical Health – Acute Kidney Injury</td>
<td>£716,766</td>
<td>Achieved</td>
</tr>
<tr>
<td>2a. Sepsis Screening</td>
<td>£358,383</td>
<td>Partial achievement</td>
</tr>
<tr>
<td>2b. Antibiotic administration</td>
<td>£358,383</td>
<td>Partial achievement</td>
</tr>
<tr>
<td>3a. Dementia FAIRI</td>
<td>£238,684</td>
<td>Achieved</td>
</tr>
<tr>
<td>3b. Dementia Training</td>
<td>£238,682</td>
<td>Achieved</td>
</tr>
<tr>
<td>3c. Dementia Carers Survey &amp; Support</td>
<td>£238,682</td>
<td>Achieved</td>
</tr>
<tr>
<td>4. Reducing avoidable emergency admissions</td>
<td>£1,433,530</td>
<td>Partial achievement</td>
</tr>
<tr>
<td><strong>Locally agreed CQUINs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Maintenance of GP Practice Data</td>
<td>£169,391</td>
<td>Achieved</td>
</tr>
<tr>
<td>6. Provision of generic medicines for Ophthalmology Patients</td>
<td>£195,212</td>
<td>Achieved</td>
</tr>
<tr>
<td>7. Access Policy</td>
<td>£814,934</td>
<td>Achieved</td>
</tr>
<tr>
<td>8. Medication Safety Thermometer</td>
<td>£298,934</td>
<td>Achieved</td>
</tr>
<tr>
<td>9. Transfer of Medication Information via Electronic Discharge Summary</td>
<td>£298,499</td>
<td>Achieved</td>
</tr>
<tr>
<td>10. Implement process to provide A&amp;E discharge notes electronically to GP practices</td>
<td>£298,499</td>
<td>Achieved</td>
</tr>
<tr>
<td>11. Implement process for all Outpatient Departments to receive electronic referrals from GPs</td>
<td>£556,717</td>
<td>Achieved</td>
</tr>
<tr>
<td>12. Clinical Correspondence with Community Services</td>
<td>£298,499</td>
<td>Achieved</td>
</tr>
<tr>
<td>13. Summary Care Record Access in Community Services</td>
<td>£298,499</td>
<td>Achieved</td>
</tr>
</tbody>
</table>
Research

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' means research which has received a favourable opinion from a research ethics committee within the National Research Ethics Service (NRES).

In April 2015 the Health Research Authority (HRA) became responsible for the Central Office for Research Ethics Committee; the predecessor of NRES and therefore now part of the Health Research Authority.

Added to this change, the HRA is rolling out a new single approval process. HRA Approval is the new process for the NHS in England that brings together the assessment of governance and legal compliance, and is undertaken by dedicated HRA staff, with the independent REC opinion.
provided through the UK Health Departments' Research Ethics Service (UKREC)

It replaces the need for local checks of legal compliance and related matters by each participating organisation in England. This allows participating organisations to focus their resources on assessing, arranging and confirming their capacity and capability to deliver the study. - See more at: http://www.hra.nhs.uk/about-the-hra/our-plans-and-projects/assessment-approval/

Therefore many of the research governance processes currently in operation within the R&D will require change and development. New policies and SOP’s will be compiled by ESHT R&D to support new ways of working.

The number of patients that were recruited to research studies during 2015/2016 to participate in research approved by a research ethics committee was 556 with many more being offered the opportunity to take part. This is an increase in participation from the previous year.

Participation in clinical research demonstrates ESHT’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff will be able to participate in good quality research that can offer the latest possible treatments. Active participation in research leads to successful patient outcomes as demonstrated in the following paper detailing research activity and the association with mortality. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0118253

ESHT was involved in conducting 44 interventional and 43 observational clinical research studies in 17 medical specialties during the year. It was our intention to increase the number of observational studies from 29 studies the previous year and this has been achieved.

There were a total of 60 clinical staff participating in research approved by a research ethics committee’s at ESHT during 2015/2016.
Achievements 2015/2016

- R&D department reconfiguration the previous year has led to the development of a clinical research team which can respond in new areas. This has enabled development of a flexible and generic workforce that can meet diverse research needs and support development of opportunities for patients in new and developing specialities. These have included surgery and anaesthetics this year.
- The 2\textsuperscript{nd} Scientific Meeting on 20\textsuperscript{th} March 2015 entitled ‘Improving care through our research’ – Organised by R&D Dept. with posters, Oral presentations and speakers.
- R&D 5 year Strategy – Current until 2019
- Supporting development of research activity as part of specialist nursing roles. We have joint appointments with clinical nurse specialist roles to enable research activity as part of care.
- Recruitment has increased in relation to the previous performance in 2015/2016 from 538 recruits to clinical research to 556.

Data Quality

During 2016/17 we will be taking the following actions to maintain and improve data quality:

- Service improvement to support heading towards the 2020 national digital roadmap.
- A review of process and function.
- Staffing – increase establishment to support the Trust and in recognition of the importance of data quality
- To analyse and identify data quality issues within new systems to the Trust e.g. System1
- Continue to provide regular data quality reports to the Quality & Standards Committee.
- Undertaking a re-audit of completeness of NHS Numbers to ensure continued progress
- Validating correct attribution on the Patient Administration System of GP Practice through the national register (SPINE).
- Visit other Trust’s Data Quality departments to gain an understanding of how other units operate and to bring back and apply good practice.
- Engage with the Clinical Units to gain understanding of how these operate and also identify areas for data quality improvement.
- Provide advice, instruction and guidance to all levels of staff on good data quality practice through training workshops and presentations to specific staff groups e.g. ward clerks, outpatient staff.
- Identifying long term data issues and determines actions to overcome these.
- Work closely with training staff to ensure training materials and scripts are accurate and support good data quality practice.

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


The latest published data includes the period April 2015 to January 2016.

The percentage of records in the published data:

- Which included the patient’s valid NHS number:
  - 99.6% admitted patient care (national rate 99.2%)
  - 99.7% outpatient care (national rate 99.4%)
  - 98.3% accident and emergency care (national rate 95.3%)
- Which included the patient’s valid General Medical Practice Code:
  - 100% admitted patient care (national rate 99.9%)
  - 100% outpatient care (national rate 99.8%)
  - 100% accident and emergency care (national rate 99.1%)

**Clinical Coding Error Rate**

There is an on-going internal audit process that is carried out within the Clinical Coding Department by the Clinical Coding Data Quality and Audit Manager. This looks at inpatient coding and ensures that areas of concern are checked and that clinical coding training needs are highlighted for appropriate attention. Compliance with the Information Governance Toolkit requirements (v.12) is essential and has been reviewed by the Trust's independent auditors.

**Information Governance Audit September 2015**

<table>
<thead>
<tr>
<th>Primary Diagnosis correct %</th>
<th>Secondary diagnoses correct %</th>
<th>Primary procedure correct %</th>
<th>Secondary procedures correct %</th>
<th>Unsafe to Audit %</th>
</tr>
</thead>
<tbody>
<tr>
<td>91.00%</td>
<td>91.21%</td>
<td>93.48%</td>
<td>87.36%</td>
<td>4.31%</td>
</tr>
</tbody>
</table>

- Primary diagnosis and primary and secondary procedure coding accuracy is good, exceeding level 2 Information Governance requirements.
- Secondary diagnosis coding accuracy is very good, at 1.21% above the percentage required to attain level 3 for Information Governance Toolkit requirement 13-505.
Trust Internal Audits have looked at Quality Coding Review with clinician validation of the coded data. Results below -

<table>
<thead>
<tr>
<th></th>
<th>Primary Diagnosis</th>
<th>Secondary Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage accuracy</td>
<td>97.3%</td>
<td>88.9%</td>
</tr>
</tbody>
</table>

- Death in Low Risk Diagnosis groups – on-going throughout year
- Quality Control – Clinical Coders – 90% accuracy audits on-going
- Stroke Validation – on-going.

**Information Governance**

The Information Governance Toolkit (IGT) is a Department of Health (DH) Policy delivery vehicle that the Health and Social Care Information Centre (HSCIC) is commissioned to develop and maintain.

It draws together the legal rules and central guidance set out by DH policy and presents them in in a single standard as a set of information governance requirements.

East Sussex Healthcare Trust (ESHT) is required to carry out a self-assessment of their compliance against the IG requirements; the trust has 45 requirements over the following six areas:

- Information governance management
- Confidentiality and data protection assurance
- Information security assurance
- Clinical information assurance
- Secondary use assurance
- Corporate information assurance

ESHT’s Information Governance Toolkit assessment score for 2015/16 was 71% and was graded as ‘green’ or satisfactory. Out of the 45 requirements 39 are at the required level 2 and 6 are at the higher level 3. For 2015/16 the trust auditor’s report gives ‘reasonable assurance’ that the trust’s submission is compliant.
What the CQC says about us

The Trust is registered with the Care Quality Commission to carry out nine legally regulated activities from 20 registered locations (there are no conditions attached to the Trust's registration). The CQC undertook an unannounced inspection of the organisation in March 2015 and the reports were published in September 2015. The reports identified concerns in a number of areas and the Trust was rated overall as Inadequate and subsequently placed in special measures. The Trust received a warning notice from the CQC but no enforcement action was taken.

CQC Ratings for East Sussex Healthcare Trust

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Inadequate</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>

CQC Ratings for the Conquest Hospital

<table>
<thead>
<tr>
<th>Urgent and Emergency Services</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

| Surgery                      | Inadequate | Requires Improvement | Good | Requires Improvement | Inadequate | Inadequate |

| Maternity and Gynaecology    | Inadequate | Requires Improvement | Good | Requires Improvement | Inadequate | Inadequate |

| Outpatients and Diagnostic Imaging | Inadequate | N/A | Good | Inadequate | Inadequate | Inadequate |

| Overall                      | Inadequate | Requires Improvement | Good | Requires Improvement | Inadequate | Inadequate |
A comprehensive action plan and trajectory have been developed to address the concerns identified. This includes cultural issues, improving the provision of outpatient services, improving aspects of medicines management, ensuring patients’ health records are better managed; ensuring there is sufficient staff to meet the needs of the service, continuing to develop local engagement and ensuring that the Trust is well led. The action plan is reviewed both internally and externally at monitoring meetings with key stakeholders.

Part 3: Review of 2015/16 quality improvement priorities

During 2015/16 the trust was re-inspected by the Care Quality Commission and provided with a rating of inadequate for well led and safe care. This resulted in a review of priorities as urgent action was required to address a number of concerns raised. However the priorities detailed below were still undertaken and as a result the Trust has partially achieved/completed the 2015/16 goals set for the remaining four priorities. These will be reviewed as part of the Quality Strategy to determine what remaining goals will need to continue as part of the complete Trust improvement programme.

Patient Experience

Priority 1: Improve the experience of our patients through improving face to face communication and the written information we provide.

Why we chose this priority

Initial effective communication with a patient or service user is a vital first step in providing compassionate care. We wanted to ensure this is effective and we do this all the time with all our patients.

We also wanted to improve the written patient information leaflets to ensure that they are up to date, in line with Best Practice Guidance (e.g. NICE), consistent across the organisation, are user friendly and provide the information patients actually need.

Improvement delivered throughout the year

The ‘Hello my name is’ campaign was launched across the trust with good engagement and success. To test whether patients felt that staff had introduced themselves appropriately we have recently included an additional question into our Family and Friends Test (FFT), initial results from the pilot area are positive. From April 2016 this has been included within the paper FFT questionnaires.

Patient information leaflets from seven specialities have been reviewed and revised across the year so that they are up to date with best practice, consistent and user friendly.
The Trust held its annual dignity event in February 2016 where improving communication was a key area of discussion. We have three patient story videos, which we use to raise awareness of communication and compassion with our staff.

Goals set for 15/16 – Partially Achieved

- We have achieved our aim of implementing a programme of on-going monitoring and review of patient leaflets, exceeding the six specialities we had set out to undertake.
- We have implemented an additional question within the FFT within a pilot area with full roll out from 2016.
- As a proportion of all complaints received by the Trust across the year the level of complaints related to communication has increased by 5.2%, however the subject matter of ‘attitude’ has seen a reduction of 4.4%.

Future plans

- Use the feedback from the FFT to shape further developments with improving communication
- The Medical Education Team is working with the ‘Make every contact count’ initiative lead to provide group teaching sessions for Junior Doctors scheduled in May/June and will also be incorporating this training for the new intake of junior doctors in August.

Priority 2: Improving compassion in care

Why we chose this priority

To ensure that all our patients have a high quality patient experience we want to provide compassionate care to all our patients.

Improvement delivered throughout the year

As part of our patient experience work we are in the early stages of how we can monitor the level of care across the trust that we should expect our patients to receive. We have started work to look at how we can improve the culture of our organisation, investing significantly in our nurse recruitment programme, and the support to staff to ‘Take A Break’, ensuring they feel they are looked after and part of the organisation.

We know that hospitals are complex and challenging places and Schwartz Rounds are one of a number of ways by which, senior staff and trust boards can signal that care is a priority and show that they recognise the demands on individuals. Whilst they don’t replace good teams they do provide space to reflect on the nature of work. Within ESHT there has been commitment and support from the Board, a senior clinician and a dedicated and proficient facilitator - Rounds have become embedded in the culture of the organisation.
Feedback from Rounds include-

- Rounds acknowledge feelings and reduce stress
- Rounds encourage networking and multidisciplinary team working
- Rounds contribute positively to hospital culture
- Power of hearing senior staff express vulnerability
- Shared understanding of experience
- Different opportunity to think when not trying to problem solve

We continue to monitor the Friends and Family Test but are also using the NHS Choices site as a source of valuable feedback. ESHT has also been supported throughout the year by Healthwatch who had completed a number of programmes of work with us looking at the patient experience. These ranged from an audit of Complaints and observations of care. The CCG have also been supporting the Trust in reviewing specific areas of care.

There has also been a small series of recordings of patient experience from Patients themselves to play for training DVD’s. These have been well received and were launched at the Dignity Day in February 2016.

Due to the numbers of areas where the CQC identified significant deficits ie safety, well led and responsive, it was felt that the domain of caring – which they reviewed as being ‘Good’ – would underpin the improvement programme and an increased focus would be undertaken on the cultural piece within the organisation.

Goals set for 15/16 – Partially achieved

- Programme of regular Schwartz rounds, with the outcomes and shared learning from these disseminated across the trust.

Future plans

We are looking to develop ways in which our staff can have time to lead, supervise and monitor the standard of care on their wards.

We will aim to have a more structured approach to managing patient experience through re-establishing our patient experience Group and developing further the patient experience strategy.

There will be a focus on consistent plans to monitor care across our Trust.
Patient Safety

Priority 3: Reduce the number of falls which cause significant harm

Why we chose this priority

Although some falls are unavoidable in healthcare, others are not and we wanted to minimise these. Doing all we can to keep our patients safe is a key quality priority for the Trust and reducing avoidable harm is central to this. Although we had already made considerable reductions in the number of falls that result in serious harm in the previous year we recognised there was further work to be done.

Improvement delivered throughout the year

In November 2015 we introduced a work based learning workbook on falls prevention. Four staff Falls Awareness and training events have taken place across the year with positive feedback.

We are regularly monitoring whether our patients are assessed for the likelihood of falls and if at risk whether they have had a further multifactorial risk assessment carried out. These monthly audits are undertaken by the ward staff and reviewed by the monthly trust falls steering group.

We have introduced the Safer Care bundle approach to the prevention and management of falls.

We have revised our root cause analysis tool for falls which have caused harm so that the causes are fully understood and the actions can be implemented to minimise or prevent them happening again.

We have ensured that there is 24/7 accessibility of falls prevention equipment within our hospitals.

Targets set for 15/16 – Partially achieved

- An overall reduction in the total falls to a rate of 7 per 1,000 bed days. We have consistently achieved this since April 2015, apart from the month of Dec 2015 with an overall annual falls rate of 6.55 per 1000 bed days
- 15% reduction in the number of falls categorised as a grade 3 moderate harm. We have successfully achieved this target and made a total 48% reduction across the year.
- We set an ambitious 20% reduction in number of staff attending falls training. We have achieved this with huge success, with falls training increasing by over 200%. In 2014/2015 210 members of staff competed training compared to a total of 665 in 15/16.
- The Trust now has a regular Falls meeting and reports from these are reviewed within the Trust as part of the quality agenda.
- The Trust Nursing and Midwifery Group also receives Falls reports, Root Cause Analysis themes and trends with actions.
- Falls prevention work book in place for all clinical staff.
Future plans

The learning from falls will be part of our 2016/2017 Trust wide falls action plan and revision of our falls policy of which we are already working on. The key areas include:

- Additional question to screening tool about the completion of lying and standing Blood Pressure (BP) and the patients identified at risk through the falling leaf campaign.
- Monitoring the compliance of lying and standing BP assessment with feedback and support for areas who are not achieving this for all appropriate patients. Introduce options for patients that are unable to comply with lying and standing BP i.e. sitting to standing, lying to sit.
- Introduction of a new screening tool for bed rails which will be included into the newly revised integrated patient documentation (IPD).
- Continue to promote the ‘Call don’t fall’ campaign, to support reduction in falls in bathrooms and side rooms.
- Focussed work streams on the reduction in the numbers of patients that fall more than once and improving the completion of the multifactorial risk assessment.
- Our falls data will be split and reported for our acute and community sites to enable us to have a focus on our community Intermediate Care areas that have higher fall rates. It will also enable us to benchmark with other community organisations.
- Falls screensaver on Trust wide computers to raise profile across Trust.
- Another 5 Falls Awareness and training events have been planned for 2016.
- Launch of post falls sticker for community hospital settings.

Priority 4: Deliver safer staffing by ensuring the right people with the right skills are in the right place at the right time.

Why we chose this priority

Appropriate number of high quality staff substantively employed by the Trust, who have attained the key skills and experience to undertake their roles but also demonstrate the right attitudes and behaviours is essential to the delivery of safe, high quality and compassionate care.
Improvement delivered throughout the year

We now have more Nursing staff working for the Trust, staff turnover is reducing and we have plans in place to continue to recruit to budgeted establishment. We have a staff engagement and wellbeing strategy which we anticipate will reduce staff turnover further and ensure that East Sussex Healthcare Trust is seen as an employer of choice within the healthcare sector.

Specifically we have:-

- Developed an overarching trust recruitment and retention strategy which was approved by the trust board in June 2015. This sets out the approaches and strategies the trust is taking to improve and maintain a high quality workforce.
- Ward Nursing establishments have been reviewed across the trust and increases in establishments agreed by the Board.
- Reviewed the skill mix of our staff and piloted new Ward Orderlies roles. Evaluation of the benefits of these roles is being undertaken, with early indication that cleaning and cleanliness scores have improved for areas that have these staff in place.
- Introduced Values based recruitment and selection process
- 87% of Student Nurses who undertook their training placements accepted substantive posts in the Trust.
- Improved the utilisation of management information so that we are able to forecast demand and capacity requirements and target recruitment appropriately.
- European and International recruitment undertaken for Registered Nurses with 70 Nurses appointed with start dates across the beginning of 2016. We have planned support programmes to ensure that these staff are supported at work, settled within the local community and remain with the Trust.
- Supported Clinical areas to meet mandatory training and appraisal compliance.
- Offered a range of different methods of training and 1:1 coaching on appraisals where required.
- Developed and introduced on-line mandatory training in addition to taught sessions to enable staff to access regular training and keep up to date.
## Future plans

- Continue further International and European recruitment. Trips planned for May and June 2016.
- Over recruit in areas where a higher turnover in staff is likely
- Roll out value based recruitment across all professions
- Develop new roles and review skills mix to keep abreast of the national shortage of staff.
- Patient representative involvement for recruiting of Healthcare assistants and newly qualified nurses

## Priority 5: Clinical Effectiveness

### Improve the care of patients with dementia

### Why we chose this priority

Dementia is a growing global challenge, and in England alone it is estimated that around 676,000 people have the condition. The term ‘dementia’ describes a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. We want to ensure that the care we provide is effective and based on best practice and research evidence.
**Improvement delivered throughout the year**

We have expanded our dementia care team to include 2 dementia support workers. This has enabled greater engagement with the wards on a daily basis to support and signpost staff, carers, patients and relatives.

We have continued to improve and increase our education programme for staff across the year to develop all staff’s awareness and understanding of dementia and its impact in order to support effective care for people living with dementia. 40 staff of all grades and disciplines have attended the more intensive 6 day Dementia Care Champions course in 2015/16. Staff have access to Dementia specialist knowledge and expertise through a dementia specialist nurse.

We have also introduced the nationally recognised Butterfly Scheme© and staff Carry Cards with the team’s contact details. In hospital, dozens of staff can pass through a patient’s life each day and in order to deliver appropriate care, they need to know that a patient has dementia or memory impairment and how best to support them. The Butterfly Scheme provides a system of hospital care for people living with dementia, or those who find that their memory isn’t as reliable as it used to be; memory impairment can make hospitalisation distressing, but it needn’t be.

We have achieved compliance with national CQUIN indicators for Dementia screening and onward referral. We are also undertaking a carers survey regularly on the wards with the feedback used to develop further improvements to the services we provide.

ESHT have participated in an East Sussex multi-agency Joint Strategic Needs Assessment (JSNA) for Dementia Care. This has been led by Public Health England and the results are due to be published in July 2016.

Dementia Care Champions conference held in February 16. Participants of the DCC course were from all areas of the Trust including Chaplaincy services and also staff from St Wilfred’s Hospice. Previous DCC’s also attended, along with representatives from external companies and members of the Eastbourne Dementia Action Alliance. Speakers included a carer, Parkinson’s Specialist Nurse, Psychiatrist and Telecare.

Volunteers are being engaged to read or sit and talk with our patients to alleviate the long days of potential isolation. Initiatives such as knitted ‘Twiddle muffs’ and lap blankets are also being introduced.
Future Plans

- Recruitment to an expanded Dementia Care Team
- Continue to develop and Implement the educational trust wide training programme
- Formation of a Multi-agency Strategic Dementia Care Plan working in collaboration with key stakeholders.
- Completion of the recommendations from the JSNA.
- Dementia Care in Acute Hospitals Project in response to recent key publications.
- A review of the Enhanced Observations process (1:1 care for patients with identified needs e.g. this may be required for patients who have been assessed as at risk e.g. of hurting themselves, of falling, or walking out of the ward area and so require closer observation).
- Bespoke Night Staff and administrative staff education. Strategies particular to their care and communication needs

Goals set for 15/16 – Partially Achieved

- We have achieved an expanded team within the year with further expansion and development currently on-going.
- We are now achieving consistent compliance with Dementia CQUIN targets.
- Our Estates department have a rolling programme for improving signage and environments to meet Dementia friendly standards.
## Review of Quality Performance

### Integrated Performance Dashboard – Apr 2015 to Mar 2016

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Performance</th>
<th>VTH</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Incident Intake Rate</td>
<td>Apr: 0</td>
<td>May: 0</td>
<td>Jun: 0</td>
<td>Jul: 0</td>
</tr>
<tr>
<td>Service Incident Intake Rate Super YOB incident</td>
<td>Apr: 0</td>
<td>May: 0</td>
<td>Jun: 0</td>
<td>Jul: 0</td>
</tr>
<tr>
<td>Inpatient suicide incidents</td>
<td>Apr: 0</td>
<td>May: 0</td>
<td>Jun: 0</td>
<td>Jul: 0</td>
</tr>
<tr>
<td>Patient Deaths Incidents (Hospital/FN)</td>
<td>Apr: 0</td>
<td>May: 0</td>
<td>Jun: 0</td>
<td>Jul: 0</td>
</tr>
<tr>
<td>Patient Deaths Incidents (Emergency/FN)</td>
<td>Apr: 0</td>
<td>May: 0</td>
<td>Jun: 0</td>
<td>Jul: 0</td>
</tr>
</tbody>
</table>

### Patient Experience

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Performance</th>
<th>VTH</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Complaints – Rate</td>
<td>Mon: 2.7</td>
<td>Tue: 2.8</td>
<td>Wed: 2.9</td>
<td>Thu: 3.0</td>
</tr>
<tr>
<td>Mixed Use Accommodation Breaches</td>
<td>Apr: 0</td>
<td>May: 0</td>
<td>Jun: 0</td>
<td>Jul: 0</td>
</tr>
</tbody>
</table>

### Key Trends & Recommendations

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Performance</th>
<th>VTH</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal Trends and family Tests recommended care</td>
<td>75%</td>
<td>VTH</td>
<td>Trend</td>
<td></td>
</tr>
</tbody>
</table>

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*www.esht.nhs.uk*
### Access and Responsiveness

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Waiting Time (in days)</td>
<td>&lt;= 4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency A&amp;E / obs to admission</td>
<td>&lt;= 45 minutes</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Referral to Treatment Centre (25%iles Value)</td>
<td>&lt;= 2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Diagnostic waiting time</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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</table>

### Workforce

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transient additional workforce</td>
<td>3.5%</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total Full Time Equivalents</td>
<td>1,905</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Percentage of staff with annual appraisal (2015/16)</td>
<td>95%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

### Activity/Effectiveness

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average LOS (beds)</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Average LOS (non-elective)</td>
<td>4.6</td>
<td>5.7</td>
<td>5.4</td>
<td>5.1</td>
<td>5.5</td>
<td>5.5</td>
<td>5.7</td>
<td>5.9</td>
<td>6.2</td>
<td>5.7</td>
<td>5.9</td>
</tr>
</tbody>
</table>

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55

www.esht.nhs.uk
Review of Quality Indicators

Amended regulations from the Department of Health require Trusts to include a core set of quality indicators in the Quality account. These indicators are set out below.

Summary Hospital-level Mortality Indicator (SHMI)

East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

SHMI is one of several statistical mortality indicators used to monitor and review the quality of care provided by the Trust. We also look at Hospital Standardised Mortality Ratio (HSMR) the Risk Adjusted Mortality indicators as well as crude rates and associated local metrics.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SHMI value</td>
<td>1.14</td>
<td>1.15</td>
<td>1.08</td>
<td>1.14</td>
<td>1.05</td>
</tr>
<tr>
<td>Banding</td>
<td>1 (higher than expected)</td>
<td>1 (higher than expected)</td>
<td>2 (as expected)</td>
<td>1 (higher than expected)</td>
<td>2 (as expected)</td>
</tr>
<tr>
<td>% of patient deaths with palliative care coding by speciality and/or diagnosis</td>
<td>17.71</td>
<td>18.05</td>
<td>22.4</td>
<td>18.2</td>
<td>14.8</td>
</tr>
<tr>
<td>% of patient deaths with palliative care coding by speciality and/or diagnosis (national average)</td>
<td>27.6</td>
<td>26.6</td>
<td>25.3</td>
<td>20.9</td>
<td>18.9</td>
</tr>
</tbody>
</table>

The most recent SHMI value for the data period January 15 to December 15 above shows a small reduction in the indicator, however the Trust remains within the higher than the expected range, band 1.
East Sussex Healthcare has taken the following actions to improve the rate and so the quality of its services by –

- All specialties conduct morbidity and mortality (M&M) meetings.
- All adult deaths are reviewed on the Trust mortality database. The Trust policy is that this occurs within 3 months of the date of death. There is a programme of quarterly quality control review of entries on the Trust’s electronic database.
- Deaths in “Low Risk Groups” are reviewed at Clinical Unit M&M Meetings. Learning from CU M&M and Clinical Governance meetings is circulated to all CUs.
- Weekly combined independent consultant clinical care and coding review of deaths started in March 2016.
- The Trust Mortality Review Group meets monthly. This reviews trends and variance, triangulating this with other quality indicators (e.g. complaints, Clinical Incidents, SIs,) and reviews unexpected deaths in which care might have been contributory to the death.
- The Mortality Overview Group (MOG), chaired by the Medical Director, meets monthly and is attended in turn by all the CUs, for detailed discussion on their mortality issues, their processes for review and learning from deaths.

Patient Reported Outcome Measures /Scores (PROMS)

East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

All NHS patients having hip or knee replacement, varicose vein surgery or groin hernia surgery are invited to fill in a PROMS questionnaire.

The questionnaire’s aim is to find out about the patients’ health and quality of life, before and after the operation. This enables hospitals to measure their success and make improvements supported by feedback the patient reported outcomes of surgical interventions and compare themselves to other trusts nationally.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16 * April 2015 – December 2015</th>
<th>National Average</th>
<th>Best performer</th>
<th>Worst performer</th>
<th>14/15 data * Provisional data</th>
<th>13/14 data</th>
<th>12/13 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Reported Outcome Measures/scores (PROMS) for Hernia surgery</td>
<td>EQ-5D Index 55.1%</td>
<td>EQ-5D Index 50.8%</td>
<td>EQ-5D Index 100.0%</td>
<td>EQ-5D Index 0.0%</td>
<td>EQ-5D Index 53.5%</td>
<td>EQ-5D Index 56.1%</td>
<td>EQ-5D Index 45.3%</td>
</tr>
<tr>
<td></td>
<td>EQ-VAS 47.3%</td>
<td>EQ-VAS 37.3%</td>
<td>EQ-VAS 73.3%</td>
<td>EQ-VAS 0.0%</td>
<td>EQ-VAS 40.2%</td>
<td>EQ-VAS 39.1%</td>
<td>EQ-VAS 35.0%</td>
</tr>
<tr>
<td>Patient Reported Outcome Measures/scores (PROMS) for Hip replacement</td>
<td>EQ-5D Index 95.0%</td>
<td>EQ-5D Index 90.1%</td>
<td>EQ-5D Index 100.0%</td>
<td>EQ-5D Index 66.7%</td>
<td>EQ-5D Index: 86.8%</td>
<td>EQ-5D Index: 88.8%</td>
<td>EQ-5D Index: 90.6%</td>
</tr>
<tr>
<td></td>
<td>EQ-VAS 58.1%</td>
<td>EQ-VAS 66.1%</td>
<td>EQ-VAS 84.4%</td>
<td>EQ-VAS 0.0%</td>
<td>EQ-VAS: 63.3%</td>
<td>EQ-VAS 59.3%</td>
<td>EQ-VAS 62.4%</td>
</tr>
<tr>
<td>Patient Reported Outcome Measures/scores (PROMS) for Knee replacement</td>
<td>EQ-5D Index 71.9%</td>
<td>EQ-5D Index 82.2%</td>
<td>EQ-5D Index 100.0%</td>
<td>EQ-5D Index 50.0%</td>
<td>EQ-5D Index: 82.6%</td>
<td>EQ-5D Index: 83.6%</td>
<td>EQ-5D Index 77.5%</td>
</tr>
<tr>
<td></td>
<td>EQ-VAS 37.3%</td>
<td>EQ-VAS 55.4%</td>
<td>EQ-VAS 100.0%</td>
<td>EQ-VAS 0.0%</td>
<td>EQ-VAS: 58.7%</td>
<td>EQ-VAS 51.5%</td>
<td>EQ-VAS 55.5%</td>
</tr>
</tbody>
</table>

The trust undertakes minimal varicose vein surgery therefore no data is available for this procedure.
East Sussex Healthcare has taken the following actions to improve the rate and so the quality of its services by:

- Ensuring our pre assessment teams distribute and collect the PROMS questionnaire
- Reviewing the data within our Governance and quality meetings

**Emergency readmissions to hospital within 28 days of discharge**

East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

The percentage of patients who were readmitted to hospital within 28 days of discharge is shown below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>National Average</th>
<th>Best performer</th>
<th>Worst performer</th>
<th>14/15 data</th>
<th>13/14 data</th>
<th>12/13 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency readmissions to hospital within 28 days of discharge Age 0-15</td>
<td>5.74%</td>
<td>9.46%</td>
<td>3.75%</td>
<td>14.94%</td>
<td>7.75%</td>
<td>7.68%</td>
<td>6.79%</td>
</tr>
<tr>
<td>Emergency readmissions to hospital within 28 days of discharge Age 16+</td>
<td>7.15%</td>
<td>11.14%</td>
<td>3.84%</td>
<td>17.2%</td>
<td>10.91%</td>
<td>12.30%</td>
<td>12.31%</td>
</tr>
</tbody>
</table>

East Sussex Healthcare has taken the following actions to improve the rate and so the quality of its services by:

- Inputting of discharge data into SECAMB’s IBIS (Intelligence Based Information System) – to inform paramedic crews of a patient’s key clinical indicators, in the case of regular attenders. Can prevent readmission if the crews are aware of normal limits of a particular patient
- PEACE Discharge planning implemented (Proactive Elderly Advanced Care) – for patients with progressive illness or with end of life planning. Identifies patients preferences and needs in terms of out of hospital care
- Newly formed Frailty Team – taking a proactive approach to patient management in their own settings
- Introduction of multi-agency Discharge Improvement Group to review discharge patterns and issues and identify themes for improvement across the health and social care economy
Responsiveness to inpatients’ personal needs

East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>National Average</th>
<th>Best performer</th>
<th>Worst performer</th>
<th>14/15 data</th>
<th>13/14 data</th>
<th>12/13 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness to inpatients’ personal needs; CQC national inpatient survey score</td>
<td>68</td>
<td>Data not available</td>
<td>67.6</td>
<td>67.9</td>
<td>67.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

East Sussex Healthcare has taken the following actions to improve the rate and so the quality of its services by

- By reviewing at the Patient Experience Steering Group in July 2016 this indicator, along with the key findings from the Inpatient Survey published in June 2016. Any recommendations made will be implemented thereafter.

Percentage of staff who would recommend the trust as a provider of care to friends or family

East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>National Average</th>
<th>Best performer</th>
<th>Worst performer</th>
<th>14/15 data</th>
<th>13/14 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff who would recommend the trust to friends or family needing treatment</td>
<td>54%</td>
<td>67%</td>
<td>89%</td>
<td>51%</td>
<td>52%</td>
<td>51%</td>
</tr>
</tbody>
</table>
East Sussex Healthcare has taken the following actions to improve the rate and so the quality of its services by:

Using ESHT staff FFT data as a source of intelligence in informing and signposting the Trust to areas for improvement in staff working life, wellbeing, conditions and work environment. The Trust also monitors staff responses three times a year through an internal mechanism.

- The Trust is using a robust Staff Operations Engagement Group (underpinned by staff representation) to promote, challenge and inform engagement, and tackle any negative perceptions of it. Initially this group focused on Staff FFT but its remit has now widened to encompass outputs from all staff surveys and external reports, including the national staff survey and Care Quality Commission (CQC) reports.

- This group has developed a detailed action plan for 2016/17 and an associated implementation plan in relation to our recently developed values and behaviours. Both of these plans contain detailed actions to address Trust wide issues and below are some of the key actions that will be undertaken during 2016/17:

- The Trust will implement results and action plans from its ‘Cultural Audit’ in order to enable staff to gain a wider understanding of its culture as well as to challenge resistance to change or cultural behaviours.

- The Trust is continuing to run a series of ‘Listening Events’ and ‘Leadership Conversations’ which are opened to all staff and attended by members of the Senior Management Team.

- The Trust is also exploring ‘You said we did’ in promoting staff engagement and demonstrating its commitment to listen and show to staff that it is making improvements they have said are important to them. Some of these Listening Events will focus on things such as fostering a culture of Good Practice and Q&A Sessions.

- Developing and introducing a ‘communications toolkit’ for all managers.

The actions listed above are just some of those that will be taken forward during 2016/17. Full details of all staff engagement actions can be found in the Staff Engagement Action Plan and Values and Behaviours Implementation plan.
East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

The NHS Friends and Family Test (FFT) was introduced in 2013 and asks patients whether they would recommend or not recommend the Trust hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>National Average</th>
<th>Best performer</th>
<th>Worst performer</th>
<th>14/15 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients who would recommend the trust to friends or family needing treatment (inpatient)</td>
<td>97.8%</td>
<td>95.78%</td>
<td>100%</td>
<td>74.17%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Percentage of patients who would recommend the trust to friends or family needing treatment (A&amp;E)</td>
<td>90.1%</td>
<td>86.55%</td>
<td>100%</td>
<td>46.33%</td>
<td>88.6%</td>
</tr>
</tbody>
</table>

East Sussex Healthcare has taken the following actions to improve the rate and so the quality of its services by

Addressing the poor response rate that has been identified as a challenge has enabled the Trust to explore the following strategies in order to improve on the response rate and the engagement of patients, their carers and family:

- We are using multiple data gathering tools (paper-based and electronic tablets) in collecting patient FFT data in clinical areas.
- We have engaged with our ward clerks and FFT link champions to drive patient, carers and family engagement in completing the patient FFT.
- We are using the ‘You Said, We Did boards’ in promoting engagement and demonstrating that we are taking seriously, all that our patients, their carers and families say.
- We are implementing complaints actions plan to include lessons for shared learning and embedding improvements in patient care, thereby creating positive patient experience, promoting its culture of openness and continuous improvements.
- We are also working with a private firm specialised in improving response rate of FFT through the use of mobile text messages.
As part of its commitment to the `Duty of Candour`, the Trust encourages staff to often say `sorry` or `apologise` to patients or complainants when errors occur rather than `defend the indefensible`.

**Percentage of admitted patients risk-assessed for Venous Thromboembolism (VTE)**

East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

This data capture is a retrospective paper based system. With pharmacists auditing risk assessment for the ward area they cover.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>National Average</th>
<th>Best performer</th>
<th>Worst performer</th>
<th>14/15 data</th>
<th>13/14 data</th>
<th>12/13 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of admitted patients risk-assessed for Venous Thromboembolism (VTE)</td>
<td>96.3%</td>
<td>96.01%</td>
<td>100%</td>
<td>78.95%</td>
<td>97.42%</td>
<td>97.05%</td>
<td>93.36</td>
</tr>
</tbody>
</table>

East Sussex Healthcare has taken the following actions to improve the rate and so the quality of its services by:

- Making improvements to the current VTE Risk Assessment data reporting process to reflect whether the VTE R.A was done on admission or within 24 hours of admission rather than `within the care episode` as was previously reported. This improvement was made as a result of findings from the CQC inspection and external audit that some patients were being risk assessed outside of this timeframe but were being reported compliant.
- The VTE paper risk assessment form which is included in the IPD has been altered to capture date and time of risk assessment being carried out (in the new version which has not yet been distributed).
- Relaunching the VTE Group and have appointed a new VTE Consultant Lead to support improvement across the organisation.
- Resuming the fatal VTE Root Cause Analysis process in order to identify fatal Hospital Associated Thrombosis and to learn lessons identified from investigation of HAT cases.
- Regular audit of VTE Risk Assessment compliance and the provision of appropriate thromboprophylaxis has been introduced by Pharmacy.
- Training and engagement sessions for VTE have been arranged for April and May of...
this year facilitated by the VTE Nurse and the Listening into Action team.

- Exploring electronic VTE Risk Assessment options including E-prescribing programmes which include VTE R.A.
- Developing automated SQL reporting to aid in monitoring compliance internally with VTE Risk Assessment, it is intended that these reports will report compliance by consultant as well as ward area and are due for launch by May 2016.
- The Trust has agreed regular reporting arrangements with commissioners to provide assurance on its VTE improvement strategy.
- A business case is being prepared to provide additional resources to support the VTE improvement processes including capturing and recording VTE incidence, and implementing non-fatal VTE Root Cause Analysis.
- Trust policy for VTE is currently being reviewed and updated to reflect these improvements.

Rate of C. Difficile Infection

East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>National Average</th>
<th>Best performer</th>
<th>Worst performer</th>
<th>14/15 data</th>
<th>13/14 data</th>
<th>12/13 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of C. Difficile Infection per 100,000 bed days</td>
<td>15.44</td>
<td>No data available</td>
<td>17.7</td>
<td>16.4</td>
<td>20.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

East Sussex Healthcare has taken the following actions to improve the rate and so the quality of its services by:

- Recruitment into vacant housekeeping posts and the establishment of an additional enhanced cleaning team
- Additional recruitment into the National Standards of Cleanliness (NSC) audit team to meet the required level of audit in all areas (very high risk, high risk, significant risk and low risk)
- Implementation of new software package to the NSC audit team to improve efficiency. Including review of risk rating and audit frequency to meet NSC standards.
- New environmental audit system allows timely accessibility and response to results. The performance against which is monitored
through each clinical unit’s accountability review meetings

- The introduction of written feedback letters to staff observed as being non-compliant with hand hygiene
- Review and ratification of hand hygiene policy to state that all ESHT staff must be Bare Below the Elbow when entering clinical areas
- Temporary workforce provided with aide memorie and induction checklist to promote compliance with Infection Control Practice
- Targeted response to site specific increased rate of CDI including, increased frequency of hand hygiene, antimicrobial and environmental auditing, hourly spot checks and daily ward check lists.

**Rate of patient safety incidents reported per 100 admissions and the proportion of patient safety incidents they have reported that resulted in severe harm or death**

We are committed to learning from patient safety incidents in order to improve the overall quality of patient care and to ensure robust strategies are put in place to prevent recurrence. The Trust is focused on promoting high levels of reporting as a positive attribute to a culture of openness and transparency. A total of 10759 patient safety incidents were reported on Datix in 2015/16 against 7357 incidents which were reported in 2014/15 thereby recording an increase of 3402 incidents or 46.24%.

It should be highlighted that a rise in the number of incidents reported is a good marker of the Trust’s commitment to a culture of openness which encourages reporting in ensuring lessons are learnt in preventing recurrence and promoting patient-centred safer care.
The following table reflects our Trust annual performance on two key indicators against national standards.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>National Average</th>
<th>Best performer</th>
<th>Worst performer</th>
<th>14/15 data</th>
<th>13/14 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of patient safety incidents reported per 1000 admissions</td>
<td>39.3</td>
<td>38.25</td>
<td>74.67</td>
<td>18.07</td>
<td>36.92</td>
<td>8.65 (per hundred admissions)</td>
</tr>
<tr>
<td>% of patient safety incidents reported that resulted in severe harm or death – This is the National and Reporting and Learning system Data between 1st April 2015 and 30th September 2015 **</td>
<td>0.5</td>
<td>0.4</td>
<td>0.0</td>
<td>2.9</td>
<td>0.3</td>
<td>0.4</td>
</tr>
</tbody>
</table>

** Please note: This was data submitted (uploaded) to the National reporting and Learning System during the stated time period which had a final date for updating incident severity following investigation outcomes on the 30th November. Some of the incidents involving major and catastrophic cases were still under investigation and therefore subsequently changed in the final severity grading after this date. The final figure for the Trust at the end of the financial year for this time period is:

** Overall indicator for % of patient safety incidents reported that resulted in severe harm or death - 0.4% (severity 4 = 0.3% and severity 5 = 0.1%).

** Data Reporting

All incidents are reported on the Trust incident reporting system (Datix). These remain as a permanent record. The initial grade of an incident is determined by the reporter, however the grade may change following investigation. There is sometimes a delay in regrading which at times is done retrospectively after uploading to the national reporting and learning system. The timeliness of this has had an effect on the comparative data.
East Sussex Healthcare has taken the following actions to improve the rate and quality of its services by

During the latter part of the year the trust has reviewed and redesigned the serious incident reporting and investigation system to provide more support and expertise to the clinical staff with undertaking investigations and identifying the learning from the events. This new process will further improve patient/family involvement in the investigation process (where they would like to be involved) therefore ensuring the duty of candour system is robust. In addition the trust has:

- Improved reporting through the use of feedback and newsletters e.g. ‘You said we did’.
- Provided staff training sessions on Datix (incident reporting system) and incident reporting, handling and duty of candour;
- Established listening events-Formation of the Datix User Forum to discuss ideas and potential improvements to the Datix system (incident reporting system).
- Enabled automatic feedback function on Datix – to inform user when incident is logged.
- Placed Datix link on the front page of staff intranet for greater visibility and easy access.
- Undertaken spot check audits on wards to determine if completed actions have been embedded in practice.

Staff Survey Results

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 use the staff survey as part of the on-going monitoring of registration compliance.

For the Trust, the survey helps to assess the effectiveness and application of policies and strategies, for example, training, flexible working and safety at work. 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. Feedback from the surveys helps inform us as a Trust on areas for development and improvement.

The survey was conducted between September and December 2015 and the results published in 2016.

40% of staff at East Sussex Healthcare NHS trust took part in the survey which is in line with the National response rate. This year some Clinical Units and Directorates gave protected time for their staff to complete the survey which meant that their completion rates were approximately 50%.
There are two ways of scoring responses to questions:

1. 5 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 one and the maximum being five

The following tables summarises the Trust's top and bottom ranking scores:

### Top scores (* denotes lower score is better)

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>ESHT score</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>*KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>*KF23. Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>*KF16. Percentage of staff working extra hours</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>*KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>29%</td>
<td>29%</td>
</tr>
</tbody>
</table>

### Bottom scores (* denotes lower score is better)

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>ESHT score</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.41</td>
<td>3.65</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and Incidents</td>
<td>3.41</td>
<td>3.71</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.31</td>
<td>3.64</td>
</tr>
<tr>
<td>KF6. Percentage of staff reporting good communication between senior management and staff</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.53</td>
<td>3.72</td>
</tr>
</tbody>
</table>
The following table outlines the largest improvements since 2014 (* denotes lower score is better)

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>ESHT score 2015</th>
<th>ESHT score 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.77</td>
<td>3.64</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.79</td>
<td>3.70</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.53</td>
<td>3.45</td>
</tr>
<tr>
<td>KF11. Percentage of staff appraised in last 12 months</td>
<td>82%</td>
<td>77%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.36</td>
<td>3.27</td>
</tr>
</tbody>
</table>

The following section presents each of the 32 Key Findings, using the data from the Trust’s 2015 survey, and compares theses with other integrated Trusts in England and to the Trust’s performance in the 2014 survey.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>ESHT 2015</th>
<th>ESHT 2014</th>
<th>National Average 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.36</td>
<td>3.27</td>
<td>3.71</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and patient care they are able to deliver</td>
<td>3.72</td>
<td>-</td>
<td>3.94</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>88</td>
<td>-</td>
<td>91</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.77</td>
<td>3.64</td>
<td>3.92</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.23</td>
<td>-</td>
<td>3.42</td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior managements and staff</td>
<td>19</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>63</td>
<td>61</td>
<td>71</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.79</td>
<td>3.70</td>
<td>3.93</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.63</td>
<td>3.69</td>
<td>3.77</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.53</td>
<td>3.45</td>
<td>3.72</td>
</tr>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>82</td>
<td>77</td>
<td>86</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>2.92</td>
<td>-</td>
<td>3.03</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>3.96</td>
<td>-</td>
<td>4.04</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.12</td>
<td>-</td>
<td>3.30</td>
</tr>
<tr>
<td>KF15. % of staff satisfied with the opportunities for flexible working patterns</td>
<td>47</td>
<td>-</td>
<td>50</td>
</tr>
<tr>
<td>KF16. % working extra hours</td>
<td>72</td>
<td>69</td>
<td>72</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>* KF17. % suffering work related stress in last 12 months</td>
<td>40</td>
<td>42</td>
<td>36</td>
</tr>
<tr>
<td>* KF18. % feeling pressure in last 3 months to attend work when feeling unwell</td>
<td>66</td>
<td>62</td>
<td>58</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health / wellbeing</td>
<td>3.33</td>
<td>-</td>
<td>3.59</td>
</tr>
<tr>
<td>* KF20. % experiencing discrimination at work in last 12 months</td>
<td>12</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>82</td>
<td>83</td>
<td>87</td>
</tr>
<tr>
<td>* KF22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>* KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>50</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>* KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>32</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td>* KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>32</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>33</td>
<td>33</td>
<td>38</td>
</tr>
<tr>
<td>* KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>29</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>87</td>
<td>88</td>
<td>90</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.41</td>
<td>3.37</td>
<td>3.71</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.31</td>
<td>3.33</td>
<td>3.64</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.41</td>
<td>3.36</td>
<td>3.65</td>
</tr>
</tbody>
</table>
Staff survey Comments from our Chief Executive /HR Director

We are really pleased that there has been improvement in some areas of our Staff survey since 2014 as we recognise that there is a direct correlation between staff engagement, patient experience and patient outcomes.

Work through our Multi professional staff engagement group and some of our Clinical units and Directorates are bringing about a much more focused approach on Staff engagement and wellbeing.

Since September last year we have tried to involve staff more in decisions that affect them and introduced a regular staff forum where staff can meet with the Acting Chief Executive who responds to any issues the staff may have. We have also tried to make sure that all staff feel that their role counts in delivering excellent patient care through events like “What have you done to make a difference today?” campaign and the week long Unsung Hero’s Event which celebrated and shared the work of our support staff. All staff also received a small token of appreciation at Christmas from the Trust Board, thanking them for their efforts during the year. The Staff engagement and wellbeing team have worked closely with two of our clinical units to identify how they can improve their staff engagement – They have introduced breakfast meetings with staff, an electronic graffiti board which can be used as a communication tool or interactively to find out staff views and a regular newsletter

At the same time we know that this is just the beginning of our improvement journey and there is still considerable work to be done. Our Trust Board have agreed that during 2016/17 we will focus on improving three priorities based on the 2015 feedback from the staff survey. These are:

- Improving the Health and Wellbeing of our staff by looking more closely at issues of reported physical deterioration and stress at work and analysing ways in which we can promote and prevent this happening
- Reviewing and where appropriate, developing the communication skills of managers to ensure the key messages upwards and downwards are communicated more effectively
- Identifying the location of spikes in harassment, bullying and abuse from managers and other colleagues and taking appropriate action to reduce this.

We will also be introducing more feedback mechanisms for staff to tell us how they feel we are progressing with the three priorities and whether it is making a difference to them engaged with.
Annex 1. Statements from Commissioners, Healthwatch and HOSC

Statement from East Sussex Health Overview and Scrutiny Committee (HOSC)

During 2015/16 HOSC has welcomed the Trust’s largely positive engagement with the Committee’s review of quality improvement activity following the 2015 Care Quality Commission (CQC) inspections. CQC’s findings presented a considerable challenge for ESHT and clearly outlined the scale of change needed within the organisation. To support this, HOSC undertook a substantial review of key areas highlighted by CQC as in need of improvement and the Committee was encouraged by the progress being made and commitment to continue this. Our report (agreed in March 2016) made a number of key recommendations for the Trust to consider and we anticipate ESHT’s response to these in June 2016.

HOSC, alongside many in East Sussex, remain focused on working where we can to identify and support the improvements in quality that patients and their friends and families deserve. We hope that the Trust remains focused on addressing the long term and systemic cultural and leadership issues in order that ESHT staff are given the support and encouragement they need to succeed at work, and provide excellent care to their patients. We agree with the CQC that staff and patient satisfaction are intrinsically linked. Until staff survey results improve we will struggle to believe that services are really where they need to be and we hope that we will see the start of an upward trend here this year.

It is critical that the quality improvement activity already underway is consolidated and extended under the Trust’s new leadership and HOSC will continue to monitor progress on behalf of local people, working closely with CQC, NHS Improvement and local Healthwatch.

HOSC is pleased to see the CQC findings and the resulting Trust Quality Improvement Programme, ESHT 2020, given due prominence in the Quality Account and the Committee supports the development of a new Quality Strategy with a focus on patient safety. HOSC also supports the planned extension of patient and staff engagement activity, both of which are essential to the Trust building trust and support and ultimately achieving its aims.
2015/16 Quality Priorities

Given the scale of challenges facing the Trust during 2015/16 it is perhaps unsurprising that most of the quality priorities are partially achieved. HOSC welcomes the Trust’s commitment to continue work on the 2015/16 priority areas through its ongoing quality improvement plan.

2016/17 Quality Priorities

It is good to see that Quality Priorities have been chosen based on a range of information and engagement, and that they will form part of the wider Quality Strategy. HOSC is particularly pleased to see the inclusion of priorities which we know to be important to local people and which need addressing – outpatient appointments, end of life care and transport. It will be important for the Trust to be clear how the findings of the transport review will be taken forward with clear actions set out.

Medicines management and unnecessary patient transfers are also areas the Committee is aware require improvement and so represent appropriate choices for additional focus over the coming year.

HOSC looks forward to working with the Trust to monitor progress over the coming year.

Healthwatch East Sussex (HWES) welcomed and reviewed the account with optimism given the high level of input it has contributed to the organisation since the publication of the second Care Quality Commission (CQC) report of March 2015, after which the Trust was placed in special measures.

Whilst the account does not fully reflect the level of input Healthwatch East Sussex has provided, we are pleased to be in a position to support and qualify some of the quality statements reported upon.

In particular; the trust’s commitment to involving patients, staff and the public to help shape the delivery of high quality and safe care and embedding the trust vision and values with staff.

In both areas, HWES can evidence through its reports that positive changes are beginning to have an impact i.e. in increased patient and public involvement, more staff members understanding the role of local Healthwatch; and more staff recognising the value of patient experiences in improving the quality of the service they deliver.

The improvement journey; HWES will continue to be involved in the Quality and Standards Committee where all the new working groups will report their progress.

HWES will continue to monitor and ensure statements made in this account are acted upon i.e. that staff continue to take ownership of the services they deliver and that people who use their services are listened to and their contributions valued and acted upon.

Supporting ESHT Priorities; again HWES welcomes the five priority areas and can evidence through its reports, where change and improvements are beginning to have an impact, (based on what patients, carers and their families have told us so far).

HWES will continue to work with trust to ensure this improvement journey continues; by gathering independent, wider patient and public views and experiences and making sure the progress achieved, continues with rigor and pace.

HWES is pleased to be able to reflect on a positive year of involvement but would also want to seek assurances going forward that any progress made or reported as achieved is sustained i.e.

Patient experience, Priority 1: Improve the experience of our patients through improving face to face communication and the written information we provide. It is to be welcomed that this aim has been achieved, HWES, will through its regular liaison and involvement with the newly restructured Patient Experience Steering Group, hold the trust to account on maintaining and sustaining these improvements.
To conclude

Going forward, HWES would want to see this level of improvement achieved across all the priority areas, a robust sustainable Quality plan; and we forward to maintaining our close working relationship as a key partner and insisting the trust achieve high quality services for local people and staff alike.
Statement from Clinical Commissioning Groups

Thank you for giving the East Sussex CCGs the opportunity to comment on the draft Quality Report for 2015/16. (Eastbourne, Hailsham and Seaford, Hastings and Rother, High Weald Lewes and Haven CCGs)

“The East Sussex Healthcare NHS Trust Quality Account has been reviewed and we confirm it demonstrates progress against Trust priorities identified for 2015/16. It provides information across the three core areas of quality which encompass patient safety, patient experience and clinical effectiveness, and demonstrates an on-going commitment to improving quality of care. The information provided within this document reflects the information that has been shared with Commissioners throughout the year.

This has been a challenging year for the organisation, particularly following the Care Quality Commission (CQC) inspection which rated the organisation 'Inadequate" (and subsequently placed it into “Special Measures”) and internal structural reorganisation, including the departure of the Trust Chief Executive and Chairman. We acknowledge the work that has been undertaken following CQC scrutiny, the progress made to date to implement the Quality Improvement Plan and, in particular, the transparent nature of the organisation whilst it works to secure sustained service improvement and deliver high standards of care. The CCG has undertaken a number of quality walks within the Trust and has observed care, kindness and compassion being delivered to patients.

The Commissioners recognise the Trust has had many challenges in meeting expected levels of performance notably in areas related to emergency care, infection control, mixed sex accommodation and patient discharge. This has had an impact upon on patient experience and the organisation’s ability to deliver other key quality standards in areas such as planned care and diagnostic services. The Commissioners will continue to work with the Trust to ensure they are supported in providing safe, effective and high quality care to our local populations.

The Trust continues to be challenged in delivering the expected standard of some key quality and patient experience measures. These are: same sex accommodation, pressure damage and infection prevention and control. The CCGs believe the Healthcare Associated Infection (HCAI) position of the Trust remains challenged and the Trust has not achieved the required target in the reduction of CDI infections during 2015/16, largely due to improvements required in cleaning and lapses of care. However, the numbers of CDI have reduced from previous years and this should be positively recognised. The requirement of zero tolerance for MRSA was missed and this challenge continues. The CCGs therefore feel that this priority has not been met and would have expected to have seen included within the quality
account the challenges the Trust continues to face in delivering improvements in these areas.

The Quality Report 2015/16 outlines priorities for improvement in 2016/17 as well as how success will be measured in future; the CCGs support these priorities and the detailed work that underpins them. We will continue to seek assurance regarding progress throughout the year via our established assurance processes. In addition we will continue to seek assurance about safer staffing, workforce development, mortality and the experience of people using the Trust’s services.

Yours sincerely

Allison Cannon
Chief Nurse

We have been engaged by East Sussex Healthcare NHS Trust to perform an independent assurance engagement in respect of East Sussex Healthcare NHS Trust’s Quality Account for the year ended 31 March 2016 (“the Quality Account”) and certain performance indicators contained therein as part of our work. 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 2016 subject to limited assurance consist of the following:

- Rate of clostridium difficile infections; and
- Percentage of patient safety incidents resulting in severe harm or death.

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

Respective responsibilities of Directors and accountants
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 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 NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 (“the Guidance”) as supplemented by the Quality Accounts reporting arrangements 2015/16 letter dated 3 February 2016; 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 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 material omissions.

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

- Board minutes for the period April 2015 to June 2016;
- papers relating to the Quality Account reported to the Board over the period April 2015 to June 2016;
- feedback from commissioners as included within the Annex to the Quality Account;
- feedback from Healthwatch East Sussex as included within the Annex to the Quality Account;
- feedback from the East Sussex Health Overview and Scrutiny Committee as included within the Annex to the Quality Account;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, in respect of 2015/16;
- the latest national patient survey for 2015;
- the latest national staff survey for 2015;
• the Head of Internal Audit’s annual opinion over the Trust’s control environment dated April 2016;
• the Annual Governance Statement dated 1 June 2016; and
• the results of the Payment by Results coding review dated September 2015.

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 Trust, as a body, in accordance with the terms of our engagement letter dated 28 April 2015. Our work has been undertaken so that we might state to the Directors those matters we have agreed with them in our engagement letter and for no other purpose.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors, as a body, and East Sussex Healthcare NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of 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 Trust.

Basis for Qualified Conclusion

Based on our testing, we have been unable to conclude that the indicator reporting the percentage of patient safety incidents resulting in severe harm or death meets any of the six dimensions for data quality for accuracy, reliability, validity, timeliness, relevance or completeness because:

- the Trust has been unable to supply an audit trail to support the data provided by the Health and Social Care Information Centre in respect of the indicator and reported in the Quality Account; and

- differences have arisen between the data provided by the Health and Social Care Information Centre and the Trust in respect of incidents which have had their severity changed following upload to the National Reporting and Learning System, as a result of a backlog of incident investigations within the Trust.
Qualified conclusion

Based on the results of our procedures, with the exception of the matters reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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.

Janine Combrinck

For and on behalf of BDO LLP, chartered accountants

London, UK

30 June 2016
Annex 3. Equality Impact Assessment

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Answer</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the Quality Account affect a group with a protected characteristic less or more favourably than another on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion of belief, sex or sexual orientation.</td>
<td>No</td>
<td>All priorities are underpinned by a commitment to improve the quality of services and outcomes for patients and carers of all protected characteristics.</td>
</tr>
<tr>
<td>2.</td>
<td>Has the Quality Account taken into consideration any privacy and dignity or same sex accommodation requirements that may be relevant</td>
<td>Yes</td>
<td>We are committed to respecting privacy and dignity and this is implicit in improving our patient experience. Our capital schemes support compliance with delivering same sex accommodation requirements.</td>
</tr>
<tr>
<td>3.</td>
<td>Is there any evidence that some groups are affected differently</td>
<td>No</td>
<td>There is no evidence that the quality improvement priorities will affect some groups differently. We recognise the need to target objectives for those who have needs relating to protected characteristics and these are considered in respect of each priority e.g. in respect of access, use of interpreters, making information available in different formats etc.</td>
</tr>
<tr>
<td>4.</td>
<td>If you have identified potential discrimination are any exceptions valid, legal and/or justifiable</td>
<td>N/A</td>
<td>No discrimination identified.</td>
</tr>
<tr>
<td>5.</td>
<td>Is the impact of the Quality Account likely to be negative and if so can the impact be avoided.</td>
<td>No</td>
<td>No negative impact identified.</td>
</tr>
</tbody>
</table>
### Annex 4. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abuse</strong></td>
<td>Abuse is defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as:</td>
</tr>
<tr>
<td></td>
<td>- Sexual abuse</td>
</tr>
<tr>
<td></td>
<td>- Physical or psychological ill-treatment</td>
</tr>
<tr>
<td></td>
<td>- Theft, misuse or misappropriation of money or property, or</td>
</tr>
<tr>
<td></td>
<td>- Neglect and acts of omission which cause harm / place at risk of harm.</td>
</tr>
<tr>
<td><strong>Avoidable Death</strong></td>
<td>Deaths that could have been avoided given a different course of action</td>
</tr>
<tr>
<td><strong>Avoidable Harm</strong></td>
<td>Harm of patients that could have been avoided given a different course of action</td>
</tr>
<tr>
<td><strong>Cardiology</strong></td>
<td>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 specialise in this field of medicine are called cardiologists.</td>
</tr>
<tr>
<td><strong>Care Quality Commission</strong></td>
<td>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></td>
</tr>
<tr>
<td><strong>Care Pathway</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Clinical Audit</strong></td>
<td>Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.</td>
</tr>
<tr>
<td><strong>Clinical Coding</strong></td>
<td>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 provide a complete picture of the patient’s care.</td>
</tr>
<tr>
<td><strong>Clinical Management Executive</strong></td>
<td>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 organisation is run effectively, efficiently and in accordance with relevant statutory obligations. It makes decisions relating to planning and delivery across all aspects of the organisation’s functions within the strategic framework provided by the Board.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>Clostridium difficile or C. Difficile / C.Diff</strong></td>
<td>Clostridium Difficile also known as ‘C.Difficile’ or ‘C. diff’, is a gram positive bacteria that causes diarrhoea and other intestinal disease when competing bacteria in a patient or person’s 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.</td>
</tr>
<tr>
<td><strong>Commissioners of services</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Commissioning for Quality and Innovation</strong></td>
<td>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></td>
</tr>
<tr>
<td><strong>Culture</strong></td>
<td>Learned attitudes, beliefs and values that define a group or groups of people.</td>
</tr>
<tr>
<td><strong>Data Quality</strong></td>
<td>Ensuring that the data used by the organisation is accurate, timely and informative</td>
</tr>
<tr>
<td><strong>DatixWeb</strong></td>
<td>On 1&lt;sup&gt;st&lt;/sup&gt; 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.</td>
</tr>
<tr>
<td><strong>Department of Health</strong></td>
<td>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.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Deteriorating Patient</td>
<td>A patient whose observations indicate that their condition is getting worse.</td>
</tr>
<tr>
<td>Dignity</td>
<td>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.</td>
</tr>
<tr>
<td>Discharge</td>
<td>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.</td>
</tr>
<tr>
<td>Enforcement action</td>
<td>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.</td>
</tr>
<tr>
<td>Essential Care Rounds</td>
<td>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 help 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.</td>
</tr>
<tr>
<td>Friends and Family Test</td>
<td>An NHS ‘friends and family’ test was implemented by Prime Minister David Cameron in April 2013 to improve patient care and identify the best performing hospitals in England. Patients are 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 allows 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.</td>
</tr>
<tr>
<td>Healthcare-associated infection</td>
<td>An avoidable infection that occurs as a result of the healthcare that a person receives.</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>Healthwatch is the independent consumer champion created to gather and represent the views of the public on issues relating to health and social care. Healthwatch plays a role at both a national and local level, ensuring that the views of the public and people who use services are taken into account.</td>
</tr>
<tr>
<td>Hospital Episode Statistics</td>
<td>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.</td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio</td>
<td>Hospital Standardised Mortality Ratio (HSMR) is an indicator of whether death rates are higher or lower than would be expected.</td>
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<tr>
<td>Key Performance Indicators (KPIs)</td>
<td>Key Performance Indicators, also known as KPI help an organisation define and measure progress toward organisational goals. Once an organisation has analysed 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.</td>
</tr>
<tr>
<td>Multidisciplinary</td>
<td>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.</td>
</tr>
<tr>
<td>MRSA</td>
<td>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 ceph-a-losporins. 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.</td>
</tr>
<tr>
<td>Malnutrition Universal Screening Tool (MUST)</td>
<td>‘MUST’ is a five-step screening tool to identify adults who are mal-nourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan.</td>
</tr>
<tr>
<td>National Confidential Enquiry into Patient Outcome and Death – NCEPOD</td>
<td>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 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.</td>
</tr>
<tr>
<td>National Institute for Health and Clinical excellence</td>
<td>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></td>
</tr>
<tr>
<td><strong>Never Event</strong></td>
<td>A Never Event is a type of Serious Incident (SI) 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’.</td>
</tr>
<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>
</tr>
<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>
</tr>
<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>PLACE</strong></td>
<td>Patient-led assessments of the care environment (PLACE). A system for assessing the quality of the patient environment introduced in April 2013 replacing the Patient Environment Action Team (PEAT) inspections.</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>
</tr>
<tr>
<td>Privacy and dignity</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>Patient Reported Outcome Measures (PROMs)</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>Providers</td>
<td>Providers are the organisations that provide NHS services, e.g. NHS trusts and their private or voluntary sector equivalents.</td>
</tr>
<tr>
<td>Registration</td>
<td>From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC).</td>
</tr>
<tr>
<td>Releasing time to care – the productive community series</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>
</tr>
<tr>
<td>Research</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>
</tr>
<tr>
<td>Root Cause Analysis (RCA)</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>
</tr>
<tr>
<td>Safeguarding</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>
</tr>
</tbody>
</table>
### Serious Incident (SI)
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.

### Summary hospital-level mortality indicator (SHMI)
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.

### Trust Board
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.

### Waterlow
The ‘Waterlow’ score (or scale) gives an estimated risk of a patient developing a pressure sore.

### Venous Thromboembolism (VTE)
Blood has a mechanism that normally forms a ‘plug’ or clot to stop the bleeding when an injury has occurred, for example a cut to the 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 the body, most commonly in the leg, it is called deep vein thrombosis (DVT). If the blood clot comes loose it can travel through the bloodstream to the lungs. This is called pulmonary embolism and it can be fatal. DVT and pulmonary embolism together are known as venous thromboembolism.
Feedback on this document is welcome...

Please email us at:
esh-tr.enquiries@nhs.net

Or write to us at:
Communications Department
East Sussex Healthcare NHS Trust
Eastbourne DGH
Kings Drive
Eastbourne
BN21 2UD

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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).