EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 1st December 2020 commencing at 09:30 via MS Teams

	AGENDA		Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 6th October 2020	A		
4.	Matters Arising	B		
5.	Board Committee Chair's Feedback		Committee Chairs	
6.	Chief Executive's Report		CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
7.	Integrated Performance Report Month 7 (October) 1. Quality and Safety 2. Access, Delivery & Activity 3. Leadership and Culture 4. Finance	Assurance	C	CND MD COO HRD DF	1015 - 1115

BREAK

STRATEGY

					Time:
8.	Building For our Future	Information	D	Tracey Rose	1130 - 1145

GOVERNANCE AND ASSURANCE

					Time:
9.	Quality Account 2019/20	Assurance	E	CND	1145 - 1215
10.	Winter Flu Plan	Assurance	F	HRD	
11.	Papers for review and noting: 1. Learning from deaths Q1 2. Infection Control Annual Report 3. Complaints Annual Report 4. Safeguarding Annual Report	Assurance	G		
12.	Trust Board meeting dates 2021	Information	H	Chair	

ITEMS FOR INFORMATION

				Time:
13.	Use of Trust Seal	I	Chair	1215 - 1230
14.	Questions from members of the public (15 minutes maximum)		Chair	
15.	Date of Next Meeting: Tuesday 9th February 2021		Chair	

Chairman

Key:	
Chair	Trust Chairman
CEO	Chief Executive
CND	Chief Nurse and DIPC
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DS	Director of Strategy
DF	Director of Finance
HRD	Director of Human Resources
MD	Medical Director

Steve Phoenix

3rd November 2020

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 6th October 2020 at 10:30 video conference via Microsoft Teams

Present: Mr Steve Phoenix, Chairman
Mrs Joe Chadwick-Bell, Chief Executive
Mrs Vikki Carruth, Chief Nurse & DIPC
Mrs Jackie Churchward-Cardiff, Vice Chair
Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mr Paresh Patel, Non-Executive Director
Mr Damian Reid, Director of Finance
Mrs Nicola Webber, Non-Executive Director
Dr David Walker, Medical Director

Non-Voting Directors:
Mr Imran Devji, Interim Chief Operating Officer
Mrs Amanda Fadero, Associate Non-Executive Director
Miss Monica Green, Director of Human Resources
Mr Richard Milner, Director of Strategy Innovation & Planning
Ms Lynette Wells, Director of Corporate Affairs
Ms Carys Williams, Associate Non-Executive Director

In attendance:
Ms Cassandra Blowers, Workforce Equalities Lead
Ms Saba Sadiq, Deputy Director of Finance (observing)
Mr Peter Palmer, Assistant Company Secretary (minutes)

053/2020 **Welcome**

1. Chair's Opening Remarks

Mr Phoenix welcomed everyone to the meeting. He noted that it was Mrs Chadwick-Bell's first meeting as Chief Executive and congratulated her on her new role. He emphasised that she had the full backing of the Board and hoped that she would be hugely successful in her new role.

He noted that it was Miss Green's final Board meeting prior to her retirement and thanked her for 23 years of service to the Trust, an outstanding contribution. She would be hugely missed by staff throughout the organisation, but her retirement was richly deserved. He offered grateful thanks from the Board. Miss Green explained that it had been a privilege to work with such committed, talented individuals and praised the position that the Trust was in as she left the organisation.

2. Apologies for Absence

Mr Phoenix advised that no apologies for absence had been received.

054/2020 **Declarations of Interest**

In accordance with the Trust's Standing Orders that directors should formally disclose any interests in items of business at the meeting, the Chairman noted that no potential conflicts of interest had been declared.

055/2020 **Minutes**

The minutes of the Trust Board meeting held on 4th August 2020 were considered and were agreed as an accurate record. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

056/2020 **Matters Arising**

There was one matter arising from the previous meeting, which had been discharged.

057/2020 **Board Committee Chair's Feedback**

i. Audit Committee

Mrs Webber reported that the Audit Committee had received an update on the development of a Data Quality Framework from internal auditors, which would allow the quality and reliability of data produced by the Trust to be assessed. The framework would also potential identify areas of focus for internal audit.

Mrs Webber praised the new format of the Board Assurance Framework (BAF) and noted that the Committee supported the recommendations being made to the Board for changes to risk ratings. The Corporate Risk Register had been reviewed, and work would be undertake to update and improve this in line with recent changes to the BAF. It had been agreed that the Quality and Safety (Q&S) Committee would take over monitoring of clinical audit within the Trust.

Internal audit had issued a report on critical financial assurances within the Trust, giving substantial assurance. Reasonable assurance had been given about governance arrangements during the pandemic, a commendable outcome given the pressure that the Trust had been under. A limited assurance opinion had been given about IT continuity, and the Associate Director of Digital would be invited to the next Committee meeting to provide further information.

Local Counterfraud services had reported on their ongoing proactive work, including liaising with financial and procurement teams about risks that had emerged during the pandemic. A review of access by external organisations to patient data was being undertaken. The Trust was examining tendering processes for Building for our Future (BFF) to ensure that it received the best possible value for money.

ii. Finance and Investment Committee

Mr Phoenix reported that the Committee had reviewed the Trust's performance during the first six months of 2020/21 under the covid financial regime. The Committee had noted and discussed the revised financial rules that had bene introduced for the remainder of the year. Preparation for 2021/22 had been discussed and a review of capital expenditure undertaken.

The Finance and Investment (F&I) Strategy Committee had reviewed organisational priorities and had undertaken preparatory discussions ahead of detailed Board conversations about a refreshed organisational strategy in November.

iii. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had discussed the newly released National People plan. The Trust had identified areas of focus and milestones emerging from the plan, and the Committee had discussed embedding the plan within the organisation.

Progress would be reported to POD on a quarterly basis.

Ms Kavanagh noted that the annual NHS staff survey had launched on 21st September. A report on employee relations had been received and discussed by the Committee, which had shown a decrease in the number of formal complaints raised by staff compared to the previous year. A lot of work had been undertaken to advertise the variety of ways in which staff could raise concern within the Trust, and to encourage them to do so. There had been an increase in sickness and absence, with a large increase due to anxiety. A lot of support was offered to staff and this remained a continued organisational focus. A report from the Guardians of Safe Working Hours was received and an issue of lack of engagement was highlighted, with a deep dive considered to look at the problem in more detail.

iv. Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Quality and Safety (Q&S) Committee had agreed the three priorities for the Quality Account. They would be:

1. Perfecting discharge
2. Embedding safety
3. Infection control excellence

Chiefs of divisions would be invited to the strategic elements of future Q&S meetings. Other issues discussed had included ophthalmology and diabetic screening waiting lists, a changing approach to managing falls, the infection control BAF and the Trust's winter plans. Concerns had been discussed about the number of patients waiting for operations and the length of their waits.

058/2020 **Board Assurance Framework**

Mrs Wells presented the BAF, noting that it had been discussed in detail at all the recent Committee meetings. Risk appetite had been added to the document since it had last been presented to the Board. She sought the Board's approval to increase the level of risk for BAF 2 in respect of access standards to 16. She also asked for approval for the reduction of the level of risk associated with BAFs 7 and 8, from 16 to 12. This was due to increased capital and bids for capital respectively. She noted that BAF 5 had been rewritten to include violence and aggression, lone working and covid risks.

Mrs Kavanagh explained that she was happy with the changes to BAF 5, noting that she felt that they more accurately reflected the mitigations that had been put in place by the organisation. Mrs Churchward-Cardiff asked for an update on the relocation of extended services noted in BAF 2. Mrs Chadwick-Bell explained that the issue was now largely resolved. She explained that a summary of the Trust's progress in restoring activity to normal, as well as progress in relocating services, would be presented to the Board at December's meeting. **TA/RM**

The Board agreed with the revised ratings for BAF 2, 7 and 8.

059/2020 **Chief Executive's Report**

Mrs Chadwick-Bell presented a verbal report, and thanked Mr Phoenix for welcoming her to her new role as Chief Executive. She explained that she was very proud to have taken on the job, having begun her career at the Trust. She would look to lead the organisation on the next step of its journey, building on all the hard work that had gone before. She thanked Dr Bull for his leadership.

The Trust was trying to return to pre-covid activity levels, working within infection control and social distancing rules to ensure patient safety. A submission had been made to NHSI with trajectories for returning financial performance and activity to normal, with good progress being made. Significant work was being undertaken to plan for the winter, in conjunction with system partners, to ensure that Trust's position was as robust as possible; a potential second surge was also being planned for.

Mrs Chadwick-Bell reported that 111 First, a telephone clinical assessment service where patients would be clinically validated to ensure that they were appropriate for A&E attendance would be launched on 15th October. This would allow patients to be directly streamed to the most appropriate service for their treatment, including to surgical pathways. This should improve the experience of patients by giving them appointment times for A&E attendance and regulating demand. Emergency patients could continue to attend A&E as usual.

The reception area of the front entrance at the Conquest had opened, with staff pleased with the improvements. She anticipated that the entrance would be fully opened by the end of October.

Mrs Chadwick-Bell reported that the Prime Minister had confirmed funding for the NHS Health Infrastructure Plan, which would lead to extensive funding for the Trust's Building for our Future (BFF) programme. Meetings had commenced with design teams and site surveys had taken place ahead of enabling works. Public engagement around BFF had begun the previous day with details available on the Trust's website, and the Trust was very keen to hear the views of patients, the public and staff.

Mrs Kavanagh asked whether there had been any initial public reaction to BFF plans and Mrs Chadwick-Bell explained that she was not aware of any feedback; the press release had only been sent out the previous day. Plans, once finalised, would be shared throughout the Trust and with the public.

Mrs Churchward-Cardiff noted the importance of ensuring that plans for BFF looked at the future of healthcare as well as current needs, and asked what advise was being received to ensure that this happened. Mrs Chadwick-Bell explained that clinicians had been asked to design their services in an innovative manner, alongside experts from across the country. These plans would be robustly tested to ensure that they met any the future needs. It was important that plans were supported by the CCGs and other stakeholders, who would provide challenge, support and advice as they progressed.

Mrs Fadero noted what an exciting time it must be to take on the leadership of the organisation and asked if there were any emerging expectations from partner organisations about BFF. Mrs Chadwick-Bell explained that the Trust did not have any designs to share yet. Partner organisations had membership of the BFF program board, and it was important that plans matched those of the Integrated Care System (ICS). Mrs Fadero noted the important of also working closely with local authorities and communities in developing plans.

Mrs Manson suggested that horizon scanning of best practices internationally should also be undertaken to ensure that the Trust was looking at all of the available options for patient treatment. Mr Phoenix agreed, noting that a lot of innovative care was taking place in India.

Mrs Kavanagh asked whether written CEO reports would be presented to the

Board in the future. Mrs Chadwick-Bell explained that she had discussed the format of her reports with Mr Phoenix. She would be reporting verbally to the Board initially, but was happy to discuss changing the format in the future if requested.

The Board noted the Chief Executive's Report.

060/2020 **Integrated Performance Report Month 5 (August)**

i. Quality & Safety

Mrs Carruth reported that a recent Never Event had taken place, relating to use of high flow air instead of oxygen. No harm had occurred to the patient involved, and significant work was being undertaken to prevent any recurrence. The issue was being monitored by Q&S.

She explained that the Trust was seeing an increase in the reporting of pressure ulcers occurring in patients' homes following patients' decisions to decline advice or treatment. Risk assessments and patient records were being used to ensure that patients' decisions were recorded, and Q&S were monitoring the issue.

One MRSA bloodstream infection had taken place in August, with the source unable to be determined. There had been recent significant workforce challenges in the Trust which had required a lot of additional capacity. New ways of working, including red and green areas, presented an ongoing challenge to staff and nursing teams were working closely with operational colleagues to manage this. She thanked volunteers for supporting the meet and greet service in the front entrances of the Trust.

Dr Walker presented information on Covid cases in East Sussex, reporting that during August admissions and positive cases had been low, with a slight rise seen in September continuing into October. Kent, and Brighton and Hove had seen similar patterns to East Sussex. Testing remained an issue, with limited supplies of reagents required for testing available. A new machine was being installed in the Trust, which would increase in-house testing capacity to several hundred tests a day.

The Summary Hospital-level Mortality Indicator (SHMI) remained stable at 97, having reduced slightly in early 2019 to 94. The reasons for the slight increase were unclear. A slight increase in crude mortality rates from 1.44 to 1.59 had also been seen, with no obvious reason. The pandemic may have led to patients not coming in for treatment as normal, which could have led to the increases being seen.

Mrs Churchward-Cardiff asked about the effect that restricted availability of Covid testing was having on staff. Dr Walker explained that staff had found getting tested for Covid symptoms difficult, with tests that had been sent to Southampton subject to a reporting delay. The in-house testing capacity would help greatly when it was introduced, particularly with staff having coughs, colds and high temperatures as a result of seasonal colds and flu. Quick testing would be crucial in enabling staff to return to work. Miss Green reported that low numbers of staff were currently absent due to Covid.

Mrs Churchward-Cardiff explained that she was concerned about the impact that Covid was having on the Trust's staffing levels. Miss Green agreed, explaining that illness and child care impacted on staff, particularly as schools

had reopened. Mrs Carruth explained that the additional capacity in the Trust would be available for tests for patients and Trust staff, as well as staff working throughout the local healthcare system, local authorities, care homes and schools.

Mrs Manson asked when the new in-house testing machine would be operational and Dr Walker anticipated that this would be within two weeks, and would potentially be able to carry out more than 600 tests a day.

Mrs Kavanagh asked whether the Trust's MRSA infection rate should be a cause for concern. Mrs Carruth explained that this related to a single positive case. It had been highlighted within the IPR due to the infrequency of cases, but was not a cause for concern. There had been a slight increase in clostridium difficile cases, but these remained well under the limit for infections and were being monitored. All infections were subject to a post infection review or Root Cause Analysis, and were also discussed at the Infection Control Committee.

Mrs Webber asked whether the three Serious Incidents (SIs) included in the IPR that mentioned delays were due to Covid. Mrs Carruth explained that the Trust had started to see a small number of SIs related to Covid. National harm reviews were being undertaken to fully understand the impact that the pandemic had had on patients, particularly those who had not been able to access services as usual due to the pandemic. Dr Walker noted that he was only aware of a single case where a delay had led to harm for a patient.

Mrs Webber asked about two SIs relating to infections in maternity services. Dr Walker explained that during the pandemic there had been issues with getting supplies, with alternatives sought which had been less effective in certain circumstances than the usual products used. There was no suggestion that the products used were unsafe, but products that had caused issues had been withdrawn from all levels of trust and reported and the original products were now being used again.

ii. <u>Access and Delivery</u>

Mr Devji reported that performance against the 62 day cancer standard had improved from July to August from 76% to 79.7%. Patients waiting for over 104 days for cancer treatment had continued to reduce, with clinically led harm reviews being undertaken for all long waiting patients. He anticipated that 62 day cancer performance would reduce in October, due to long waiting patients beginning treatment, and would remain low until this backlog was cleared.

During September, a cancer focus week had taken place where there had been a focus on patient pathway validation, meetings with cancer tracking teams and speciality teams and checking and reinforcing of harm reviews. The Trust's elective care board was meeting on a fortnightly basis, reviewing the Trust's Referral to Treatment (RTT) position. This had led to improved performance of 75% against the RTT standard in September. 235 patients had waited for over 52 weeks for treatment, and 50% of those patients had now been issued with appointment dates. 40% of the Trust's outpatient appointments were taking place on a non-face to face basis.

The Trust's performance in September against the 1% six week diagnostic standard had been 28.1%. Radiology activity numbers had increased, demonstrating improving performance continued and mutual support arrangements across Sussex were being reviewed, including potential support

from the independent sector to improve the position further.

A&E performance during August had been 89.6% against the four hour standard, the reduction in performance driven by a middle grade vacancy at EDGH. Performance had improved to 91.2% in September, and the Trust was in the top ten nationally for performance during October. Mr Devji praised the performance and improvements realised by A&E teams.

Mrs Churchward-Cardiff noted her concern about virtual patient appointments, asking if they could lead to extended patient pathways due to delays in diagnostic appointments. Mr Devji explained that the virtual appointments were clinically driven, and that new patients were mainly seen on a face to face basis. The Trust was very mindful of the risks and were closely monitoring processes. Dr Walker reported that some high risk medical staff were anxious about returning to face to face appointments, and appointments needed to be managed in a way that kept both patients and staff safe.

Mrs Chadwick-Bell explained that the Trust was working with PA Consulting to look at rapid improvements that could be achieved in eight specialities by designing clear pathways where patients could be seen safely on a non-face to face basis for both new and follow up appointments. These appointments would be designed into patient pathways and clinically driven.

Mrs Fadero noted the importance of ensuring that the learning that had come out of recent rapid improvement events was embedded into the organisation beyond the initial focussed week of work. She hoped that the outcomes of the work with PA Consulting would be presented to the Board in the future.

Mrs Manson asked for an update on elective inpatient performance, noting that the four week average reported had been 63% against planned performance in September of 75%. Mr Devji explained that the Trust had submitted an anticipated performance level for September of 65%, against a national expectation of 80% performance. Performance was now ahead of this target at 66%; it would be challenging to reach the target of 75% in November. Mrs Chadwick-Bell noted that capacity for elective patients would increase the following week when Michelham Ward reopened at EDGH, allowing orthopaedic work to resume at the hospital. This would lead to improved performance.

iii. <u>Leadership and Culture</u>

Miss Green reported that the Trust's vacancy rate in September had been 9.5%, comparing favourably to other NHS trusts. At the same time during 2019/20 it had been 10%. The highest vacancy rates were seen amongst medical and dental staff at 17.8%. There had been good recent recruitment in these areas as well as for nurses and Allied Health Professionals. Covid restrictions had made it harder for new staff to join the Trust, but 50 overseas nurses would be joining the Trust by the end of November.

Turnover within the Trust in September had been 10.1%, which was a very positive figure. The main reasons staff gave for leaving the organisation were retirement or for career advancement. The Trust would look at the leadership opportunities that could be made available. 84% of workforce spend in September had been on substantive staff, with a good balance between spend on agency and substantive staff.

Staff sickness had increased slightly, with the highest rates seen in estates and

facilities. Musculoskeletal issues, stress and anxiety were the highest causes of sickness and lots of support was being offered to staff, with good feedback about this being received. Staff were being risk assessed to ensure that they were safe to work during the pandemic, with 96% of all staff having had a risk assessment.

Mrs Churchward-Cardiff explained that she was concerned about the resilience of staff, particularly middle managers who were already under a lot of pressure to improve performance, with winter still to come. Miss Green agreed, explaining that support was offered to individual staff and to teams. She would look at what additional measures could be put in place to support middle management. Mrs Carruth reported that she held weekly virtual huddles with matrons, and encourage managers to access help when required.

Mrs Churchward-Cardiff asked why appraisal rates in the Trust had fallen. Miss Green explained that operational colleagues were under significant pressure and were struggling to undertake formal appraisals. Dr Walker noted that the GMC had asked the Trust to stop appraisal of medical staff during the pandemic, and this had only restarted in October. He anticipated that the appraisal rate would improve as outstanding appraisals were undertaken.

Mrs Churchward-Cardiff asked if it was a good time for the Trust to recruit staff particularly to science and technology roles. Miss Green explained that there were a lot of opportunities for recruitment across the organisation, but recruitment of medical and dental staff continued to be difficult.

Mrs Webber asked whether the turnover figure for staff could be presented with junior doctor rotation taken out of the figures. She was unsure if this was responsible for the upward trend being reported. Miss Green explained that this data could be taken out, but the upward trend continued even with the removal. Mrs Webber asked whether covid could be removed from increasing staff sickness figures, as it was hard to identify whether this was a matter of concern or directly related to the pandemic. Miss Green explained that the increase was due to Covid, and that staff sickness was reviewed in detail by POD.

Mrs Fadero noted that if a second wave of the pandemic arrived, the Trust would have to continue to manage business as usual. She asked how the Board could ensure staff welfare as they tried to manage winter pressures, a second wave of covid and restoration of activity. Mr Phoenix noted that this was an anxiety shared across the NHS. Miss Green explained that the Trust was doing all it could to plan for the winter, taking on additional temporary staff where they were needed. Dr Walker noted that a second wave would be much harder for medical staff due to business as usual continuing. During the first wave, many services were stopped, allowing doctors to provide support where it was needed.

Mr Reid congratulated Miss Green on the significant improvements seen in recruitment and retention of staff. He noted the importance of ensuring that increases to workforce establishment were tracked on a long term basis; not doing so could lead to the Trust being less sustainable in the longer term.

iv. <u>Finance</u>

Mr Reid explained that the national financial regime that had been introduced for months 1-6 of the year would soon be ending. The Trust would be held to account for delivering financial performance after October, and would return to tracking efficiencies and delivering financial plans. There was a risk that targets

would not be met by either the Trust or the system. The Trust had submitted a financial phase three restore and recover plan and would find out at the end of October whether this had been accepted.

During September a capital adjustment had been made with the Trust receiving £234m from the Department of Health to pay off historic debts; this would lead to a stronger balance sheet moving forward. The Trust's capital plan had significantly improved with £55m of investment planned during the year, with funding from a number of sources including BFF and from the ICS.

Mr Patel asked about the potential risk to the system's finances of £350m. Mr Reid explained that the final targets for the system and trusts had not yet been agreed. There was no risk to the plan until month seven where a backdated claim process would be undertaken by the ICS and CCGs to verify claims made by the Trust for funding related to Covid. On benchmarking, the Trust had made higher claims than other Trusts, and conversations with the system had already taken place about this.

Mrs Webber asked whether Executives felt that the summary page of the IPR reflected how the organisation felt. Mrs Chadwick-Bell explained that she felt that that it provided an accurate representation of the Trust, highlighting key issues. She explained that the written summary would be improved in future reports to more clearly highlight any areas of concern.

The Board noted the IPR Report for Month 5 and actions in place

061/2020 **Integrated Care System Collaborative Workstream**

Mr Phoenix noted that the ICS was crucial for the Trust and that it had been very helpful in setting the direction for the organisation moving forward. Mr Milner presented a document setting out how decisions would be made by the ICS and key workstream areas for the acute collaborative. Restoration and recovery across the system would be crucial moving forwards. It was vital that organisations across Sussex approached issues collaboratively, as everyone was facing similar issues; the ICS provided a forum in which to do this.

Mrs Churchward-Cardiff asked how public consultation would take place if decisions were made by the ICS about care taking place in specific locations. Mrs Chadwick-Bell explained that no significant service changes were being planned by the ICS, but if this was the case the ICS and commissioners would lead the process which would include public consultation.

Mrs Manson asked why the Trust was not represented on the mental health collaborative. Mrs Chadwick-Bell explained that the various organisations in Sussex came together at the ICS partnership board and included all provider organisations, commissioners and local authorities. None of the acute organisations had a place on the mental health collaborative board and she agreed to discuss the issue with the ICS. She noted that the Trust participated in the East Sussex mental health board.

Mrs Fadero note that collaboratives had been meeting for at least 18 months and asked what they would view as a successful 2020. Mr Milner explained that restoration and recovery, mutual aid and support and service model changes were dominant topics. The introduction of digital pathology would be a crucial area, enabling beneficial changes across the health system.

The Board noted the ICS Collaborative Workstream Update.

062/2020 **Winter Planning**

Mr Devji presented the paper, explaining that across the system there was an anticipated winter bed gap of 111 beds (92 acute and 19 community). A productive session had taken place with system partners a couple of weeks before, where commissioning of 47 additional beds had been agreed. Internally an additional 24 acute beds would be made available on Glynde Ward, with a further six beds available near to Lewes. System-wide winter planning was being undertaken by the ICS, with twice weekly meetings taking place.

Mrs Manson asked what plans were being made for a second wave of the pandemic, asking whether the identified gap of 111 beds included contingency for this. Mr Devji explained that the ICS had planned for different scales of a second wave, with a trigger point approach being taken to managing any second wave. Conversations and resilience planning were taking place across the system. Dr Walker noted that it was likely that any second wave of Covid would impact on the number of patients willing to come into the Trust for treatment for other conditions.

Mr Patel asked whether, if a second wave was greater than anticipated, plans to open a Nightingale Hospital in Brighton would be resurrected. Mrs Chadwick-Bell explained that this was not being considered. A nationally funded six week hospital discharge fund would allow the system to purchase additional capacity if it was required.

Mrs Churchward-Cardiff asked about the staffing implications of opening additional capacity within the Trust. Mr Devji explained that a decision had been made that it would be better to flex capacity when required rather than permanently increasing, as there was a danger of normalising the additional capacity. Mrs Churchward-Cardiff noted that high levels of activity were becoming normal for the organisation and raised concern about the effects of moving staff between wards. Mrs Chadwick-Bell explained that the additional beds would not be introduced until January and discussions continued about whether they would be substantively staffed. Mrs Carruth noted that the Trust's primary concern would be ensuring safety, continuity and leadership in escalation areas and to do this it was important that substantive staff worked alongside temporary staff.

Mrs Fadero noted the large number of actions that were planned to manage both winter and the pandemic. She asked which action would have the greatest impact. Mr Devji explained that delivery and strengthening of the patient flow program would have a very positive effect on the Trust. System-wide, ensuring sufficient bed capacity would be crucial. He praised the urgency, pace and response seen in system-wide discussions.

063/2020 **NHS Charities Together**

Mrs Wells formally acknowledged the incredible generosity of the public in making donations to the Trust during the pandemic. She thanked members of public for all they had done to support the Trust. Mr Phoenix agreed, noting the outpouring of support that had been seen during the pandemic. Mrs Fadero explained that she had wanted to give the public a round of applause after reading the paper and thanked them for their support.

064/2020 **Workforce Equality**

Miss Green explained that the Trust's equality agenda had been divided earlier in the year. Mrs Blowers had been appointed as Workforce Equality Lead and

had undertaken an enormous amount of work undertaken since joining the Trust. She explained that an action plan had been developed, using evidence based on the specific workforce equality requirements of the Trust. The Trust had made good progress and had recently received a disability confidence employer certificate.

Mrs Blowers presented the Workforce Equality report, explained that a lot of progress had been made with Workforce Race Equality Standards (WRES) over the last year. She explained that a talent management strategy would look to improve recruitment and retention of BAME staff, along with career conversations. A number of events had been organised to celebrate Black History month, including talks, drop in sessions, and food in staff restaurants.

Mr Phoenix asked for further information about the Band 5 ceiling for BAME clinical staff mentioned in the report. Mrs Blowers explained that this referred to nursing staff, but would benefit from greater clarification within the report. Mr Phoenix drew the Board's attention to the request within the report to ensure that staff networks had chairs and vice-chairs, and resources. He explained that Board sponsors for the disability and LGBTQ+ networks were being sought, and he offered to take on the role of Board champion for the BAME network. Mrs Carruth offered to be Board champion for LGBTQ+ and Mrs Webber offered to be Board champion for the disability network. Mrs Fadero noted that she was also interested in linking in to the BAME network.

Mrs Kavanagh explained that the report had been discussed by POD who had endorsed the approach being taken to workforce equality. Mrs Fadero praised the progress being made by Mrs Blowers.

065/2020 **Papers for Review and Noting**

Learning from Deaths, Quarter Four

The Board noted the Learning from Deaths report.

Health and Safety Annual Report

The Board noted the Health and Safety Annual Report.

Organ Donation Annual Report

The Board noted the Organ Donation Annual Report.

066/2020 **Board and Committee Meetings**
Minutes from the following meetings were noted:

- Audit Committee, 30th July 2020
- POD Committee, 23rd July 2020

The Board noted the Committee Minutes.

067/2020 **Use of Trust Seal**
There were six uses of the Trust Seal reported:

Sealing 52 – East Sussex County Council, 6th August 2020
Partnership Agreement for Health Visiting Services for 3 years.

Sealing 53 – Aramark Limited on 18th August 2020
Licence to carry out works on Ground Floor Café at EDGH

Sealing 54 – East Sussex County Council, 1st September 2020
Deed of Extension for Mortuary services until 31st March 2020

Sealing 55 – Wilmott Dixon Ltd, 15th September 2020
Construction delivery agreement for fire compartmentation at EDGH

Sealing 56 – Phoenix Software on 16th September 2020
Contract for provision of N365 digital licenses for 3 years +1 year +1year

Sealing 57 – H&A Munro, 25th September 2020
Lease of Unit 10, Wheel Farm Business Park, for provision of district nursing services for 6 years.

068/2020 **Questions from Members of the Public**

Mrs Walke explained that she was very encouraged about BFF. She hoped that plans would allow innovative changes to take place. She thanked the Board for their hard work during the pandemic and explained that she was pleased to represent members of the local public in saying thank you to the Trust.

Mr Phoenix explained that conversations had taken place with local MPs about BFF as plans were being developed and these would continue throughout the process. MPs had been very supportive of the Trust's plans. The programme would represent the biggest single investment made in healthcare in East Sussex in at least a generation, and would be an important legacy for staff who worked on the project over the next few years.

Mrs Walke thanked Mrs Chadwick-Bell for contacting Save the DGH and offered to meet them. She explained that she was very pleased with her appointment and was looking forward to working with her and other new members of the Board.

069/2020 **Date of Next Meeting**

Tuesday 6th October 2020

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 4th August 2020 Trust Board Meeting

Agenda item	Action	Lead	Progress
058/2020 – Board Assurance Framework	Restoration and Recovery update to be presented at the next Board meeting, including update on relocated services	**TA/RM**	Paper on agenda for meeting.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period October 2020 (Month 7)

Content

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust

About our IPR

- Our IPR reflects how the Trust is currently working and how the on-going journey of improvement and excellence, reflected within our Strategy and Operational Plan (2019/20), is being delivered.
- Throughout our work we remain committed to delivering and improving on:
  - Care Quality Commission Standards
    - Are we safe?
    - Are we effective?
    - Are we caring?
    - Are we responsive?
    - Are we well-led?
  - Constitutional Standards
  - Financial Sustainability in the long term plan
- Our IPR, therefore, aims to narrate the story of how we are doing and more importantly how we will be doing as we look towards the future.
- Detailed data can be found within the IPR Data Detail (appendix A).

Our AMBITION is to be an outstanding organisation that is always improving
Our VISION is to combine community and hospital services to provide safe, compassionate and high quality care to improve the health and well-being of the people of East Sussex

East Sussex Healthcare NHS Trust

Performance Summary

Safe	Target	Sep-20	Oct-20	Variation	Assurance
Serious Incidents	<>	2	3	Common Cause	No Target
Never Events	0	0	0	Common Cause	Inconsistent
Falls, per 1000 Beddays	< 5.5	6.9	7.0	Concern	Inconsistent
Pressure Ulcers, grade 3 to 4	0	0	1	Common Cause	Inconsistent

Infection Control	Target	Sep-20	Oct-20	Variation	Assurance
MRSA Cases	0	0	0	Common Cause	Inconsistent
Cdiff cases	< 5	10	4	Common Cause	Inconsistent
MSSA cases	<>	0	2	Common Cause	No Target

Mortality	Target	Prev	Latest	Variation	Assurance
RAMI	<>	82.9	82.7	Common Cause	No Target
SHMI (NHS Digital monthly)	<>	0.96	0.96	Common Cause	No Target

Caring	Target	Sep-20	Oct-20	Variation	Assurance
Complaints received	<>	46	55	Common Cause	No Target
A&E FFT Score	> 96%				
Inpatient FFT Score	> 96%				
Out of Hospital FFT Score	> 96%	FFT suspended mid March 2020			
Maternity FFT Score	> 96%				
Out of Hospital FFT Score	> 96%				
Outpatient FFT Score	> 96%				

Key to variation and assurance flags	
Variation (current month)	Assurance (last seven periods v target)
Improvement	Consistently Hit
Common Cause	Inconsistent
Concern	Consistently Missed

Operational Performance (Responsive)	Target	Sep-20	Oct-20	Variation	Assurance
A&E 4 hour target	> 95%	91.3%	89.0%	Improvement	Inconsistent
12 Hour DTAs	0	0	0	Common Cause	Consistently Hit
Acute Non Elective LoS	3.6	4.0	3.8	Common Cause	Inconsistent
Community LoS	25	27.0	24.9	Common Cause	Inconsistent
RTT under 18 weeks	> 92%	78.7%	85.1%	Concern	Consistently Missed
RTT 52 week wait	0	174	112	Concern	Consistently Missed
Out of Hospital within target wait time	<>	88.0%	83.0%	Common Cause	No Target
Diagnosic under 6 week	< 1%	32.0%	29.6%	Concern	Consistently Missed
Cancer 2 week wait	> 93%	97.6%		Common Cause	Consistently Hit
Cancer 62 day	> 85%	76.1%		Common Cause	Consistently Missed

Organisational Health	Target	Sep-20	Oct-20	Variation	Assurance
Trust Level Sickness Rate	<>	4.6%	4.5%	Concern	No Target
Trust Turnover Rate	10.4%	9.9%	9.8%	Improvement	Consistently Hit
Vacancy Rate	9.3%	-0.6%	0.6%	Improvement	Inconsistent
Mandatory Training	90%	86.8%	88.1%	Common Cause	Consistently Missed
Appraisal Rate (%) 12 months	85%	75.2%	75.0%	Concern	Consistently Missed

Exceptions in month	Target	Sep-20	Oct-20	Variation	Assurance
VTE Assessment compliance	95%	93.2%	93.0%	Concern	Consistently Missed

Phase 3 Recovery	Nat. Target	ESHT Target	ESHT Actual
First Outpatient Attendances	100%	90%	86%
FollowUp Outpatient Attendances	100%	96%	85%
Elective DayCase Spells	90%	86%	83%
Elective Ordinary Spells	90%	75%	89%
Diagnostic Tests	100%	99%	101%

Quality and Safety

Delivering safe care for our patients
What patients are telling us?
Delivering effective care for our patients
Challenges and risks

Safe patient care is our highest priority

Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Summary

East Sussex Healthcare NHS Trust

Quality and Safety

October 2020 Data

Complaints received
Rate of complaints was highest in WC&SH and this was reviewed and discussed at their Div IPRM by the COO and Chief Nurse. No specific themes or trends otherwise.

Falls
The rate of falls for Oct was 6.9 per 1000 bed days and is within control limits. A cluster review has been commissioned in medicine to review significant falls re: themes, trends and lessons learned.

Infection Control
The number of Clostridium difficile infections was within the monthly limit in Oct and the trust remains within the annual limit (based on previous year). Post infection reviews are underway with plans to increase anti-microbial ward rounds on wards of high incidence.
Prevention and control of RSV and Seasonal influenza in addition to COVID surge, form part of winter planning and patient pathways are being assessed to try to limit the impact of these infections during the coming months. The new IPC BAF continues to be reviewed at the Q&SC with good progress and assurance to date.

COVID-19
Since October, COVID cases in the community have started to rise in East Sussex, but to a lesser degree than elsewhere in the UK and in particular, the North of England. Some of the cases are wrongly attributed to us from University students living away from home. This explains the preponderance of the younger age groups affected. Admissions have just started to rise slowly across our sites.

Serious incidents
There were 3 serious incidents reported in month. Serious Incident Investigations are underway.

Pressure Ulcers
Rates remains within control limits with common cause variation.
The recent increase in category 2 damage amongst acute inpatients has reduced and remains subject to close surveillance by the PURG.

Workforce
Staff absence for October is comparable with 2019/2020 data but workforce challenges continue with ongoing and considerable use of temporary workforce required to staff escalation areas and support recovery of planned activity. At time of writing absence is slowly increasing. A further cohort of international nurses are arriving on the 20th November and are being supported by our health and well-being team. Options for supporting Covid safe staff breaks/restoration are being explored and the psychological welfare of ESHT staff is being supported through a large number of initiatives.

Mortality
Our current SHMI is 96. RAMI results suggest there had been an increase in mortality, over and above any coding issues, however we remain better than average.

Vaccination and testing
The trust will be supporting the national drive regarding the provision of mass vaccination for the public, our staff and also offering regular testing to relevant staff. SROs are in place for both with the Chief Nurse and the Chief People Officer.

Author(s)

Vikki Carruth
Chief Nurse and Director of Infection Prevention & Control (DIPC)

David Walker
Medical Director

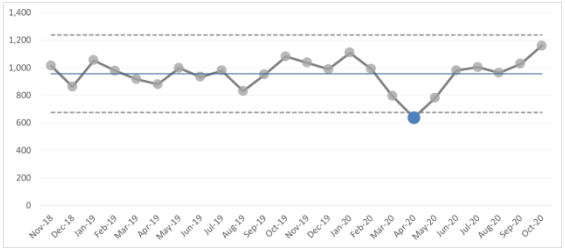
Safe Care – Incidents

East Sussex Healthcare NHS Trust

Quality and Safety

Patient Safety Incidents
(Total Incidents ESHT and Non ESHT)

Target: monitor
Variation normal
Current Month: 1159



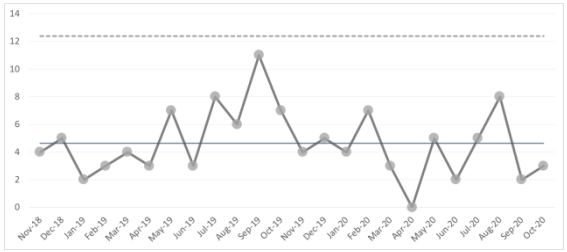
The number of patient safety incidents reported is now stable and at a level of reporting pre Covid-19.

Top 3 categories for **ESHT safety incidents** are:

- Slips, Trips and Falls (153) – A cluster review for significant falls is being led by the Medicine division.
- Medication-related incidents (103) – no specific concerns and monitored via PS&QG
- Antenatal, Maternity and Postnatal care (100) – no specific concerns and no particular themes or trends.

Serious Incidents
(Incidents recorded on Datix)

Target: monitor
Variation: normal
Current Month: 3



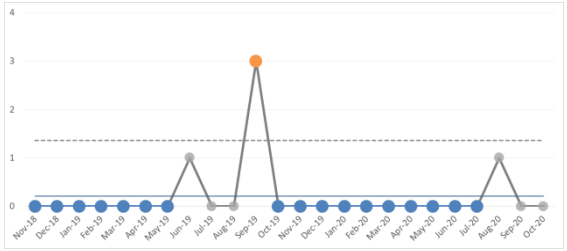
Serious Incident Management
There were 3 **serious incidents** reported during October:

- 1 x cardiac arrest during emergency surgery.
- 1 x fall to fracture
- 1 x delay in Gynae surgery

At the end of October there were 29 Serious Incidents open in the system; 20 under investigation and within timescales, 0 kept open by the CCG, 7 with CCG for closure and 2 incidents are with the HSIB.

Never Events
(Incidents recorded on Datix)

Target: 0
Variation: normal
Current Month: 0



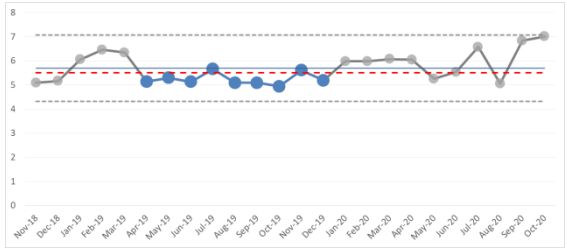
Duty of Candour:
For October verbal DoC was 71% with exceptions at 7% and written was 75% with exceptions at 18% . This is a rolling 12 month figure and is discussed at the Weekly Patient Safety Summit, Senior Leaders Forum and the Quality & Safety Committee.

Safe Care - Falls

East Sussex Healthcare NHS Trust

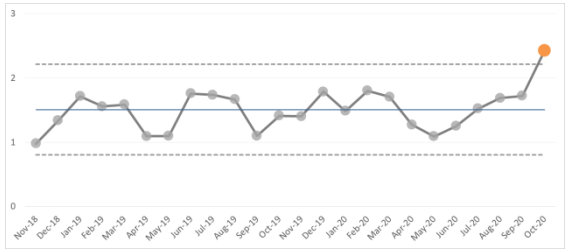
Total Falls Per 1000 bed days

Target: 5.5
Variation: Normal
Current Month: 7.0



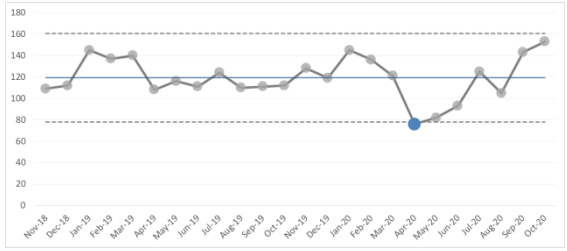
Falls with Harm Per 1000 beddays

Target: monitor
Variation: Normal
Current Month: 2.4



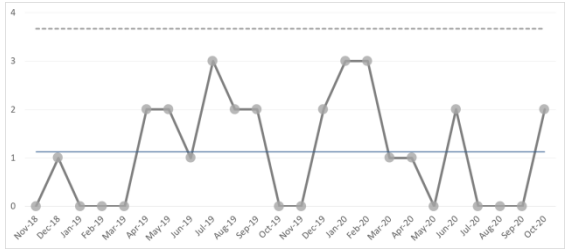
Total Falls

Target: monitor
Variation: normal
Current Month: 153



Major or Catastrophic Falls

Target: monitor
Variation: normal
Current Month: 2



There has been a small increase in the rate of falls in October with the rate near the trust's determined Upper Control Limit albeit just within normal variation. Work is ongoing with discussion at the Q&SC. Clinical areas remain very busy with additional areas open to support BAU as well as recovery and heading into Winter. The IPC requirements for Covid continue to present significant workforce and operational challenges in some areas. Donning (applying) additional PPE in some circumstances may mean slightly longer response times in certain clinical situations.

A cluster review for falls resulting in severe harm is being undertaken by the Medicine Division and will report back to the Falls Group, PS&QG and the Q&SC.

An initial review of falls with severe harm during 20/21 has indicated similar themes to last year. There is a sustained focus on Quality Improvement work in this area.

- Work is underway redesigning the risk assessment tool with plans to pilot as soon as possible in Medicine Division.
- A review of training and education is underway aimed at more simply assessing risk and the impact of falling for very high risk patients.
- An environmental risk assessment tool is being piloted in three areas to assist ward staff to be more aware of clinical environments to determine if anything else can be done to reduce risk.
- Medicine are trialling a new way of raising awareness of the risk of falls to patients with capacity, which will be reported back to the Falls Steering Group.

The numbers of inpatients who have more than one fall remains very low with twice weekly reporting to the Chief Nurse.

There were two falls with harm in October now being investigated as SI's.

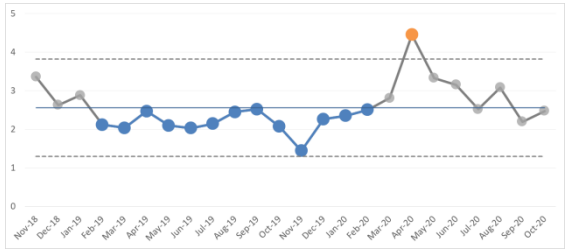
Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

Quality and Safety

Pressure Ulcers Per 1000 bed days (Grade 2,3,4)

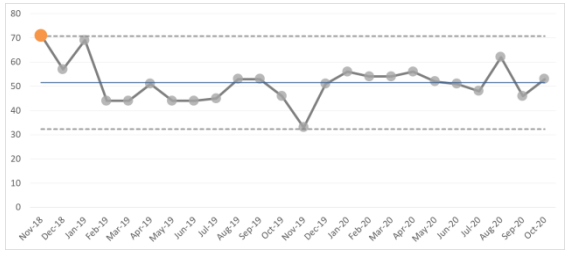
Target: monitor
Variation: normal
Current Month: 2.5



Incidence is returning to pre Covid levels as activity and acuity return to more usual levels and in some cases higher than usual. Rates remains within control limits with common cause variation.

Pressure Ulcers Category 2 (inpatient and community)

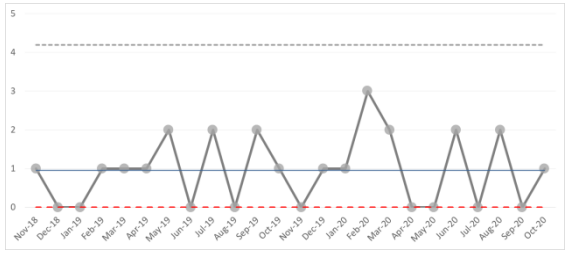
Target: monitor
Variation: normal
Current Month: 53



Of the 53 category 2 pressure ulcers reported in October ; 29 occurred in the acute hospitals, 3 in the intermediate care hospitals and 21 amongst patients in the community. No specific themes or trends to report.

Pressure Ulcers Category 3&4

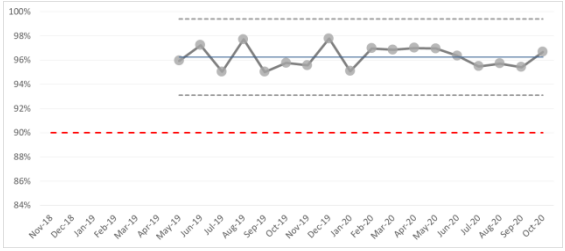
Target: zero
Variation: normal
Current Month: 1



One category 3 pressure ulcer was reported in October with full RCA underway.

Pressure Ulcers Assessment Compliance

Target: 90%
Variation: normal
Current Month: 96.7%



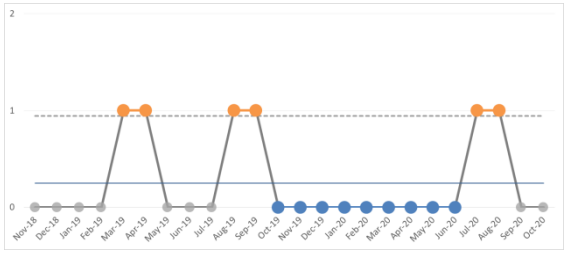
Consistently achieved since May 2019.

Safe Care - Infection Control (non COVID)

East Sussex Healthcare NHS Trust

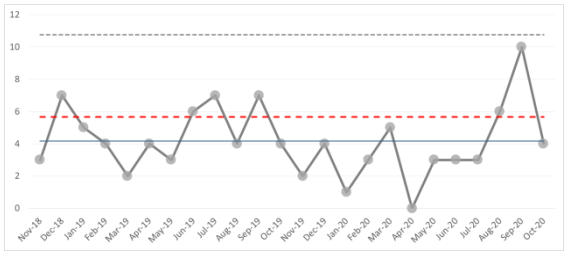
MRSA cases

Target: zero
Variation: normal
Current Month: 0



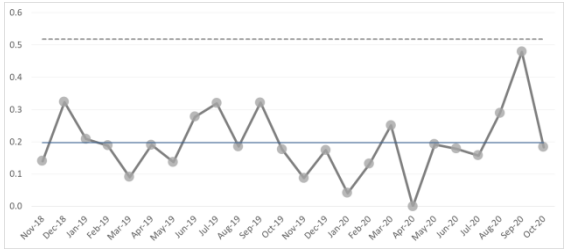
CDIFF cases

Target: 5.66
Variation: normal
Current Month: 4



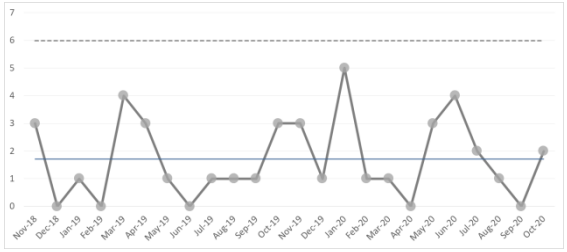
CDIFF per 1000 bed days

Target: monitor
Variation: normal
Current Month: 0.18



MSSA

Target: monitor
Variation: normal
Current Month: 2



MRSA bacteraemia –
There were no attributable MRSA bacteraemias reported for the month of October.

Clostridium Difficile –
For the month of October, we reported 4 hospital attributable cases against a limit of 5. Of those 4 cases, 3 were HOHA (Hospital Onset Healthcare Associated) and 1 was a COHA (Community Onset Healthcare Associated). Post infection reviews are underway.

Publication of annual data and commentary for mandatory reportable healthcare associated infections 2019/20 and limit setting has been postponed until November 2020.

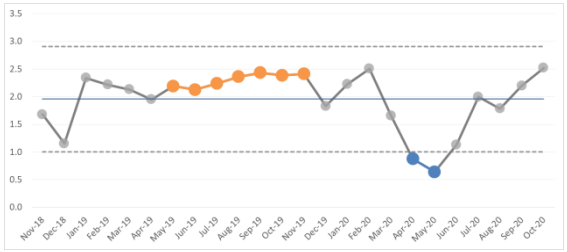
MSSA bacteraemia -
For the month of October, we reported 2 hospital attributable cases. One from a ward at EDGH, was assessed as potentially avoidable as it was due to a urinary tract infection in a patient with a long term catheter who later required stent insertion for kidney stones.

The new IPC BAF continues to be reviewed at the TIPCG with good progress to date.

What patients are telling us?

East Sussex Healthcare NHS Trust

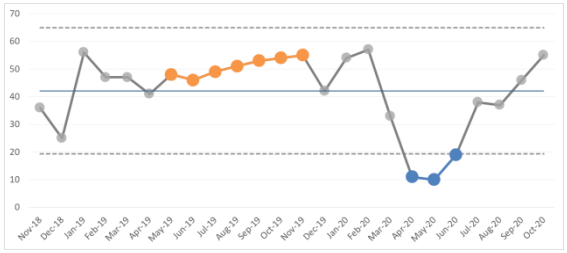
Complaints Received per 1000 bed days



Target: Monitor
Variation: normal
Current Month: 2.5

Themes continue to be about standard of care, patient pathway and communication with issues relating to lack of confidence in delivery of care and missed diagnosis. Work is ongoing with divisions to address themes. Response times overall are very good with specific discussions and reviews at divisional IPR's.

Complaints Received

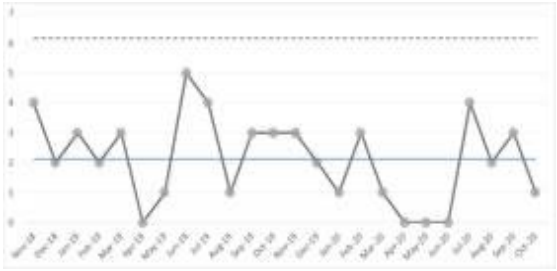


Target: Monitor
Variation: normal
Current Month: 55

- Medicine - 16 complaints – 1.2 per 1000 bed days*
- Urgent Care - 8 complaints
- DAS - 13 complaints – 2.6 per 1000 bed days*
- Out of Hospital - 6 complaints
- WC&SH – 6 complaints – 4.9 per 1000 bed days*
- Other depts - 2 complaints

* This includes all complaints not just inpatient stays

PHSO contacts



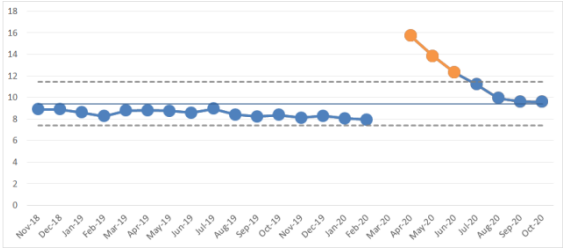
Target: Monitor
Variation: normal
Current Month: 1

In October there was 1 contact which was to provide an outcome on a case the PHSO had made enquiries about. No further action is being taken.

Effective Care – Nursing & Midwifery Workforce

East Sussex Healthcare NHS Trust

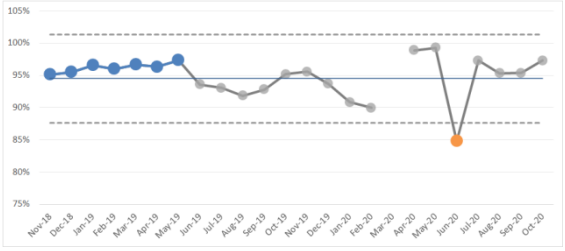
CHPPD
(Trust)



Target: monitor
Variation: normal
Current Month: 9.6

Care Hours Per Patient Day (CHPPD):
Care Hours Per Patient Day is now at an expected level.
The Model Hospital data has now been updated for *August 2020* and ESHT CHPPD at that time was 9.9 in line with the national acute and integrated peer medians which were 9.7 and 9.1 respectively.

Staff Fill Rate
(total)



Target: 100%
Variation: normal
Current Month: 97.3%

Staff fill rate – planned vs actual:
The fill rate for nursing across the Trust has improved in October although this has continued to be a daily challenge as escalation areas remain open, elective admissions continue, and caring for patients with COVID-19 means an increased requirement for staffing numbers. Recruitment continues and the Trust has welcomed a cohort of International Nurses in October.

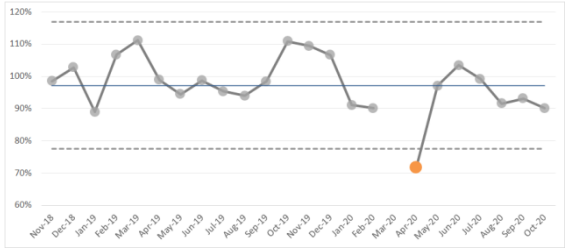
Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

Staff Fill Rate (Bexhill)

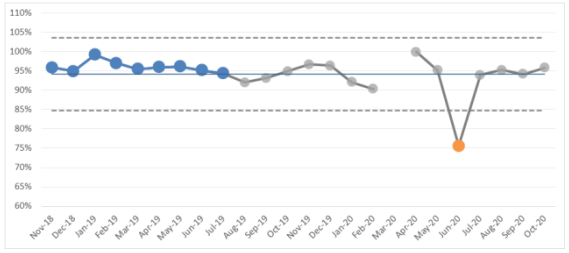
Target: 100%
Variation: normal
Current Month: 90.1%



Fill rate reduced slightly in October due to unavailability of Registered Nurses and an increased requirement to care for patients with COVID-19. This gap was supported by teams across the trust with daily review and management by clinical and operational teams.

Staff Fill Rate (Conquest)

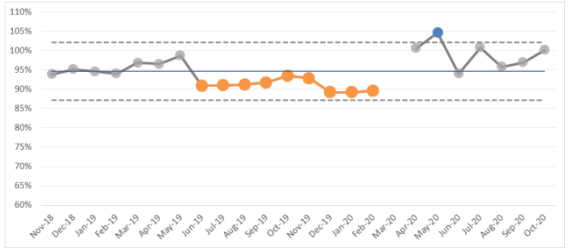
Target: 100%
Variation: normal
Current Month: 95.8%



Whilst supporting our community hospitals (Rye Memorial and Bexhill Irvine Unit), the Conquest Hospital has managed to maintain their fill rate with the support of the TWS team.

Staff Fill Rate (Eastbourne DGH)

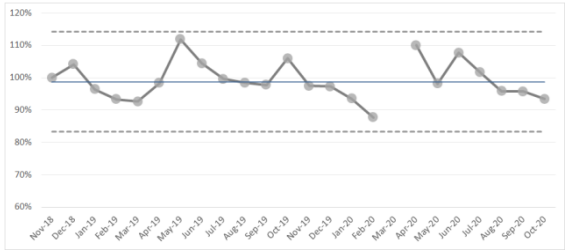
Target: 100%
Variation: normal
Current Month: 100.1%



The fill rate for Eastbourne Hospital was at 100% however the actual versus planned requirement has increased in some areas due to escalation beds being open in a number of areas. This increases the fill rate against agreed establishment, as more staff are required than an area is established for so this shows as an increased fill rate. Some wards have also needed to increase to Covid templates at times.

Staff Fill Rate (Rye Memorial)

Target: 100%
Variation: normal
Current Month: 93.4%



Rye Memorial Care Centre shows a decreased fill rate which is attributable to a reduced number of Health Care Assistants during the day shift. The Conquest Hospital continues to support staffing at Rye on a daily basis.

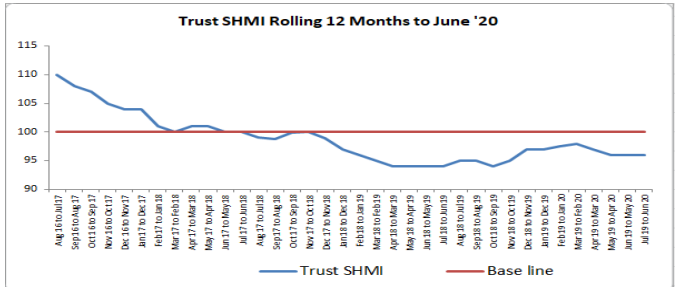
Effective Care - Mortality

East Sussex Healthcare NHS Trust

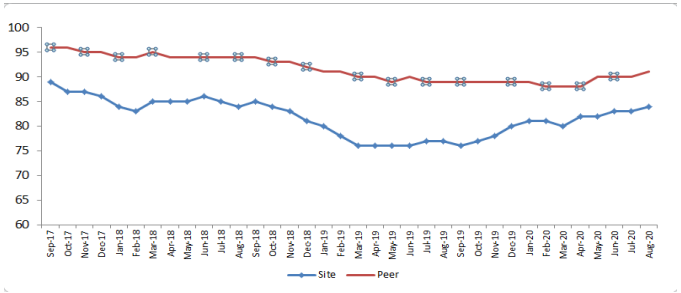
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

Summary Hospital Mortality Indicator (SHMI)

Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures

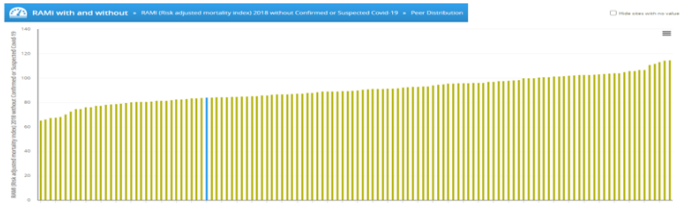


Risk Adjusted Mortality Index (RAMI) – without confirmed or suspected Covid-19



- SHMI – July 2019 to June 2020 is showing an index of 0.96
- RAMI 18 without confirmed or suspected Covid-19 – September 2019 to August 2020 (rolling 12 months) is 84 compared to 77 for the same period last year. August 2019 to July 2020 was 83.
- RAMI 18 including Covid-19 was 90 for the month of August and 80 for July with a peer position of 95 and 83 respectively. As with SHMI, RAMI is not designed for this type of pandemic activity, so RAMI without Covid-19 has been provided for consistency.
- Crude mortality without confirmed or suspected covid-19 shows September 2019 to August 2020 at 1.61% compared to 1.45% for the same period last year.
- The percentage of deaths reviewed within 3 months was 71% in July 2020, June 2020 was 70%.

RAMI Peer Distribution without confirmed or suspected covid-19



RAMI v Peer

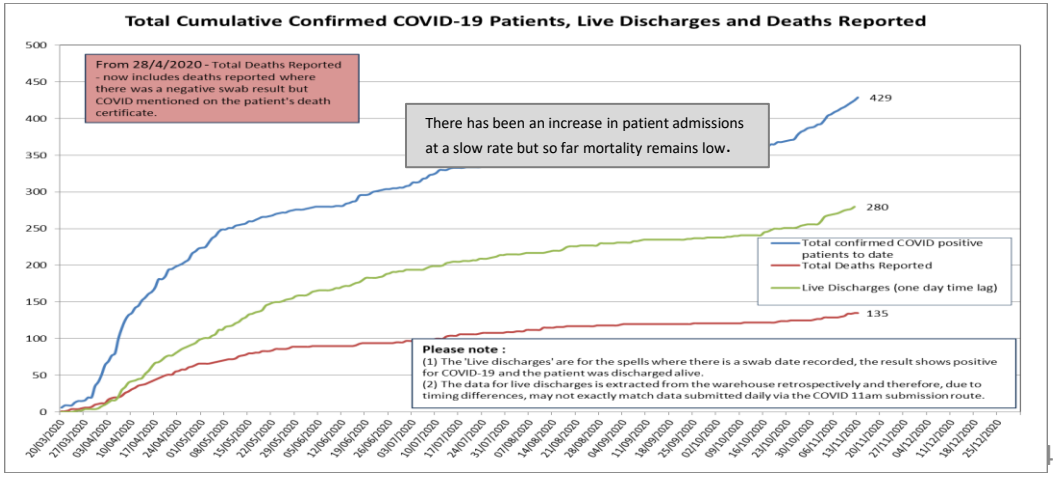
This shows our position nationally against other acute trusts - currently 34/126

October 2020 Main Cause of In-Hospital Death Groups (ESHT)

Pneumonia	30
Cancer	19
Cerebro-vascular Incident	10
Sepsis/Septicaemia	8
Chronic Obstructive Pulmonary Disease (COPD)	7
Heart Failure	6
Myocardial Infarction (MI)	6
Liver Disease	4
Bowel Obstruction	2
Community-acquired Pneumonia	2
COVID-19	2
Acute Kidney Injury (AKI)	1
Atrial Fibrillation (AF)	1

COVID has remained in a low position in October with 2 deaths. There was 1 death in September.

There are:
28 cases which did not fall into these groups and have been entered as 'Other not specified'.
19 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.



Workforce

Delivering safe care for our patients
What patients are telling us?
Delivering effective care for our patients
Challenges and risks

Safe patient care is our highest priority

Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Annual turnover** has reduced by 0.1% to 9.8% reflecting 597.7 FTE leavers in the rolling 12 months **Monthly sickness** has reduced by 0.1% to 4.2%. **Annual sickness** rate has reduced by 0.1% to 4.5% **Mandatory Training** compliance rate has increased by 1.3% to 88.1%	The **Trust vacancy rate** has increased by 1.2% to 0.6% . **Current vacancies** are showing as 37.1 ftes **Appraisal** compliance has reduced by 0.2% to 75.0%	 **Monica Green** Director of Human Resources

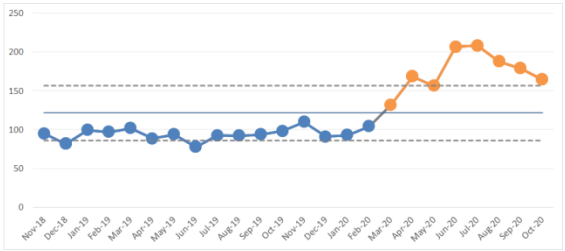
Actions:

- Monitoring of COVID 19 travel restrictions continue to ensure recruited staff arrive at the Trust as soon as possible. A further 22 International nurses arrived on the 23rd October, with 21 due to arrive on the 27th November. The planned intake for 2020/21 is 100 .
- Medacs continue to source candidates for difficult to recruit medics posts.
- IPR Workforce plans have been updated to reflect the change in budgets with Finance continuing to make adjustments. However vacancies are being approved via IPRs.
- Business Planning has commenced and the initial agreement with divisional ADOs is to use the planning that was disrupted due to Covid.
- Appraisal training currently delivered via MS Teams. Since 3rd Jun 2020, 141 staff have attended the training. From 5th Nov to 5th Jan a further 15 MS teams sessions with 300 places will be available.
- Occ Health & Wellbeing providing 7 day access for staff COVID enquiries & to support management of staff contacts for positive COVID cases.
- As at 18th Nov, 7,352(98.9%) total risk assessments have been completed with 98.8% of 'at risk' & 98% BAME staff covered. Currently there are only 85 outstanding risk assessments to be completed and the majority are for new starters.
- The national staff survey has been issued with 7,327 surveys delivered via email and hard copy. As of 16th Nov, 50% had been completed.
- Women's Consultants network is due to have its inaugural meeting on the 4th Dec 2020 as part of our approach to developing staff networks and addressing gender pay gap areas.
- Health and Wellbeing checks for the new international Nurses have been put in place with regular checks on their first few weeks.
- Continuing to work across the Health and Care system to provide a range of Leadership Development opportunities. The latest offerings include a series of leadership modules to support middle managers, foundations in coaching, Stepping up Programme and OD Practitioner programme.
- Job Planning for Medics programme is business as usual with consistently over 90% interacting with the system. AHP and Nursing in progress
- Covid planning and reporting underway to support operationally led surge plans for Winter that include links with EPRR and IMT to profile staffing gap risks
- Launch of ESHT Workforce System & Rostering Review to prepare for procurement of workforce systems in 2021. The outcome is to minimise manual intervention, multiple touch points and reduce the time operational teams update so they can be released to focus on their non-admin work. Second outcome will be to ensure that all workforce systems adhere to NHSI/E guidance, fit for purpose, bundled pricing negotiated and intuitively designed for end user ease.

Workforce – Contract type

East Sussex Healthcare NHS Trust

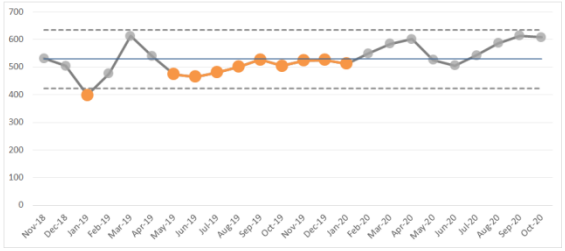
Agency FTE Usage



Current Month: 164.3

- Agency fte usage has reduced by -14.6 fte overall, down to 164.3 fte usage. Reductions this month most marked for Registered Nursing (-16.7 ftes), notably on Baird, Michelham, Hailsham, AMU and Frailty Unit. Agency medical usage reduced by -1.6 ftes overall with reductions in Emergency Care, Elderly Care and Pathology

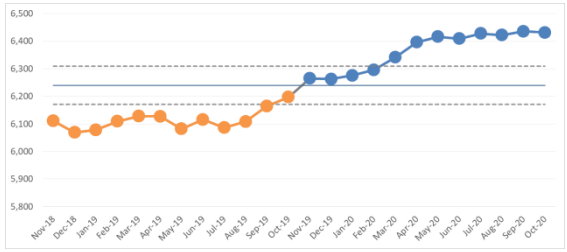
Bank FTE Usage



Current Month: 608.1

- Bank fte usage was fairly stable with a small reduction of -5.2 ftes compared to last month. There was a reduction of -2.7 locum ftes including ENT, Elderly Care and Community Paeds and -3.1 bank AHPs (Radiographer and Physio usage)

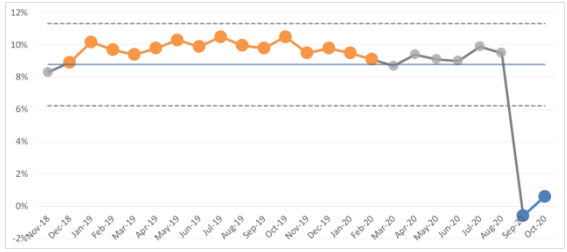
Substantive FTE Usage



Current Month: 6,431.3

- Substantive fte usage remained largely stable this month with only a slight decrease of 4.4 ftes. Medical usage (+5.3 ftes) and Registered Nursing usage (+2.3 ftes) were slightly up, the largest drop was for Ancillary staff (-28.8 ftes), with the transfer out of Laundry Services this month.

Vacancy Rate



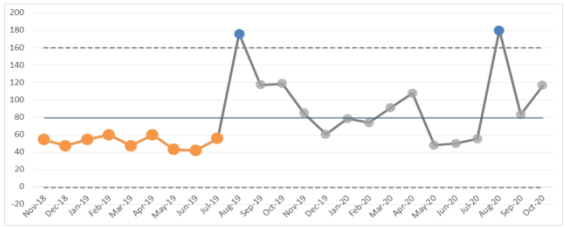
Current Month: 0.6%

- In Oct 20 there were 37.1 fte vacancies in the Trust (0.6% vacancy rate), a net increase of 74.7 ftes since last month. This is largely due to the additions to the budgeted fte establishment that have taken place this month. The vacancy rate is still historically low, due to the changes in the budgeted establishment in September, but should show a clearer picture once further fte establishment changes take place in November

Workforce - Churn

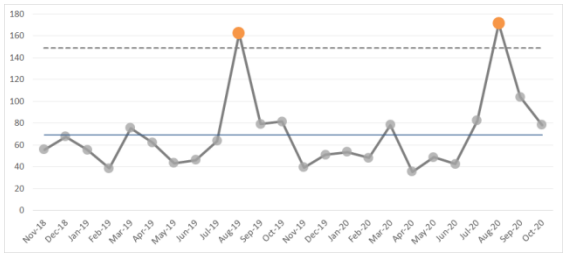
East Sussex Healthcare NHS Trust

Starters FTE



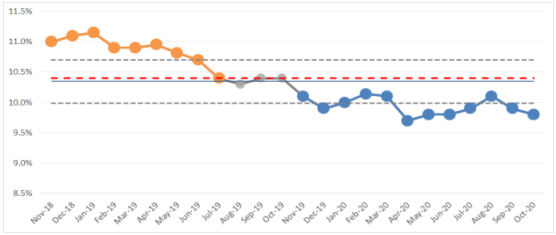
Current Month: 116.7

Leavers FTE



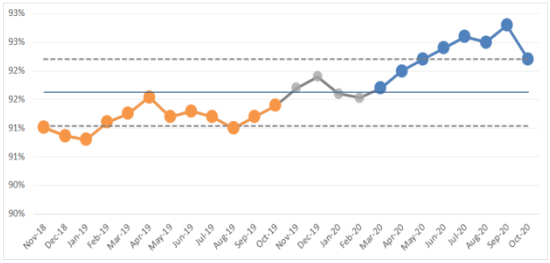
Current Month: 78.3

Annual Turnover Rate



Current Month: 9.8%

Retention Rate



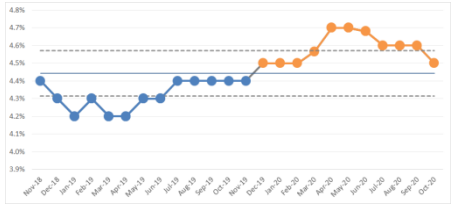
Current Month: 92.2%

- 116.7 ftes joined the Trust this month and 78.3 ftes left. Over the last 12 months there has been a net increase of 197.1 fte staff.
- COVID travel restrictions continue to impact on Time to Hire for medical & nursing international candidates. Medacs continue to assist with sourcing candidates for difficult to recruit posts. Focus remains on Consultant posts in Cardiology, Histopathology, Microbiology and Gastroenterology.
- 22 International nurses arrived at the Trust on the 30th October, with a further 21 due on the 27th November. This is part of the planned recruitment for 2020/2021. A total of 100 will arrive at the Trust by March 2021.
- Ongoing recruitment campaign for Radiographers sourcing candidates for Eastbourne. At Conquest, 3 offers made following Teams interviews. Candidates due to arrive before the end of December 2020.
- Turnover has decreased by 0.1% to 9.8% (597.7 fte leavers in the last 12 months) as the wider employment market is increasingly uncertain. Worth noting that ESHT are an exemplar for turnover rates. Additional Prof & Tech staff (i.e. Pharmacy, Operating Dept Practitioners and other technical staff) have the highest turnover at 15.7% (22.2 fte leavers). Healthcare Scientists (i.e. Biomedical Scientists, Cardiology & EME Technicians) have the second highest turnover at 12.1% (17.5 fte leavers),
- The retention rate (i.e. % of staff with more than 1 year's service with ESHT) has reduced by 0.6% to 92.2%.

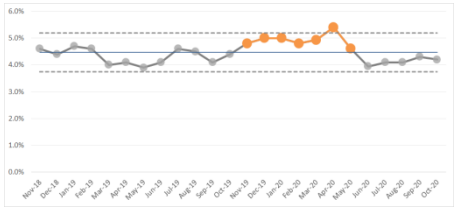
Workforce - Sickness

East Sussex Healthcare NHS Trust

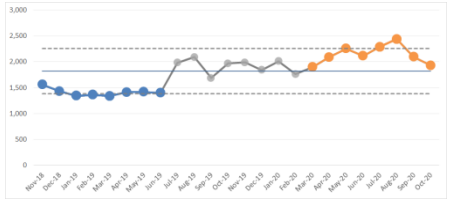
Annual Sickness Current Month:4.5%



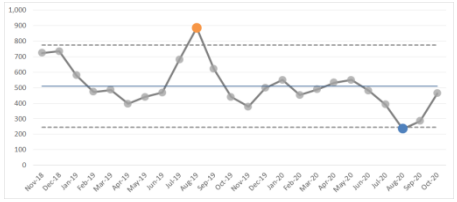
Monthly Sickness Current Month: 4.2%



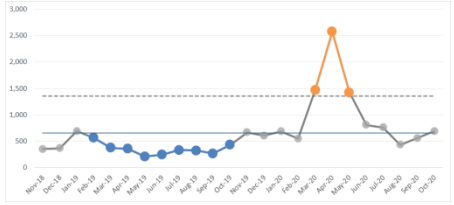
Anxiety/Stress/Depression



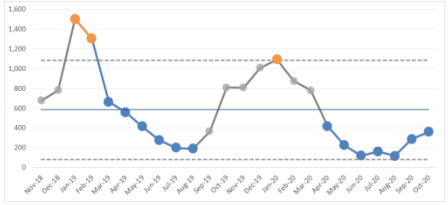
Back Problems



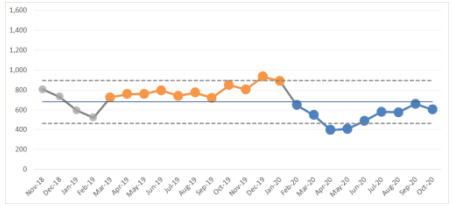
Chest & Respiratory Problems



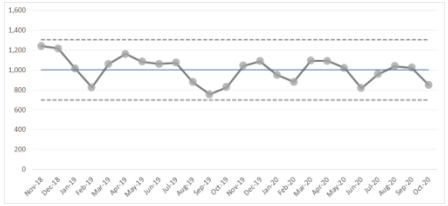
Cough, Cold & Flu



Gastro-intestinal Problems



Other MSK problems



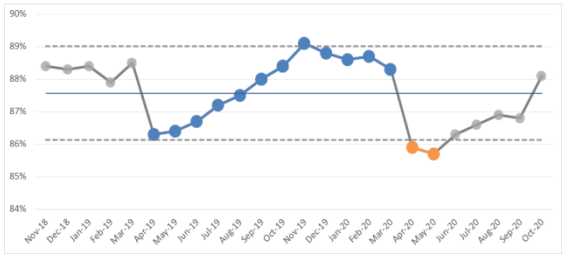
- Annual sickness has reduced by 0.1% to 4.5% this month. Monthly sickness also reduced by 0.1% to 4.2% and is tracking below the comparative rates for 2019/20 hence the fall in the annual rate.
- Overall there has been a reduction of 34 fte days lost to sickness this month, compared to September.
- There were significant reductions in fte days lost due to anxiety/stress/depression (-165) which continues on a downward trajectory in response to the targeted actions that have been put in place (though is still the highest known reason for absence at 1,931 fte days lost in Oct). Other musculoskeletal problems also fell by 173 fte days lost. Back problems saw an increase of 179 fte days lost (to 464 days lost), as did Chest & Respiratory illnesses (which includes Coronavirus) up by 131 fte days lost (to 690).
- Anxiety/stress remains a key focus with Occupational Health commencing a contact programme for staff currently on 3rd day of absence for anxiety/stress to ensure support is offered with a view for an earlier return to work before the requirement of a GP certificate. Operational HR are working closely with managers to ensure Healthroster is updated, to support the above programme and prevent unnecessary contact and further stress where it is known a traumatic incident has occurred. With some staff being identified as clinically vulnerable, it is essential managers record absence appropriately.
- Risk assessment compliance monitoring is in place to ensure staff are adequately protected. As of 18th November, 98.8% of staff had completed their risk assessment (98.8% of "at risk" and 98% BAME staff).

Workforce - Compliance

East Sussex Healthcare NHS Trust

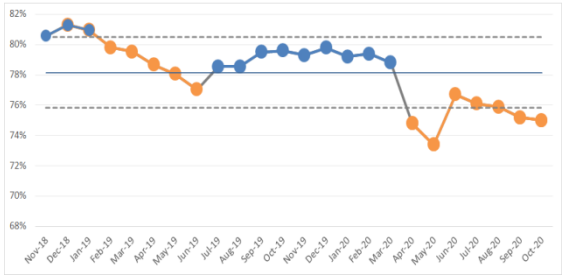
Mandatory Training Compliance

Current Month: 88.1%



Appraisal Rate

Current Month: 75.0%



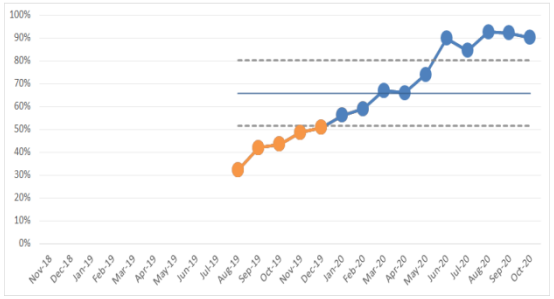
- The overall mandatory training compliance rate has increased by 1.3% to 88.1%.
- The increase this month is largely due to the transition to a 2-yearly requirement for clinical staff for Moving and Handling (where previously most clinical staff required annual renewal). Compliance rates for other topics have dropped slightly, this month, due to recent pressures. Learning & Development will tackle this by working with Divisional Governance Leads to target staff whose e-learning has lapsed, to identify any issues which are preventing them from completing.
- Appraisal compliance rate this month decreased by -0.2% to 75.0%, this is 4.6% less in comparison to the same period in previous years, which is due to extra winter and COVID pressures in DAS and Urgent care services.
- Guidance from government meant that doctors did not have appraisals which has also impacted on figures.
- Divisions are working on action plans to improve compliance and OH and the Health and wellbeing are providing extra support to alleviate the pressures.
- However other areas have actually improved their compliance this months: Medicine increased by 0.1% to 71.1%; Women & Children, increased by 0.7% to 81.3% and Estates & Facilities, increased by 7.1% to 79.7%

Workforce – Job Planning

East Sussex Healthcare NHS Trust

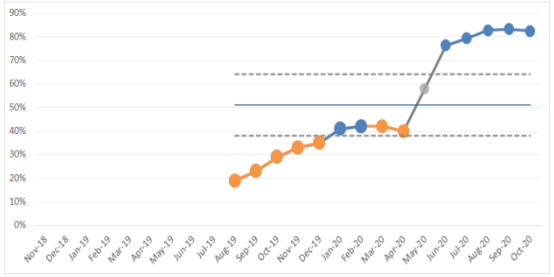
Consultant eJob-Planning Fully Approved Rate

Current Month: 90.2%



SAS Grades eJob-Planning Fully Approved Rate

Current Month: 82.5%



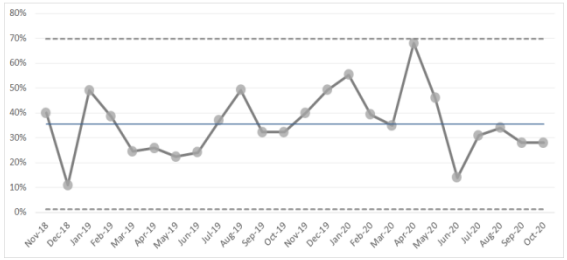
- The associated graph reflects a 24 month view as data is only available from July 2019, when progress reporting was first started.
- As of 8th October 2020, 221 of 245 consultants (90.2%) and 85 of 103 SAS grades (82.5%) had fully approved job plans.
- Overall Trust compliance rate is 87.9%.
- Diagnostics Anaes & Surgery compliance rate is 89.7%
- Medicine compliance rate is 87.3%
- Women & Children compliance rate is 93.1%
- Urgent Care compliance rate is 69.2%.

Workforce – Roster Completion

East Sussex Healthcare NHS Trust

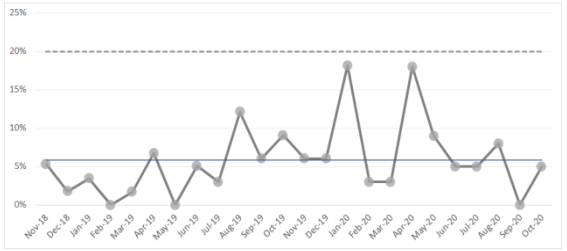
6 week Nursing Management Roster Approval Rate

Current Month: 28.0%



8 week Nursing Management Roster Approval Rate

Current Month: 5.0%

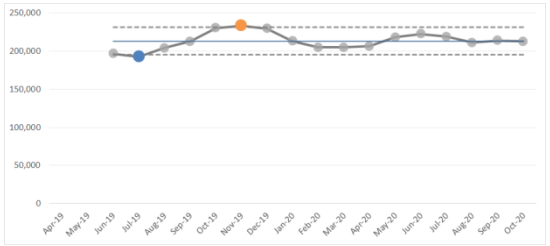


- The following charts show the % of approved rosters as at 6 & 8 weeks prior to commencement.
- For the period commencing 5th Oct ’20, 28% of rosters had been approved at 6 weeks before commencement and 5% had been approved at 8 weeks prior to commencement. This compares to 28% at 6 weeks and 0% at 8 weeks for the previous roster period.
- Monthly reports are produced and sent to Assistant Directors of Nursing and compliance is monitored at the Safer Staffing meeting. During the pandemic, some rostering has been shorter term due to the changing ward footprint.

Workforce – Salary Overpayments

East Sussex Healthcare NHS Trust

Salary Overpayments



Current Month: 212,399

- Outstanding debts as of Oct 20 totalled £212,399 against a 12 month average of £215,616. New debt added in Oct equated to £28,469, from 28 new cases
- There are currently 264 overpayment cases in all; 54 relating to current staff and 210 for leavers.
- The most common reason for debts is late notification of leaving (33% of cases, i.e. 87 instances). This data is now being monitored via Divisional IPR meetings in order to reduce recurrence.
- Finance are currently reviewing the controls specifically relating to salary sacrifice arrangements with external suppliers for high cost goods i.e. I-pads to ensure affordability
- HR Workforce are introducing a new web based single change form to bring together new starters, staff changes and leavers. This will ensure that , via a quick click form, it will take less time and be easy to use to encourage managers to log in a timely and accurate way.
- Further analysis underway to identify where supportive management training is needed. These continued to be reported and discussed at IPRs.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Our front door - Urgent Care

How our patients flow through the hospital

Our Cancer Services

Our Out of Hospital Services

We will operate efficiently & effectively

Diagnosing and treating our patients in a timely way that supports their return to health

Summary

Access and Responsiveness

East Sussex Healthcare NHS Trust

Author

Tara Argent
Chief Operating Officer

Positives

Our response to the Covid-19 pandemic has led to significant changes in the way non-elective and elective care is being delivered. This has been driven by our clinical colleagues ensuring safety, maintaining patient experience within the context of change whilst delivering effective outcomes of care.

Diagnostic services continue to recover at pace although there is a huge challenge of clearing the backlogs due to activity displacement as a result of prioritising clinically urgent and Covid-19 preparedness.

The Trust has continued to run Cancer Recovery focus weeks with all services, in order to review all patients on the waiting list. This has supported the continued reduction of the 62 day backlog over the past three months, whilst patient pathways over 104 days have also continued to reduce .

For Elective Care, the priority is to continue to treat patients based on clinical urgency and chronological waits within all of the available capacity.

Over the past 6 months the Trust has reported patients waiting longer than 52 weeks for elective surgery. The Trust is now demonstrating a positive recovery with numbers reducing from a high of 250 in August down to a current level of 119, a majority of these cases have a TCI (to come in) date.
The Trust's new Harm review policy and process is in place for any patient waiting longer than 62/104 days (Cancer) and 52 weeks (RTT).

Challenges & Risks

As an organisation we are responding to the Governments announcement of a second national lockdown from the 5th of November and taking the necessary actions to protect our staff and maintain acute and elective activity. A Trust Incident Control Centre (ICC) has been stepped led by Liz Fellows who will act as the Trusts Bronze controller the ICC will oversee the Winter, COVID19 and EU Exit (D20) response for the organisation.

The past few months have been particularly challenging for our Emergency Departments and although we saw performance improve in September, we have seen it drop below 90% in October with 89%. This was against a national average of 84.4% and positioned ESHT, 29th out of 115 reporting organisations. The risk we have ahead of us is an increasing level of attendances across both our sites amidst workforce gaps that are challenging to fill.

Our DM01 (Diagnostic 6 week standard) services have been negatively affected during the pandemic as a result of displaced activity prioritising clinically urgent and Covid-19 activity. We have seen positive levels of activity recovery over the past two months but all modalities continue to hold large backlogs of patients.

The Trust RTT performance position has show very encouraging results over the past few months with ESHT ranked 4th out of 113 providers in the country last month. However, the Trust does face a number of challenges over the coming months especially if we continue to see Covid cases increase . As part of our restoration and recovery, we will also have to mitigate against the potential loss of any Independent Sector capacity due to the ending on the national contract at the end of December.

Restoration & Recovery

East Sussex Healthcare NHS Trust

Current SitRep position

As part of the Phase Three recovery letter from Sir Simon Stevens, the ask of providers was: ***In September at least 80% of last years activity for both overnight electives and day case procedures, rising to 90% in October.***
The ask was also for Outpatient New and Follow Up activity levels to be at 100 from September.
In regards to Diagnostics, the ask was for all modalities to be at 90% from September rising to 100% from October.

NHSE does not allow providers to count any Independent Sector (IS) capacity that the Trust has commissioned in our activity returns. The Trust is currently utilising Spire Sussex, The Horder Centre and Benenden Hospital. If this activity was to be included then we would see activity percentages for Day Case (DC) and In-Patients (IP) increase by approximately 2% for DC and 6% for IP.

In response to the NHSE Phase 3 recovery objectives, the Trust submitted a 'stretch but realistic' trajectory along side the requirements for delivering these targets. A full in-depth review with the senior Executive team and each individual service was carried out in order to complete the required submission and associated trajectory for delivery.

The four main area of challenge against the 90/90/100 delivery are:

1. Anaesthetic cover :
    - Theatre Capacity
    - ITU – needing to maintain Green/Amber capacity
    - Independent sector delivery – End of national contract – 31st December 2020
2. Ring fenced Elective Bed capacity
3. Workforce (vacancy factor and isolation restrictions) and agency/locum capacity
4. Inability to count Independent Sector activity that would have previously been assigned to the Trust

Restoration & Recovery

East Sussex Healthcare NHS Trust

	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Activity by POD	Final/ Traj	Final/ Traj	ESHT Final Trajectory Submission				
Day case	78% / 80%	84% / 86%	90%	90%	90%	90%	90%
Elective inpatient	78% / 65%	88% / 75%	78%	80%	75%	90%	90%
Outpatient (new)	89% / 83%	89% / 90%	92%	93%	93%	100%	100%
Outpatient (follow up)	83% / 82%	87% / 96%	100%	100%	100%	100%	100%
Activity by POD (Diagnostics)	Final/ Traj	Final/ Traj	ESHT Final Trajectory Submission				
MRI	97% /92%	99% / 95%	95%	95%	95%	95%	95%
CT	95% /100%	107% / 100%	100%	100%	100%	100%	100%
Non-Obstetric Ultrasound	98% /100%	94% / 100%	100%	100%	100%	100%	100%
Colonoscopy	129%/100%	147% / 100%	100%	100%	100%	100%	100%
Flexi Sigmoidoscopy	129%/100%	124% / 100%	100%	100%	100%	100%	100%
Gastroscopy	80%/80%	110% / 90%	100%	100%	100%	100%	100%

- October 2020 activity performance against last year using SEM (Standard Extract Mart) planning data rules
- Data correct as of 23/11/20

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

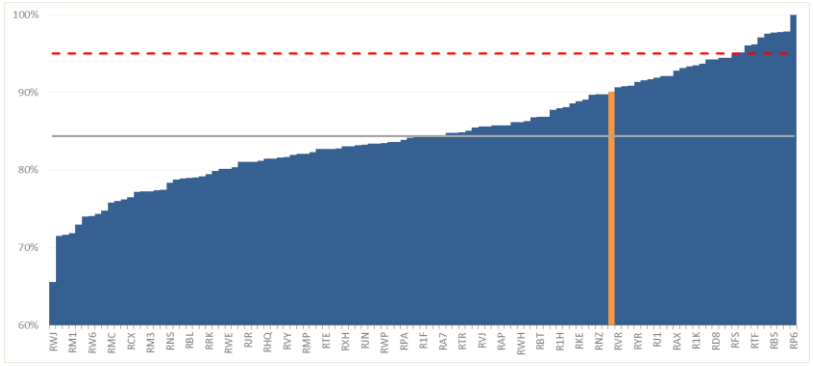
*NHS England has yet to publish all October 2020 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

October 2020 Peer Review

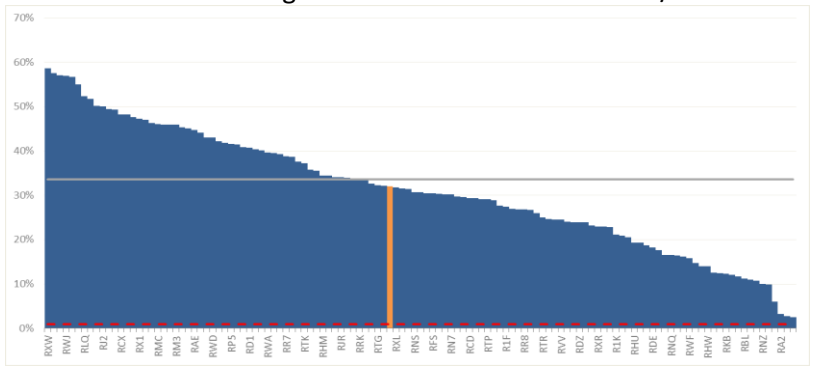
National Average: 84.4% ESHT Rank: 29/115



Planned Care – Diagnostic Waiting Times

September 2020 Peer Review*

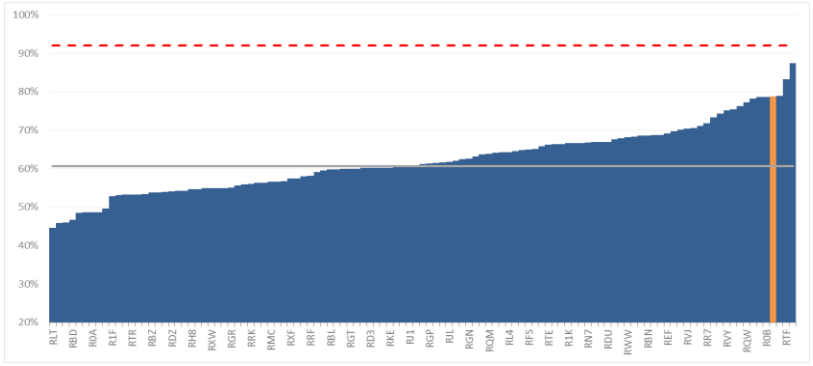
National Average: 33.6% ESHT Rank: 67/123



Planned Care – Referral to Treatment

September 2020 Peer Review*

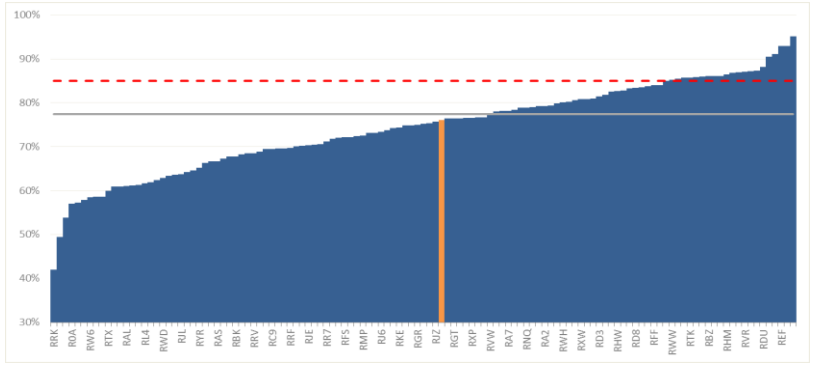
National Average: 60.6% ESHT Rank: 4/113



Cancer Treatment – 62 Day Wait for First Treatment

September 2020 Peer Review*

National Average: 77.4% ESHT Rank: 59/123

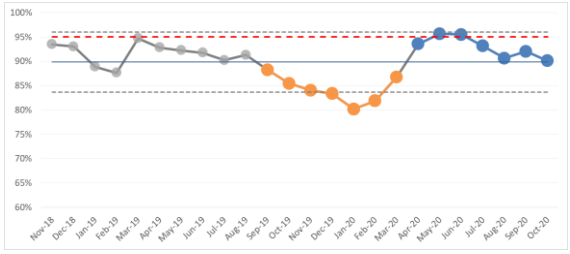


Urgent Care – Front Door

East Sussex Healthcare NHS Trust

A&E Performance
(Local System)

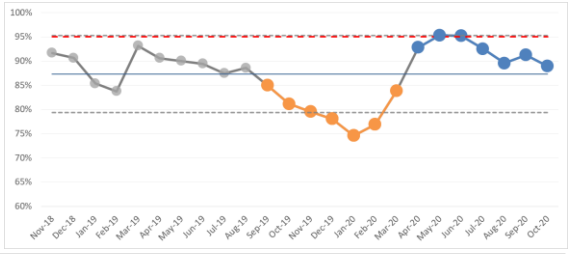
Target: 95%
Current Month: 90.1%



From 1st October to the 31st October 2020, the A&E Performances (including Walk in Centre Numbers) were:
Trust 90.1% – CQ 93.0% – EDGH 87.3%
An overall decrease of 2.0% from the previous month.
ED has an Improving Performance Action plan in place along with weekly meetings to discuss patient safety issues, recruitment and improvements to process.

A&E Performance
(ESHT Total Type 1 & 3)

Target: 95%
Current Month: 88.9%

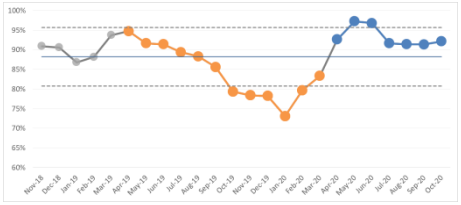


From 1st October to the 31st October 2020, the A&E Performances (Type 1 and Type 3 only) were:

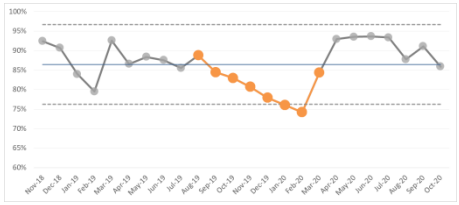
Trust 88.9% – CQ 92.2% – EDGH 85.9%

An overall decrease of 2.4% from the previous month.

CONQ



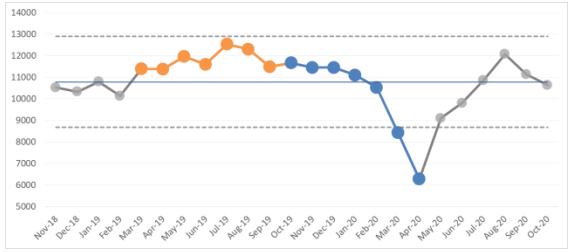
EDGH



For Conquest, the highest breach reason in October was "Specialist Assessment - Medicine" with 101 breaches.
For EDGH, the highest breach reason in October 2020 was "MAU Bed" with 333 breaches.

A&E Attendances
(ESHT Total Type 1 & 3)

Target: Monitor
Current Month: 10,633



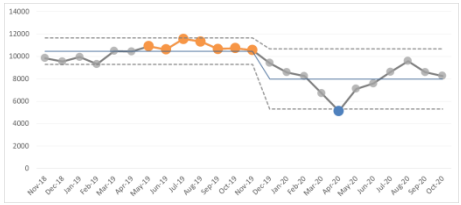
On average, there were 343 attendances per day in October 2020 for the Trust, 167 attendances for Conquest and 176 attendances for EDGH.

The average number of attendances for October 2019 (same time last year) was 376 per day (8.8% more that this year).
For Conquest it was 187 and EDGH it was 189.

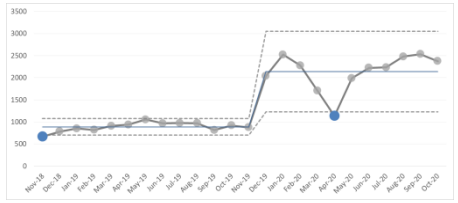
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

ESHT Total Type 1



ESHT Total Type 3

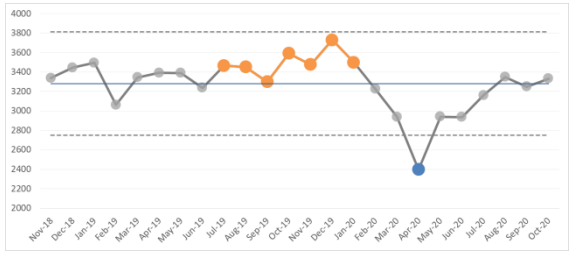


Types of A&E service:
Type 1: Consultant led 24 hour service with full resus facilities.
Type 3: Other type of A&E/minor injury units/Walk-in-Centres/Urgent Care Centre.

On average there were 266 Type 1 attendances and 77 Type 3 attendances per day in October 2020.

Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,333

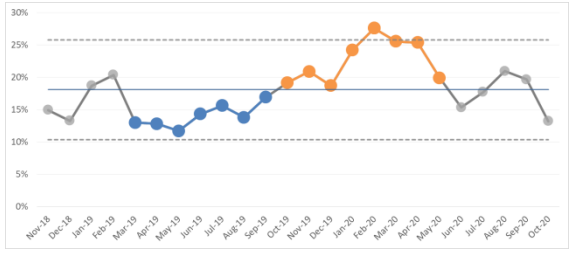


On average there were 108 conveyances per day in October 2020.

The average number of conveyances for October 2019 (same time last year) was 116 per day.

Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 13.2%

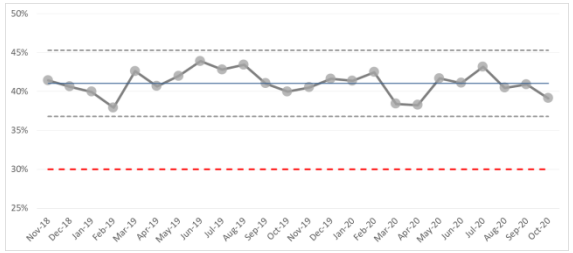


On average there were 54 conveyances at Conquest and 54 conveyances at EDGH per day in October 2020.

The average number of conveyances for October 2019 (same time last year) for Conquest it was 59 and for EDGH it was also 57 per day.

Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 39.1%



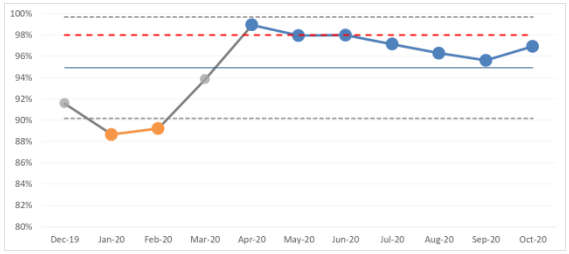
From 1st October to the 31st October 2020, the SDEC Performances were:

Trust 39.9% – CONQ 41.4% – EDGH 37.8%
Conquest increased by 0.4% and EDGH decreased by 3.3% from the previous month.

Urgent Care – UTC

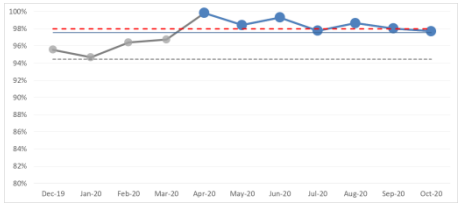
East Sussex Healthcare NHS Trust

UTC 2 Hour Standard
(Treatment start within 2 hrs)

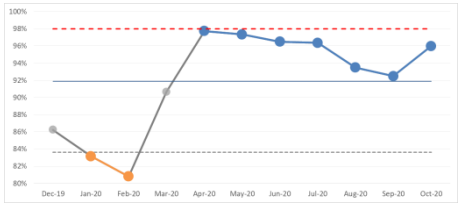


Target: 98%
Current Month: 95.6%

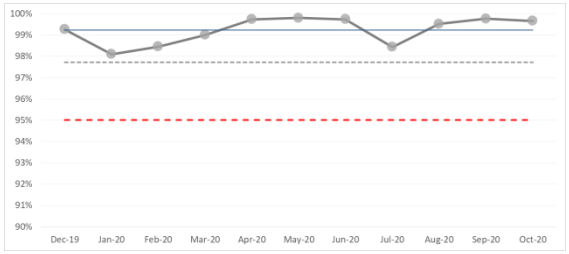
CONQ



EDGH

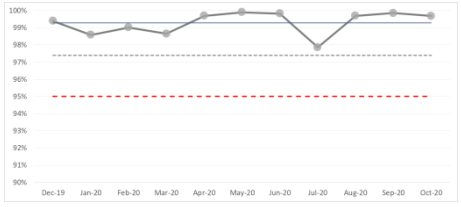


UTC 4 hour standard
(Visit complete within 4 hours)

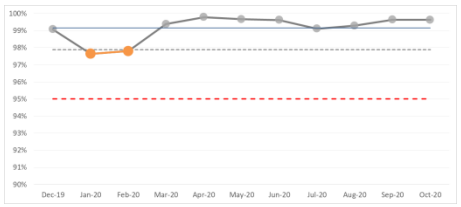


Target: 95%
Current Month: 99.8%

CONQ



EDGH



UTC GP Front Door Model agreed.

Processes are now in place to report UTC attendances.

Continuing to receive high numbers of referrals from 111 especially OOHs. Deep dive completed work continues with 111 to ensure other non-ED pathways are sign-posted to rather then ED first priory option unless ED appropriate or Bookable appointments.

From September 2020 to October 2020 Comparison.

2 Hour
TRUST – 1.3% increase (95.6% to 96.9%)
CONQ – 0.3% decrease (98.0% to 97.7%)
EDGH – 3.5% increase (92.5% to 96.0%)

4 Hour
TRUST – 0.1% decrease (99.8% to 99.7%)
CONQ – 0.2% decrease (99.9% to 99.7%)
EDGH – Unchanged (99.6% to 99.6%)

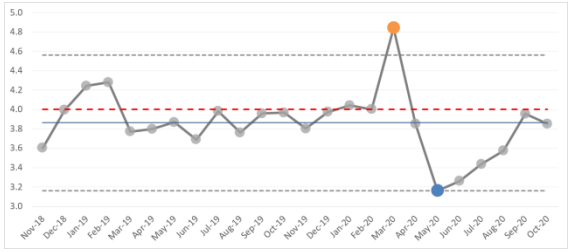
Urgent Care - Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

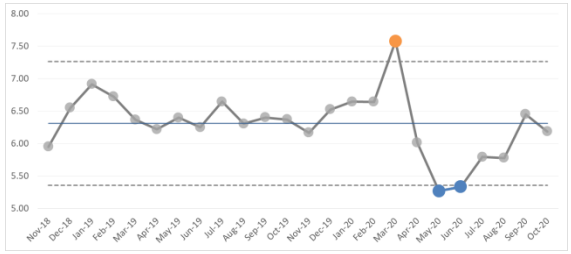
Non-elective Length of Stay (Acute)

Target: 3.60
Current Month: 3.85



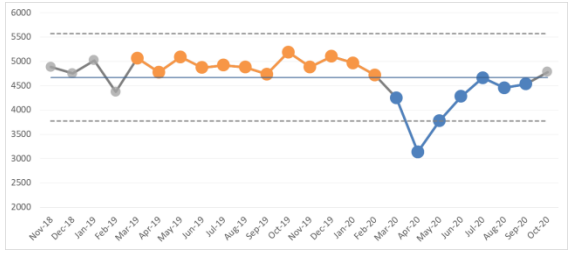
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 6.2



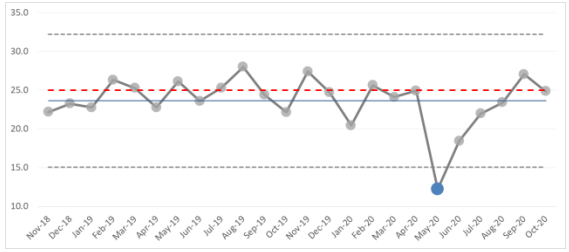
Non-elective Spells

Target: Monitor
Current Month: 4,782



Intermediate Care Units Average LoS (Community)

Target: 25.0
Current Month: 24.9



Rapid improvement week commenced at EDGH 14th September, a de-brief has been held and learning to be shared with Divisional teams. An improvement action plan will be confirmed and implemented.

Discharge Hub working 7 days per week on all medically fit patients on pathways 0 – 3. Out of hospital staff are supporting the hub due to redeployed staff returning to substantive roles. A plan is in place and key posts will be recruited to in the Hub to enable both Acute site Hubs to continue to function 7 days / week.

NEL length of stay decreased by 0.15 of a day from September to October.
NEL length of stay excluding zero length of stay decreased by 0.3 of a day from September to October.

Increased discharges occurred and actions are being taken through the daily discharge leadership meeting. Further actions are being taken through the Patient Flow Programme Board. All available community capacity is being utilised. Spot purchase placements continue to be made. A plan is underway to ensure ESHT meets the new guidance for the remobilisation of services within health and care settings – as of Sept '20.

Nervecentre is progressing well – nearly all wards are using this consistently. The site teams are utilising this to enable timely patient transfers.

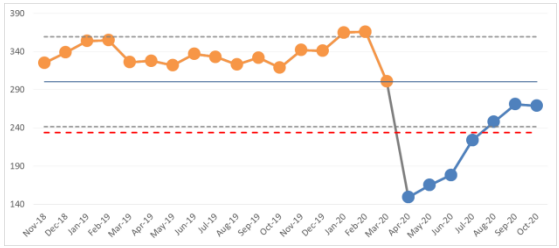
Urgent Care - Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

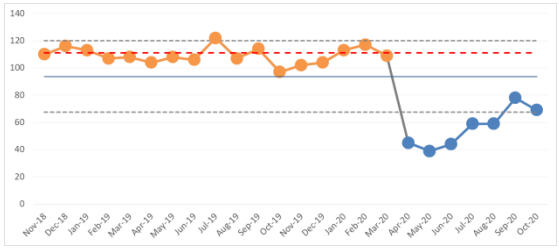
Adult inpatients in hospital for 7+ days (Acute)

Target: 234
Current Month: 269 (Daily Avg.)



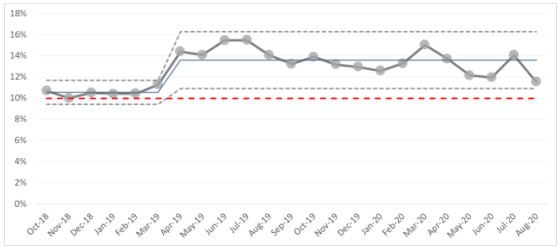
Adult inpatients in hospital for 21+ days (Acute)

Target: 111
Current Month: 69 (Daily Avg.)



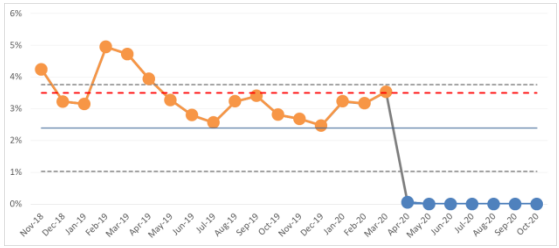
Emergency Re-Admissions within 30 days

Target: 10%
Current Month: 11.6% (Aug-20)



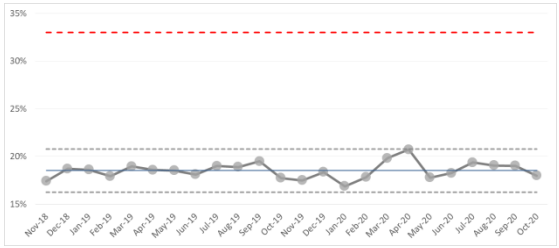
Delayed transfer of care (National Standard)

Target: 3.5%
Current Month: 0.0%



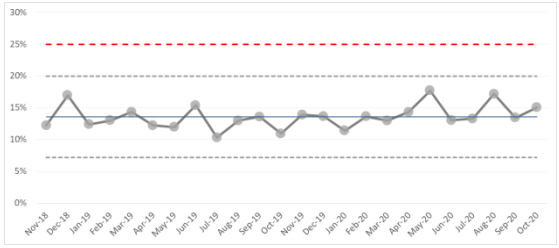
Patients discharged before midday %

Target: 33%
Current Month: 18.0%



Patients discharged on weekend day

Target: 25%
Current Month: 15.0%



The stranded patient numbers has seen a slight decrease to 269 across both acute sites, previously 271. 21 day (LLOS) patients has decreased to 69 in October from 78 in September.

October has seen a decrease in patients discharged before midday, whereas the percentage of weekend discharges has increased on September.

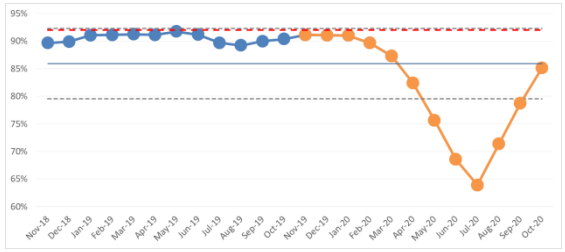
The established emergency readmission rate metric uses finance flags to exclude readmissions in cases where either the initial admission or readmission was an ambulatory tariff. The tariff was discontinued for 19/20, so there has been a step change in the readmission rate because ambulatory admissions are no longer identified as exclusions.

Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

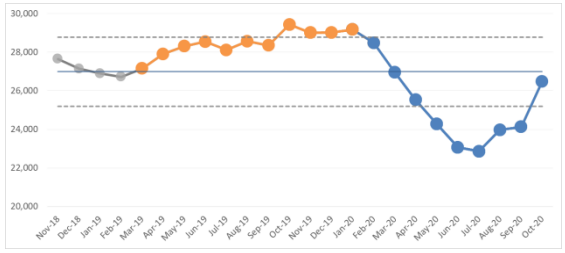
RTT Incomplete Standard

Target: 92%
Current Month: 85.1%



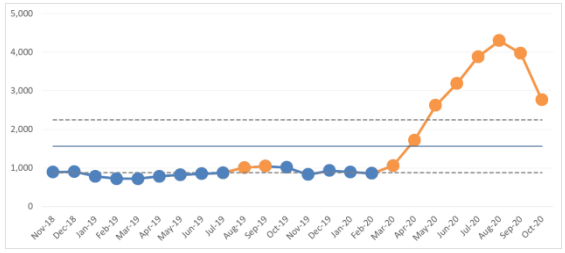
RTT Total Waiting List Size

Target: 26,965
Current Month: 26,485



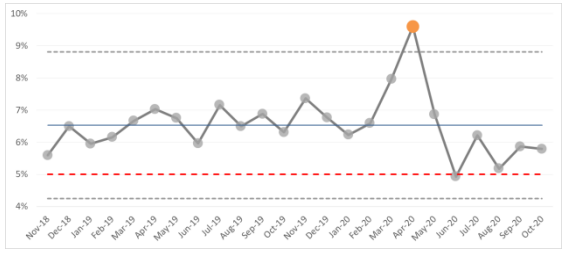
RTT 26 Week Waiters

Target: Monitor
Current Month: 2,766



Cancellations On The Day (Activity %)

Target: 5%
Current Month: 5.8%



The past three months have demonstrated that the Trust is on a positive and steady road to recovery of the 18 week standard. An early forward view of November would suggest that we will see further improvement of this standard.

The Trust waiting list in October has increased which was due to a technical error with partial booking of patients.

Due to the focus on reducing backlogs, the number of patients waiting over 26 week reduced considerably in October.

Medicine as a Division continues to deliver RTT and although some services were unable to achieve 92% (Gastro, and Cardiology), there was positive improvement in October. Gastro is heavily reliant on Endoscopy to diagnose patients but has a sizable backlog to address. Cardiology has also suffered with limited diagnostics (echos) taking place.

Surgical specialities along with Gynaecology continue to face the challenge of achieving the 92% standard due to the size of the backlog that has built up over the past 6 months. However, General Surgery, ENT, Urology and Gynaecology have taken huge strides in their recovery over the past month.

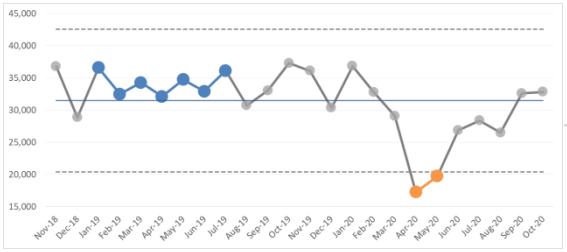
Utilisation of the Independent Sector has continued throughout September and into October with Radiology, T&O and Gynae all using Spire.
The Trust is also using theatre capacity at the Horder Centre for T&O along with some limited usage of Benenden hospital for Urology services.

Planned Care – Outpatient Delivery

East Sussex Healthcare NHS Trust

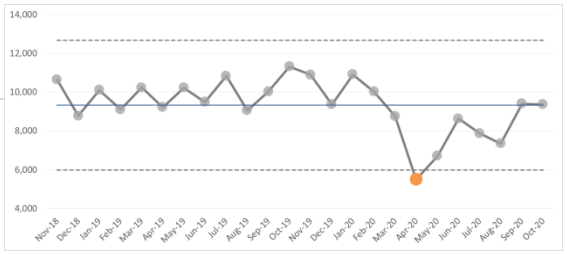
Access and Responsiveness

Outpatient Total Activity
(New and Follow-up)

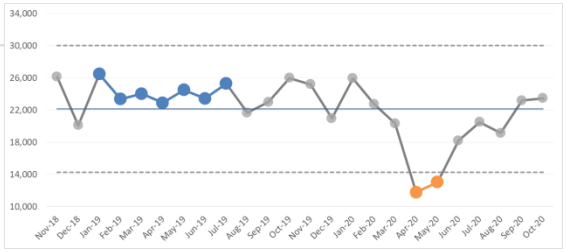


Target: Monitor
Current Month: 32,835

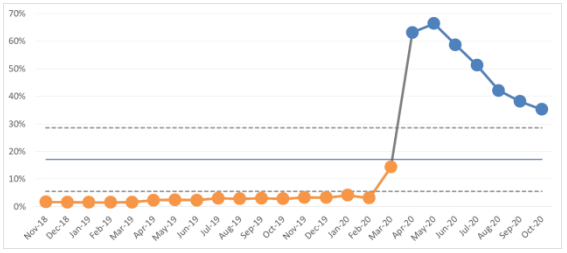
New



Follow-up

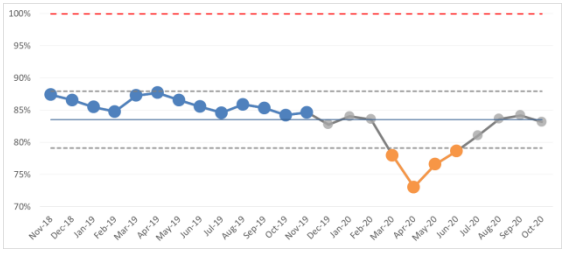


Non Face to Face Outpatients Activity
(Activity %)



Target: Monitor
Current Month: 35.3%

Outpatient Utilisation
(XX1 and Non XX1 Clinics)



Target: 100%
Current Month: 83.2%

Clinic utilisation and Outpatient activity has started to recover over recent months.

Through our recovery & transformation programmes we are looking to maintain a high level of virtual activity (25% new OPAs & 60% FU is target). In key specialties there are a range of rapid improvement initiatives to support the requirements of Phase 3

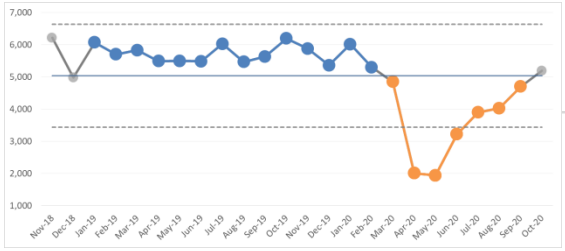
Planned Care – Admitted Delivery

East Sussex Healthcare NHS Trust

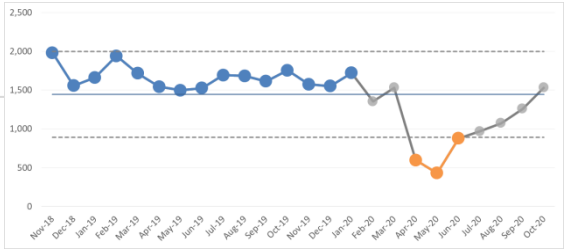
Access and Responsiveness

Elective Spells
(Day case and Elective IP)

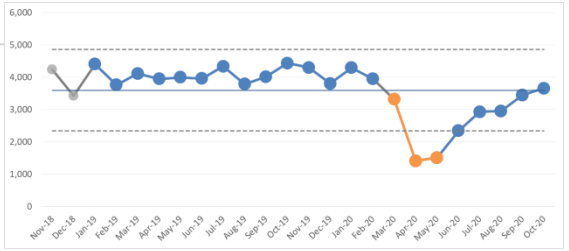
Target: Monitor
Current Month: 5,191



Elective IP

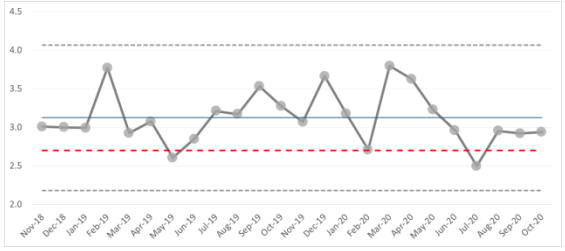


Day case



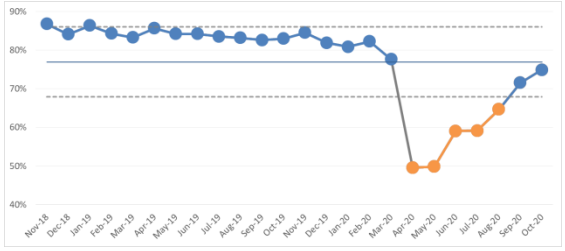
Elective Average LoS
(Acute)

Target: 2.7
Current Month: 2.9



Theatre Utilisation

Target: 90%
Current Month: 74.9%



October has seen the continued recovery of elective activity, moving the Trust closer to pre-covid levels. The theatre activity taking place continues to work to restrictions in terms of utilisation time due to theatre deep clean times although significant improvements have reduced cleaning times to 10 minutes between cases in 'Green' theatres.

Over the past five months, the Trust has seen an increase in utilisation and activity as part of the Restore & Recovery programme. The 6-4-2 theatre utilisation meetings have been reinstated in order to ensure all theatres are working at full capacity.

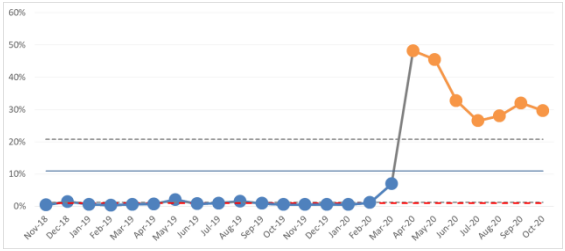
The past three months have seen the Elective Length of Stay (LoS) stabilise but remain just above the target of 2.7 days . This could be contributed to by the acuity of cases and the focus on clinical priority 2 & 3 patients.

Planned Care – Diagnostic

East Sussex Healthcare NHS Trust

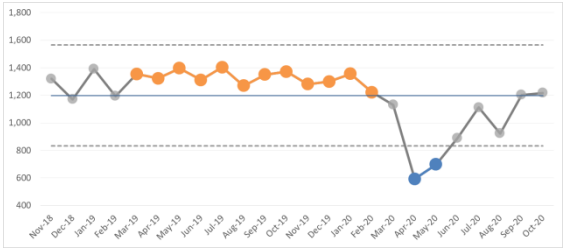
Diagnostic Standard

Target: < 1.0%
Current Month: 29.6%



Endoscopy Demand
(Waiting List Additions)

Target: Monitor
Current Month: 1,218

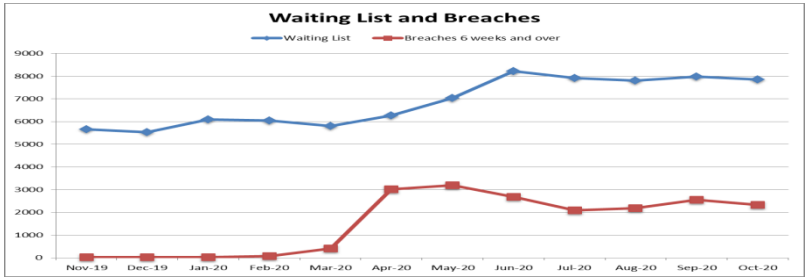


Octobers DM01 performance improved slightly by 2.5% whilst the waiting list size was reported at 7,861, of which there were 2,329 breaches.

This was made up of : 366 Magnetic Resonance Imaging, 892 Computed Tomography, 155 Non-Obstetric Ultrasound, 36 Urodynamics, 205 Colonoscopy, 96 Flexi Sigmoidoscopy, 15 Cystoscopy and 553 Gastroscopy.

Non-Obstetric Ultrasound demonstrated the greatest reducing in breaches with 155 compared to 478 the previous month.

Although most modalities are back to achieving pre-covid activity levels, the greatest challenges that they all face is the clearance of the backlog patients that built up during the height of the pandemic.



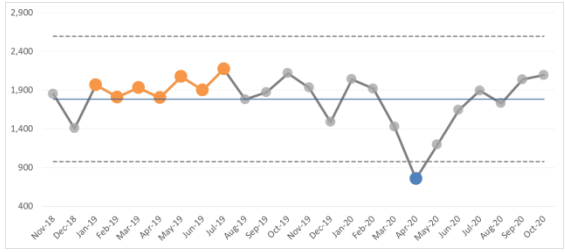
Breach Rates	Trend	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Magnetic Resonance Imaging		1.17%	1.26%	1.40%	3.24%	10.57%	61.58%	48.91%	26.40%	15.14%	16.52%	14.84%	22.96%
Computed Tomography		0.00%	0.00%	0.21%	0.15%	8.49%	48.76%	44.80%	36.44%	32.32%	35.71%	41.41%	37.64%
Non-obstetric ultrasound		0.06%	0.58%	0.27%	0.57%	1.89%	41.25%	28.81%	11.70%	7.76%	11.66%	21.12%	7.70%
Barium Enema		--	--	--	--	--	--	--	--	--	--	--	--
DEXA Scan		--	--	--	--	--	--	--	--	--	--	--	--
Audiology - Audiology Assessments		0.00%	0.00%	0.00%	0.00%	0.00%	33.04%	91.79%	77.48%	97.32%	98.61%	71.43%	100.00%
Cardiology - echocardiography		--	--	--	--	--	0.00%	--	--	--	--	--	--
Cardiology - electrophysiology		--	--	--	--	--	--	--	--	--	--	--	--
Neurophysiology - peripheral neurophysiology		--	--	--	--	--	--	--	--	--	--	--	--
Respiratory physiology - sleep studies		0.00%	--	--	0.00%	0.00%	--	--	0.00%	0.00%	0.00%	--	--
Urodynamics - pressures & flows		17.65%	7.69%	6.67%	0.00%	56.00%	100.00%	87.50%	76.47%	70.83%	54.55%	73.53%	64.29%
Colonoscopy		0.00%	0.00%	0.27%	0.29%	3.08%	35.14%	50.57%	49.22%	47.54%	40.90%	35.18%	32.28%
Flexi sigmoidoscopy		0.00%	0.00%	0.00%	0.00%	4.82%	30.19%	44.65%	57.79%	53.14%	55.21%	57.30%	56.80%
Cystoscopy		15.52%	0.00%	0.00%	0.00%	28.57%	86.96%	57.14%	58.82%	48.72%	46.03%	28.00%	35.71%
Gastroscopy		0.00%	0.44%	0.37%	0.39%	7.10%	38.86%	50.89%	47.50%	54.88%	54.53%	54.93%	56.95%
Total		**0.55%**	**0.60%**	**0.57%**	**1.21%**	**6.97%**	**48.17%**	**45.48%**	**32.73%**	**26.48%**	**28.08%**	**31.98%**	**29.63%**
Surgery		0.60%	0.66%	0.62%	1.32%	7.30%	50.08%	44.58%	28.91%	19.86%	22.45%	27.50%	24.24%
Medicine		0.00%	0.15%	0.28%	0.30%	4.86%	36.19%	49.92%	49.57%	51.67%	49.27%	47.71%	48.11%

Cancer Pathway

East Sussex Healthcare NHS Trust

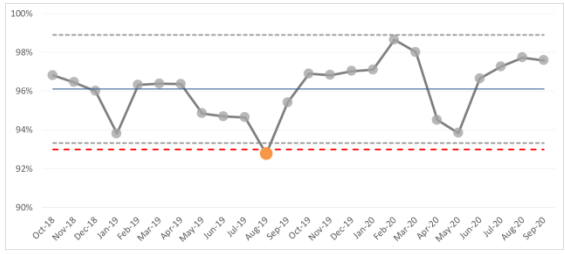
Two Week Wait Referrals

Target: Monitor
Current Month: 2,095



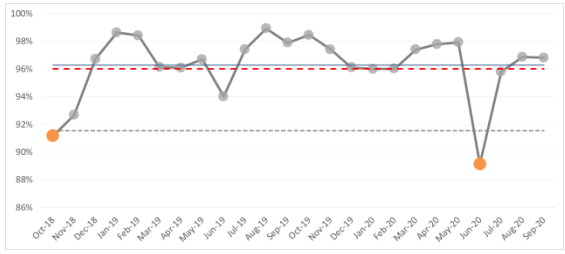
Cancer 2WW Standard

Target: 93%
Current Month: 97.6%



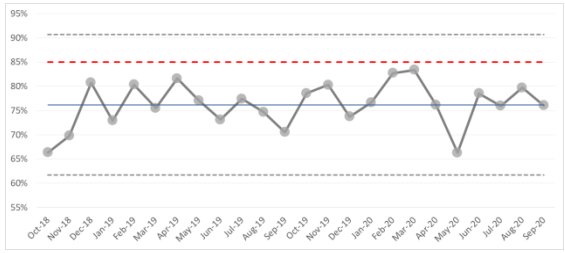
Cancer 31 Day Standard

Target: 96%
Current Month: 96.8%



Cancer 62 Day Standard

Target: 85%
Current Month: 76.1%



The Trust has continues to meet the 2 week wait cancer standard and will report compliance for September and October. Following a couple of challenging months the 31 day standard has been achieved in August and September.

The Trust continues to face the challenge of treating the number of patients waiting over 62 days and 104 days which in turn impacts on performance. September has seen performance slightly decline by 3.6%. This was against a national average of 77.4% and placed ESHT 59th out of 123 reporting organisations. Upper GI performance had a particularly challenging month (slide 39) due to a number diagnostic delays in patient pathways with other providers.
Validation of October's data will not be available until early December but early intelligence suggests a position of approximately 71%.

It should be noted that due to the focus on clearing the backlog, the forward view for the coming months is that the Trust will continue to see performance percentages reported in the low 70's.

October saw the highest 2ww referral rate for over a year with 2,095 referrals.
The Waiting list size has shown a further increase over the past month to Circa 1950.

- 2WW Standard: 44 breaches out of 1825 patients first seen.
- 31 Day Standard: 5 breaches out of 157 treatments.
- 62 Day Standard: 31 breaches out of 129.5 treatments.
- 8 out of the 31 breaches for September were impacted in some way by Covid-19, either through surgical restrictions, diagnostic restrictions e.g. endoscopy, consideration of the risk of specific treatment type or cancelled/delayed clinics .

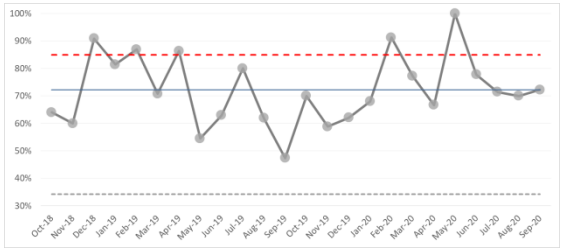
The Trust reported 12.5 treatments on or over 104 days, 2.5 of these were shared treatments with other Trusts (Brighton, Kings & Guildford) and there were 6 individual patients in total.

The 28 Day Faster Diagnostic Standard (FDS) for September was 61.6% against a target of 75%.

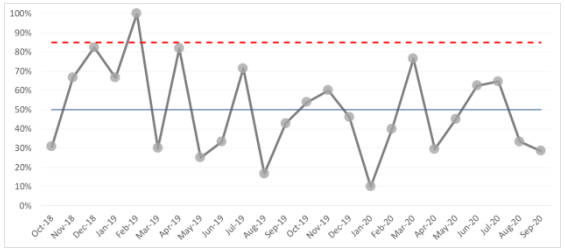
2WW Referral to First Treatment 62 Days

East Sussex Healthcare NHS Trust

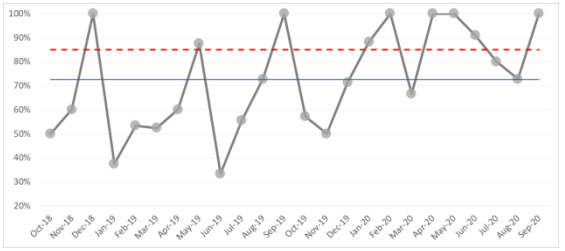
Breast



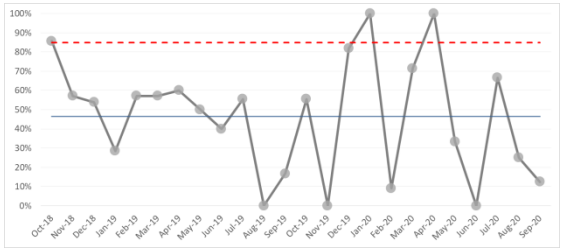
Gynaecology



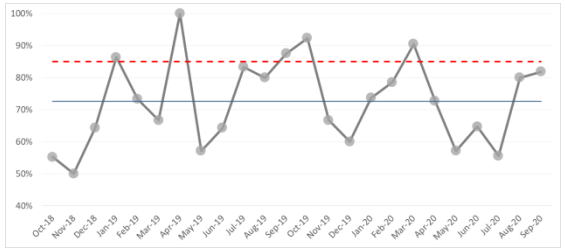
Haematology



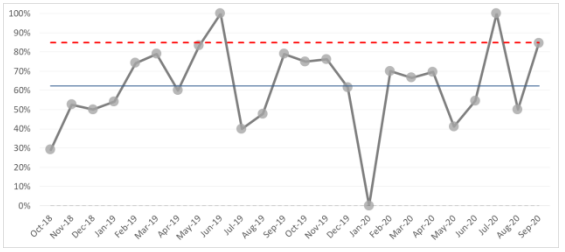
Head & Neck



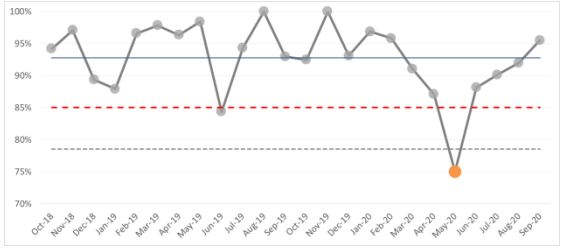
Colorectal



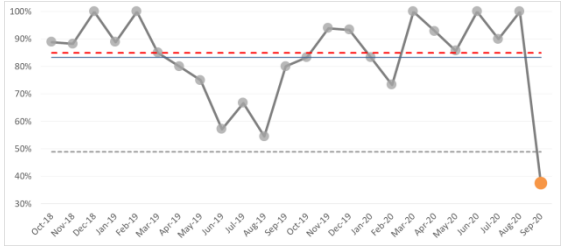
Lung



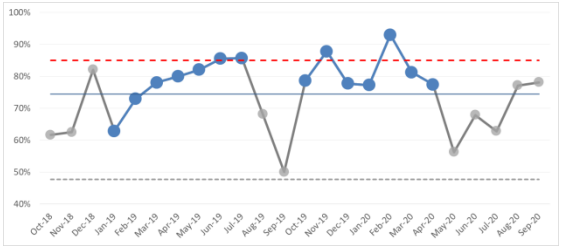
Skin



Upper GI



Urology



Financial Performance

Trust Financial Performance

Statement of Financial Position

Workforce Expenditure

Non Pay Expenditure, Efficiencies & Capital

Receivables, Payables & Cash

Divisional Financial Performance

We will use our resources economically, efficiently and effectively
Ensuring our services are financially sustainable for the benefit of our patients and their care

Finance Report Summary - Month 7

East Sussex Healthcare NHS Trust

Income YTD

	Pr Year Actual £k	19/20 M8-10 Average	Actual £k	Variance £k
Contract/Block Income	221,673	232,428	233,401	973
Divisional Income	26,461	25,147	14,321	(10,826)
Pre Top-Up Income	**248,134**	**257,575**	**247,722**	(9,853)
FRF/Block Top-up	8,588	14,957	21,109	6,153
COVID-19 Expense Claim	0	0	12,554	12,554
COVID-19 Income Claim	0	0	8,822	8,822
Top-up Income	**8,588**	**14,957**	**42,485**	27,529
Total Income	**256,722**	**272,531**	**290,207**	17,676

The Trust's income is above the 19/20 M8-M10 planning average income by c. £18m YTD. This is mainly due to the block top up and retrospective true-up of £27m. Without these element the Trust's income would be £9.9m below the 19/20 M8-M10 planning average. The Elective Incentive Scheme (£301k) where income is withheld should the agreed activity levels not be reached has not been applied in accordance with NHSE/I instructions.

Operational Deficit YTD

	Pr Year Actual £k	19/20 Mth 8-10 Average £	Actual £k	Variance £k
Permanent	(108,792)	(155,115)	(167,226)	(12,111)
Temporary	(14,181)	(22,269)	(28,278)	(6,009)
Total Pay	**(122,974)**	**(177,384)**	**(195,504)**	(18,121)
Non Pay Costs	(65,025)	(91,357)	(95,534)	(4,176)
Operating Costs	**(187,998)**	**(268,741)**	**(291,038)**	(22,297)
Operational Deficit	**68,724**	**3,790**	**(831)**	**(4,621)**

The Trust is reporting a deficit in M7 of £0.9m which is in line with the financial plan. The Trust has spent £22m YTD more than the NHSE/I planning average of which £18m is a pay and £4m is non-pay. The 19/20 M8-M10 planning assumption expected the Trust to be better than break even by £5m YTD. The Trust is forecasting a year end deficit of £6.8m (this includes COVID-19 and restore and recover expenditure).

COVID-19 Claim YTD

	Qtr 1	Qtr 2	Qtr 3	YTD
Pay	3,285	4,158	1,246	8,689
Non-pay	2,234	1,190	441	3,865
Planning Assumption	3,589	3,500	0	7,089
Loss of Income	135	79	0	214
(Loss)/Surplus Adjustment	(229)	1,748	0	1,519
Total	**9,015**	**10,674**	**1,687**	**21,376**
Amounts Validated	8,768	6,290	1,687	15,058
Residual Risk	**(247)**	**(4,384)**	**0**	**(6,318)**

The Trust's retrospective COVID-19 true-up claim of £19.7m YTD covers increased operating costs due to COVID, a planning assumption gap and non-patient care income losses. The retrospectivre true-up is no applicable. The Trust has been allocated a COVID-19 block fund of £11m for quarter 3 and 4which it can spend against.

Workforce

	Pr Year Actual WTE	19/20 M8-10 Average	Actual Average WTE	Variance WTE
Permanent	6,038	6,195	6,357	(162)
Temporary	582	633	578	54
Total Pay	**6,620**	**6,828**	**6,936**	(108)

The Trust has used on an average basis 108 FTE above the 19/20 M8-M10 planning average. The Trust has recruited 162 FTE above the planning assumption. Many of these relate to pre-COVID-19 service developments and the need to run red and green areas. These are mitigated against by reduced temporary workforce staff numbers.

Agency Spend YTD

	Pr Year Actual £k	19/20 M8-10 Average £	Actual £k	Variance £k
Medical	1,749	2,661	2,528	133
Nursing	860	1,423	2,155	(732)
AHP's	505	1,191	1,178	13
Admin	302	450	506	(57)
Other	157	67	25	41
Total	**3,573**	**5,791**	**6,392**	(601)

Agency spend is above the 19/20 M8-M10 planning average by 10% with nursing having the highest spend. This is mainly due to the Trust's response to delivering the COVID-19 response including having staff for red and green areas and service developments. Medical agency is below the planning assumption.

Non-pay Spend YTD

	Pr Year Actual £k	19/20 Mth 8-10 Average £	Actual £k	Variance £k
Drugs	18,690	30,642	26,811	3,831
Clinical Supplies	14,898	21,351	18,471	2,880
Purchased Services	4,288	5,605	5,846	(241)
Other	18,042	17,661	26,278	(8,618)
Finance Costs	9,107	16,098	14,244	1,854
Total	**65,025**	**91,357**	**91,651**	(294)

Non-pay spend is slightly above the M8-M10 planning average. This is largely due to the revenue impact of the Trust's capital investment resulting in increased depreciation.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	72,315	70,215
Year End Forecast	2,100	2,100	2,100	0

The cash balance remains high as the cash has been received in advance of the period it relates to causing a higher than usual cash balance. Work is being performed to reduce the cash balance.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	18,264	14,010	4,254
Year End Forecast	45,137	45,931	(794)

At M7 the CRL forecast for is £45.1m as additional bids require formal approval from NHSE/I and COVID funding is awaiting approval. Should approval be granted the forecast CRL would increase to £56.1m. This consists of internally generated depreciation of £13,384k, plus other funding including; year 2 of fire compartmentation £6m; Building For Our Future (incl HIP2/seed) £10,375k; bids for medical equipment £4m; integrated theatres £250k; Scan4Safety £1.5m; and cath labs £3,250k; critical infrastructure funds (CIF) £8.22m; Local Health and Care Record £373k; and A&E winter £3.7m. The Trust is currently behind plan YTD as scheme phasing has materialised at a different pace to the plan largely due to the impact of COVID and final decisions on scheme requirements.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	86.25%	78.12%	93.58%	90.24%
NHS Invoices	92.20%	99.69%	87.48%	96.26%

86% of trade invoices were paid within 28 days which equates to 78% of the total value paid in month. This is a 17% improvement in month in invoices paid within the target of 28 days.

92% of NHS invoices were paid within contract or within 28 days of receipt which was 100% of the total NHS invoices paid. This is a 4% improvement in the number of NHS invoices that were paid within the 28 day target.

Divisional Performance

Division	In the Month: Plan FTE	Actual FTE	Variance FTE	Plan £k	Actual £k	Variance £k	Year to Date: Plan £k	Actual £k	Variance £k	Forecast Outturn: Plan £k	Actual £k	Variance £k
Diagnostics, Anaesthetics & Surgery	1,684.66	1,739.38	(54.72)	(9,986)	(10,013)	(27)	(69,883)	(66,707)	3,176	(120,531)	(120,531)	0
Medicine	1,555.64	1,480.26	75.38	(6,456)	(6,690)	(234)	(45,190)	(44,908)	282	(78,467)	(78,467)	0
Urgent Care	415.71	382.98	32.73	(1,737)	(1,914)	(178)	(11,901)	(13,222)	(1,321)	(21,084)	(21,084)	0
Out of Hospital Care	1,136.37	1,053.21	83.16	(4,386)	(4,154)	232	(30,104)	(29,325)	778	(52,361)	(52,361)	0
Women's, Children's & Sexual Health	726.96	677.69	49.27	(3,223)	(3,024)	199	(22,678)	(21,408)	1,270	(39,004)	(39,004)	0
Estates & Facilities	724.49	679.17	45.32	(2,478)	(2,618)	(140)	(16,816)	(19,262)	(2,446)	(29,329)	(29,329)	0
Corporate	1,090.89	1,029.18	61.71	(4,884)	(4,325)	559	(33,116)	(31,987)	1,130	(57,551)	(57,551)	0
Central	0.00	121.14	(121.14)	32,317	31,602	(716)	228,855	225,435	(3,420)	391,488	391,488	0
Total	**7,334.72**	**7,163.01**	**171.71**	**(833)**	**(1,138)**	**(305)**	**(833)**	**(1,385)**	**(552)**	**(6,839)**	**(6,839)**	**0**

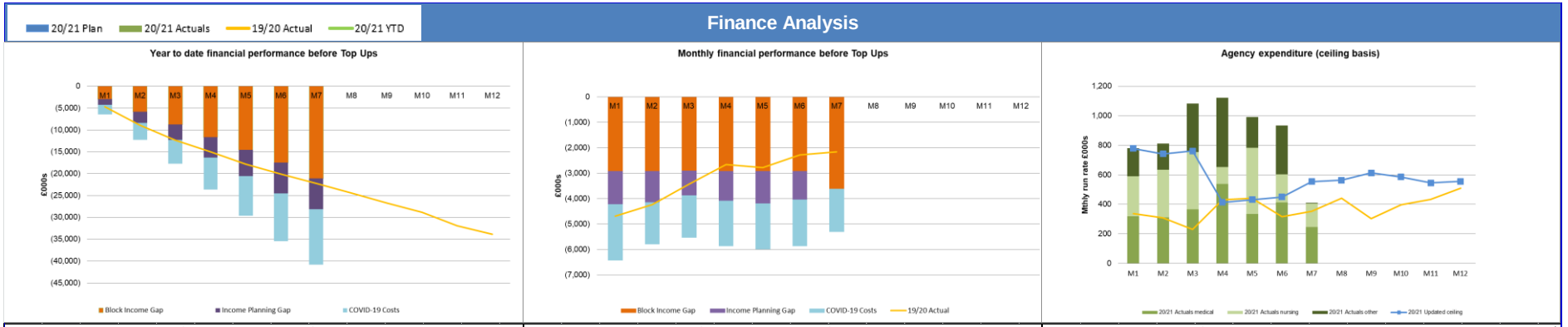
Key Risks

Key Risk 1	The amended financial regime is based on the average income for months 8 to 10 plus a 3.2% inflator. This has the potential to create cost pressures as the block contract is based on a period of time and not on forecast outturn.
Key Risk 2	Continued recruitment to vacant posts and service developments which commenced prior to the amended financial regime could lead to expenditure commitments higher than the funding allows in the block funding for 2020/21.
Key Risk 3	The Trust is required to submit plans to deliver 90% or 100% activity levels. This will incur additional costs. Should we not achieve these activity trajectories then there is a potential for reductions to our block contract even if the system were to achieve a breakeven position.
Key Risk 4	The Trust will receive a revised block value. It is unclear at this stage whether or not this will resolve our block income gap or the income planning gap identified in the current financial regime.

Mitigations

Mitigation 1	An expenditure forecast will be undertaken to understand both the financial opportunities and challenges and put in place early mitigation for the challenges.
Mitigation 2	An update of the Trust's financial plan is being undertaken based on month 1 as a benchmark to monitor pay spend and permanent recruitment
Mitigation 3	The focus will continue to be on productivity and efficiencies to ensure that we meet the required activity trajectories, manage our costs to avoid the risk of a reduced block contract.
Mitigation 4	We have been advising our NHSE/I team of the issues with our block income contract and are hopeful that they will take this feedback on board.

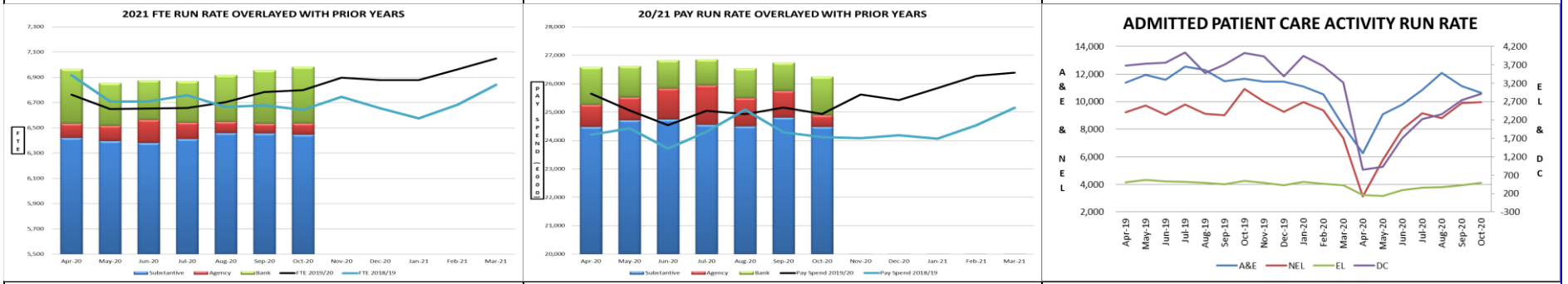
Finance Analysis



As at M7 the Trust is reporting a YTD deficit pre-top up and True up of £40.8m. This is currently due to a block income gap of £21.2m, an income planning gap of £8.8m and COVID-19 related expenditure of £12.6m.

In the month the Trust is reporting a deficit pre-top up and true up of £5.3m. This is currently due to the block income gap of £3.6m and COVID-19 related expenditure of £1.7m. The increasing deficit run rate is due to increased COVID-19 related expenditure and also as a result of restoring 'normal' activity levels. Ideally, the block income gap should track the 19/20 actual trajectory.

It is key that the Trust continues to focus on cost control as it has a block contract in place until March 2021. NHSE/I are encouraging providers to restore their non-patient income back to 19/20 levels.

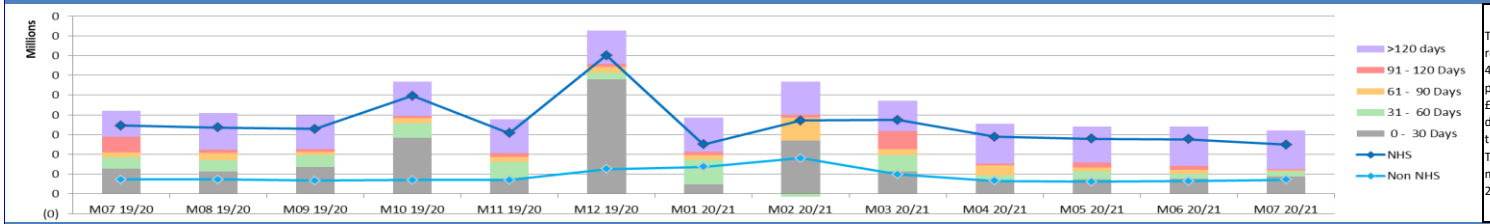


The FTE run rate for 2020/21 is higher than both 18/19 and 19/20. This demontrates the Trust's investments prior to the pandemic and current financial regime. The trend appears to represent an increase as activity recovers.

The pay spend is above the run rate of prior years and reflects the increased cost of operating set against a backdrop of COVID-19 (i.e. running 'Red and Green' areas) as well as the impact of service developments which commenced prior to the current financial regime. The small decrease in run rate relates to the reduced need for additional and backfill of staff as the pandemic impact is currently reduced.

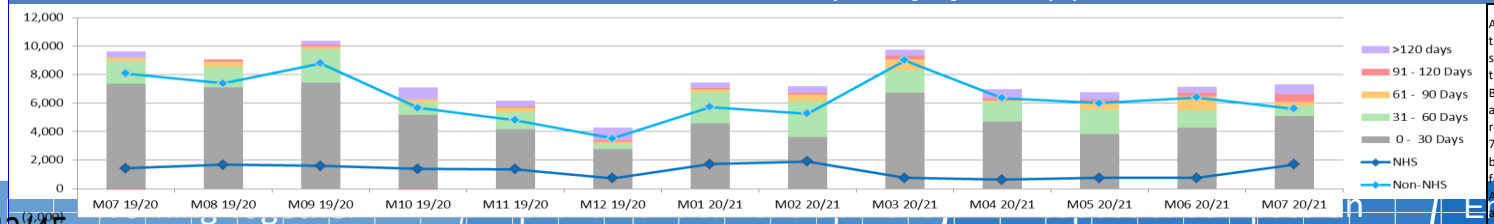
Admitted patient care (excluding critical care) shows a steep decline in April due to COVID and a consistent recovery thereafter. A&E leads the way with 90% of prior year activity followed by Electives & NEL at 78%. Daycases are 90% of prior year levels of activity. The expectation is all these are to reach 90% by October onwards as a minimum to avoid Elective Incentive Scheme penalties that may be applied to the Trust.

Receivables Ageing Run rate (£k)



The sales ledger balance at the end of October is £6.4m which is a reduction on the previous month of £0.4m. This reduction is reflected in 45 fewer invoices held on the sales ledger at the end of the month. The position reflects an improvement in aged debt (invoices > 30 days) of £0.6m. 72% of the total debt owed to the Trust is due and is aged over 30 days. Most of the debt owed to the Trust is from other NHS bodies and therefore there is a low risk of non-recovery.
There are NHS invoices currently being disputed relating to; prior year market rent recharge from NHSPS £0.955m; SLA year-end settlement 2018/19 £0.281m and delayed discharges £0.092m.

Payables Ageing Run rate (£k)



A slight increase in month of £0.1m on the creditor position increasing the purchase ledger total to £7.3m. The number of invoices on the system fell by 244. Whilst the total purchase ledger position increased, the value of debt owed to suppliers (aged > 30 days) reduced by £0.7m. Balances that are aged and not ready for payment reflect invoices that are awaiting authorisation or the receipting of the goods/services received.
77% of the outstanding invoices are payable to trade suppliers and the balance to NHS providers. The Trust processes weekly payment runs and forecasts to pay £5.0m per week.
Actual payment runs depend on the level of invoices on the system that are ready for payment and due for payment.

M7 to M12 Run Rate

The M7 run rate was £831k deficit (a £2k improvement against the M7 plan)

	M7 Outturn	M8 Plan	M9 Plan	M10 Plan	M11 Plan	M12 Plan	Total
	£000	£000	£000	£000	£000	£000	£000
Planned monthly surplus/(deficit)	(833)	(911)	(1,041)	(1,325)	(1,198)	(1,531)	(6,839)
Acutal monthly surplus/(deficit)	(831)						(831)
Variance from planned monthly deficit	**2**						**2**
Planned Income pre COVID-19 and top up	35,897	35,854	35,760	35,583	35,715	35,254	214,062
Actual Income pre COVID-19 and top up	36,094						36,094
Income Variance	**197**						197
Planned expenditure (pay and non-pay)	(40,352)	(40,352)	(40,432)	(40,530)	(40,535)	(40,404)	(242,605)
Actual expenditure (pay and non-pay)	(40,548)						(40,548)
Expenditure Variance	**(196)**						(196)
Planned COVID Income (including pass through)	2,143	2,143	2,143	2,143	2,143	2,143	12,856
Actual COVID Income (including pass through)	1,688						1,688
COVID Income Variance	**(455)**						**(455)**
Planned COVID Expenditure	(2,142)	(2,142)	(2,142)	(2,142)	(2,142)	(2,145)	(12,855)
Actual COVID Pay Expenditure	(1,246)						(1,246)
Actual COVID Non-Pay Expenditure	(441)						(441)
COVID Expenditure Variance	**(455)**						**(455)**
Actual block income top up	3,622						3,622
Monthly deficit pre income top up	(4,453)						(4,453)
Operational Deficit	**(831)**						**(831)**

Improvement/Deterioration of deficit compared to prior month

Statement of Financial Position - Month 7

	Year to date				Forecast Outturn			
	19/20 Actual (£m)	20/21 Plan (£m)	20/21 Actual (£m)	Variance (£m)	20/21 Plan (£m)	20/21 Outturn (£m)	Variance (£m)	
Non Current Assets								
Property, Plant and Equipment	229.5	230.1	234.7	4.6	252.6	275.1	22.6	
Intangible Assets	2.4	1.8	2.8	1.0	2.3	2.5	0.2	
Other Assets	3.0	9.8	3.1	(6.8)	8.8	3.1	(5.7)	
Total Non Current Assets	**234.9**	**241.7**	**240.6**	**(1.2)**	**263.7**	**280.7**	**17.0**	
Current Assets								
Inventories	7.3	6.6	6.9	0.3	6.6	6.6	0.0	
Trade and Other Receivables	47.3	41.6	25.4	(16.2)	37.6	50.5	12.9	
Cash and Cash Equivalents	2.1	8.9	72.3	63.4	2.1	2.1	0.0	
Non Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Total Current Assets	**56.8**	**57.1**	**104.7**	**47.6**	**57.1**	**59.2**	**12.9**	
Current Liabilities								
Trade and Other Payables	(28.8)	(34.8)	(49.9)	(15.1)	(32.5)	(45.6)	(13.1)	
Borrowings	(234.1)	(4.8)	0.0	4.8	(5.3)	0.0	5.3	
Other Financial Liabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Provisions	(0.4)	(0.4)	(0.3)	0.1	(0.4)	(0.3)	0.1	
Other Liabilities	(1.4)	(2.2)	(32.8)	(30.6)	(2.2)	0.0	2.2	
Total Current Liabilities	**(264.6)**	**(42.1)**	**(83.0)**	**(40.8)**	**(42.1)**	**(45.9)**	**(5.6)**	
Non-Current Liabilities								
Borrowings	(1.8)	(20.1)	0.0	20.1	(27.1)	0.0	27.1	
Trade and Other Payables	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Provisions	(2.8)	(2.0)	(2.8)	(0.8)	(1.8)	(2.8)	(1.0)	
Total Non Current Liabilities	**(4.6)**	**(22.1)**	**(2.8)**	**19.3**	**(28.9)**	**(2.8)**	**26.1**	
Total Assets Employed	**22.4**	**234.6**	**259.4**	**24.9**	**249.7**	**291.1**	**50.3**	
Financed By								
Public Dividend Capital	162.6	386.4	401.1	14.6	388.6	438.2	49.6	
Income & Expenditure Reserve	(230.5)	(249.5)	(231.9)	17.7	(245.6)	(237.4)	8.2	
Revaluation Reserve	90.2	97.7	90.2	(7.5)	97.7	90.2	(7.5)	
Total Tax Payers Equity	**22.4**	**234.6**	**259.4**	**24.9**	**240.7**	**291.1**	**50.3**	

Summary & Next Steps

1. On 2 April 2020, the Department of Health and Social Care (DHSC) announced reforms to the NHS cash regime for the 2020/21 financial year which included that all interim revenue and capital loans as at 31 March 2020 would be extinguished and replaced with the issue of Public Dividend Capital (PDC). In addition, the Trust was moved to block contract payments as part of the NHS response to COVID-19.
2. The effective date for the extinguishing of debt was 30 September 2020; at the time the plan was generated, the assumed debt conversion was April 2020 hence the variance.
3. All outstanding interim loans totalling £234m have been repaid and replaced by Public Dividend Capital.
4. The one remaining normal course of business loan (NCB) was repaid in October, as a result of this transaction the Trust does not have any borrowings.
5. Due to the financial regime changes the Trust has been moved on to block contract payments. Funding is being received in advance causing a higher than usual cash balance at the end of month.

Capital Programme Summary - Month 7

YTD Capital Programme Performance	Original Plan £000	Revised Plan £000	CRG Plan £000	YTD Plan £000	Actual Expenditure £000	Variance to YTD Plan £000
Brought Forward	-	-	250	-	-	-
Estates	3,559	3,559	7,431	400	1,395	995
Backlog Maintenance	2,783	2,783	1,820	800	1,489	689
Digital	1,975	1,975	3,327	650	733	83
Medical Equipment	3,667	3,667	3,709	2,838	966	(1,872)
Finance	1,500	1,500	1,500	750	875	125
Unplanned urgents	545	350	350	400	350	(50)
Fire compartmentalisation	6,020	6,020	4,000	3,240	3,170	(70)
Medical Equipment Bid	4,000	4,000	3,773	-	-	-
Building For Our Future (HIP2)	4,230	10,375	9,758	2,160	1,887	(273)
Integrated Theatres	250	250	300	250	-	(250)
Track4Safety barcode implementation	1,500	1,500	1,500	-	-	-
General Provision	301	-	733	-	-	-
Cardiology Cath Labs	3,250	3,250	2,687	3,250	18	(3,232)
Local Health Care Record	-	373	373	-	373	373
Breast Screening Mobile Units	-	26	26	26	26	-
Clinical Ward Internal Courtyards	-	1,800	1,800	900	29	(871)
Energy Centre Conquest	-	450	450	450	-	(450)
Energy Centre EDGH	-	720	720	-	-	-
Helipad area	-	2,143	2,143	-	87	87
Temporary Accommodation	-	3,107	3,107	1,035	302	(733)
COVID-19	-	1,115	1,115	1,115	853	(262)
CYBER SIEM Solution	-	100	100	-	-	-
A&E Winter	-	3,700	3,700	-	498	498
Oxygen	-	1,024	1,024	-	636	636
Perkin Elmer	-	323	323	-	323	323
Adopt & Adapt	-	630	630	-	-	-
COVID-19	-	1,374	259	-	-	-
Total Owned	**33,580**	**56,114**	**56,908**	**18,264**	**14,010**	**(4,254)**
Donated	1,000	1,000	1,000	200	22	(178)
Less donated Income	(1,000)	(1,000)	(1,000)	(200)	(22)	178
Total	**33,580**	**56,114**	**56,908**	**18,264**	**14,010**	**(4,254)**

Capital Resource Limit (CRL)	£k
Planning CRL	**34,580**
2020/21 Opening CRL	**13,834**
Fire Compartmentation	6,020
Building For Our Future (HIP2)	10,375
Local Health Care Record (LHCRE)	373
Breast Screening Mobile Units	26
COVID-19 reimbursement	1,115
Critical Infrastructure Funds (CIF)	8,220
A&E Winter	3,700
COVID-19 (2020/21 approved bids only)	1,374
Cyber SIEM solution	100
Closing Working CRL	**45,137**
Business cases (NHSE/I yet to be approve	**9,000**
Adopt & Adapt (awaiting MOU)	**630**
Oxygen (awaiting MOU)	**1,024**
Perkin Elmer (awaiting MOU)	**323**
Forecast CRL	**56,114**
Overplanning margin	**794**

Capital Commentary

At the end of October the forecast CRL is £56.114m however the working capital is £45.137m as bids of £9m need formal approval from NHSE/I and COVID funding is awaiting approval.
CRL is the maximum that can be spent on capital purchases in year however actual permitted expenditure is determined by the capital departmental expenditure limit (CDEL) and this is based on actual depreciation in year, loan repayments and asset disposals.
The Trust has a £1.1m overplanning margin which will be managed on a monthly basis by the CRG.

Building for our Future

Meeting information:			
Date of Meeting:	1st December 2020	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Tracey Rose

Purpose of paper: (Please tick)			
Assurance	☐	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The paper provides a summary of the Building for our Future Programme and the progress made to date regarding engagement with our stakeholders.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

- Finance and Investment committee bi-monthly
- Executive Directors monthly
- BFF Programme Board monthly

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

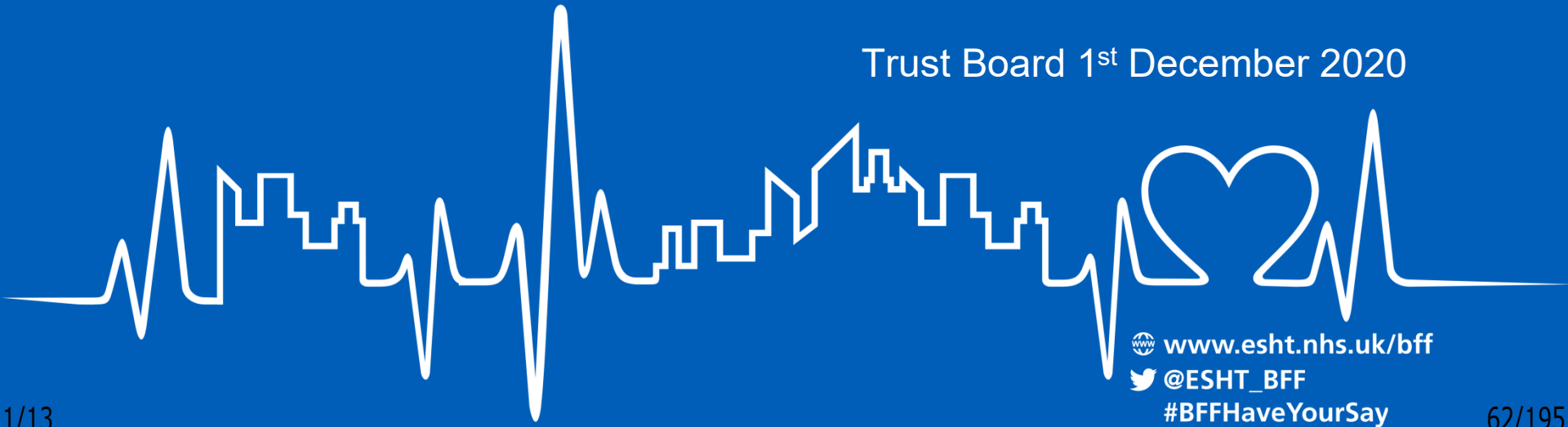
The Trust Board are asked to note the summary of the Building for our Future Programme

NHS
East Sussex Healthcare
NHS Trust

Building for our future

Providing the best possible care in East Sussex by transforming our hospitals

Trust Board 1st December 2020



www.esht.nhs.uk/bff
@ESHT_BFF
#BFFHaveYourSay

Introduction

East Sussex Healthcare NHS Trust

Building for our Future : Introduction

East Sussex Healthcare NHS Trust

- In October 2019, the Trust received the welcome news that it had been included within the Health Infrastructure Programme (“HIP”) and received seed funding to develop a business case to reshape its estate.

- This has become the **Building for our Future Programme**

- The Programme will help the Trust evaluate how it can make best use of existing assets and resources to focus on areas of clinical needs and improve its infrastructure that meets modern healthcare demands.

Building for our Future : The Vision

East Sussex Healthcare NHS Trust

A comprehensive **program** of **new build and refurbishment** across Conquest, Eastbourne and Bexhill.

Aim - To **transform our estate** to help us **deliver safe, effective and world class healthcare** to the population of **East Sussex**.

Building for our Future: Aims

East Sussex Healthcare NHS Trust

We will continue to:

- **deliver** acute and community care as we believe that this best meets the healthcare needs of our population
- **provide** services on our two acute hospital sites - Conquest Hospital and Eastbourne DGH
- **provide** appropriate urgent care at Conquest Hospital and Eastbourne DGH to best meet the needs of our population, particularly the frail and elderly
- **meet** our obligations under the Sussex Trauma Network by retaining the trauma unit at Conquest
- **deliver** obstetrician-led services at Conquest Hospital, with a high quality midwife-led unit at Eastbourne and home birth option which offers choice to all women in East Sussex
- **deliver** clinical oncology at both our main hospital sites to ensure we can meet the needs of our population

We will:

- Reduce critical infrastructure risk across Conquest, Eastbourne and Bexhill hospitals
- Create space that is fit-for-purpose
- Extend and improve facilities for Emergency Care, ensuring that the departments are the right size and shape for the model of care
- Provide additional bed capacity, outpatients, theatres, endoscopy, diagnostic services and wards, to ensure alignment to system demand
- Improve access to Ophthalmology facilities
- Improve access to Interventional Cardiac facilities

Building for our Future – Programme Timeline

East Sussex Healthcare NHS Trust

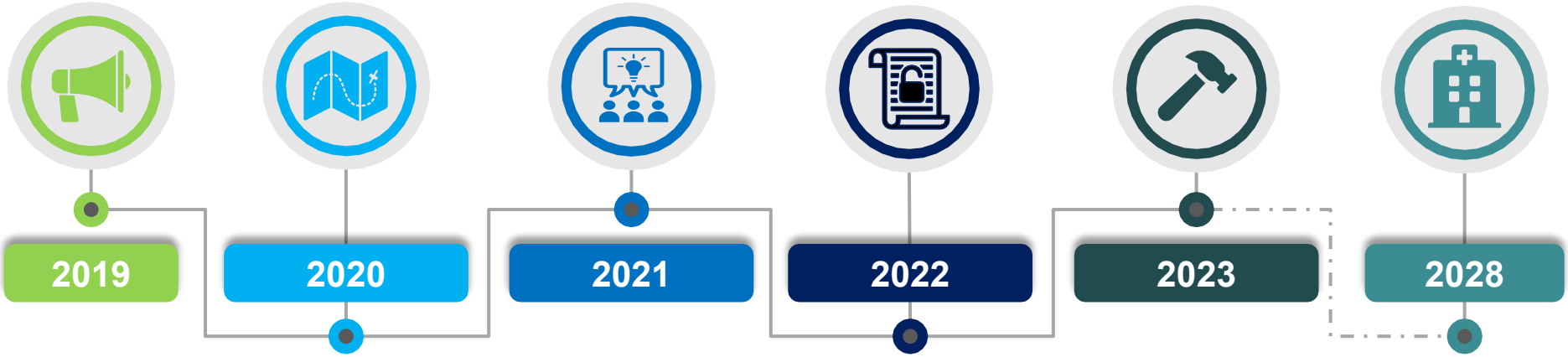
Although timings may be subject to change, we are working towards **starting construction during 2023.**

Our first Strategic Outline Business Case for our Building for our Future plans will be completed in early 2021, with NHS approval in the spring of 2021. We aim to have the next stage of the Outline Business Case and Full Business Case completed by spring 2022, with the intention of construction commencing on-site during mid-2023.

Subject to Planning, **completion should take place in 2028** following a five year building and refurbishment programme.

Building for our Future – Programme Timeline

East Sussex Healthcare NHS Trust



2019 – FUNDING ANNOUCEMENT

- Develop resource plan

2020 – STRATEGIC OUTLINE CASE (SOC)

- Implement resource plan
- Commence staff and patient engagement
- Develop hospital design brief
- Develop procurement strategy
- Commence enabling works

2021 – OUTLINE BUSINESS CASE (OBC)

- Submission of SOC for approval *(early 2021)*
- Commence development of OBC
- Continue staff and patient engagement
- Develop and implement change plans
- Acute cardiology and ophthalmology service change (subject to agreement)
- Continue enabling works

2022 – FULL BUSINESS CASE (FBC)

- Submission of OBC for approval *(early 2022)*
- Commence development of FBC *(expected Spring 2022)*
- Commence contractor procurement *(subject to procurement strategy)*
- Continue enabling works
- Implement change plans

2023 – CONSTRUCTION COMMENCES

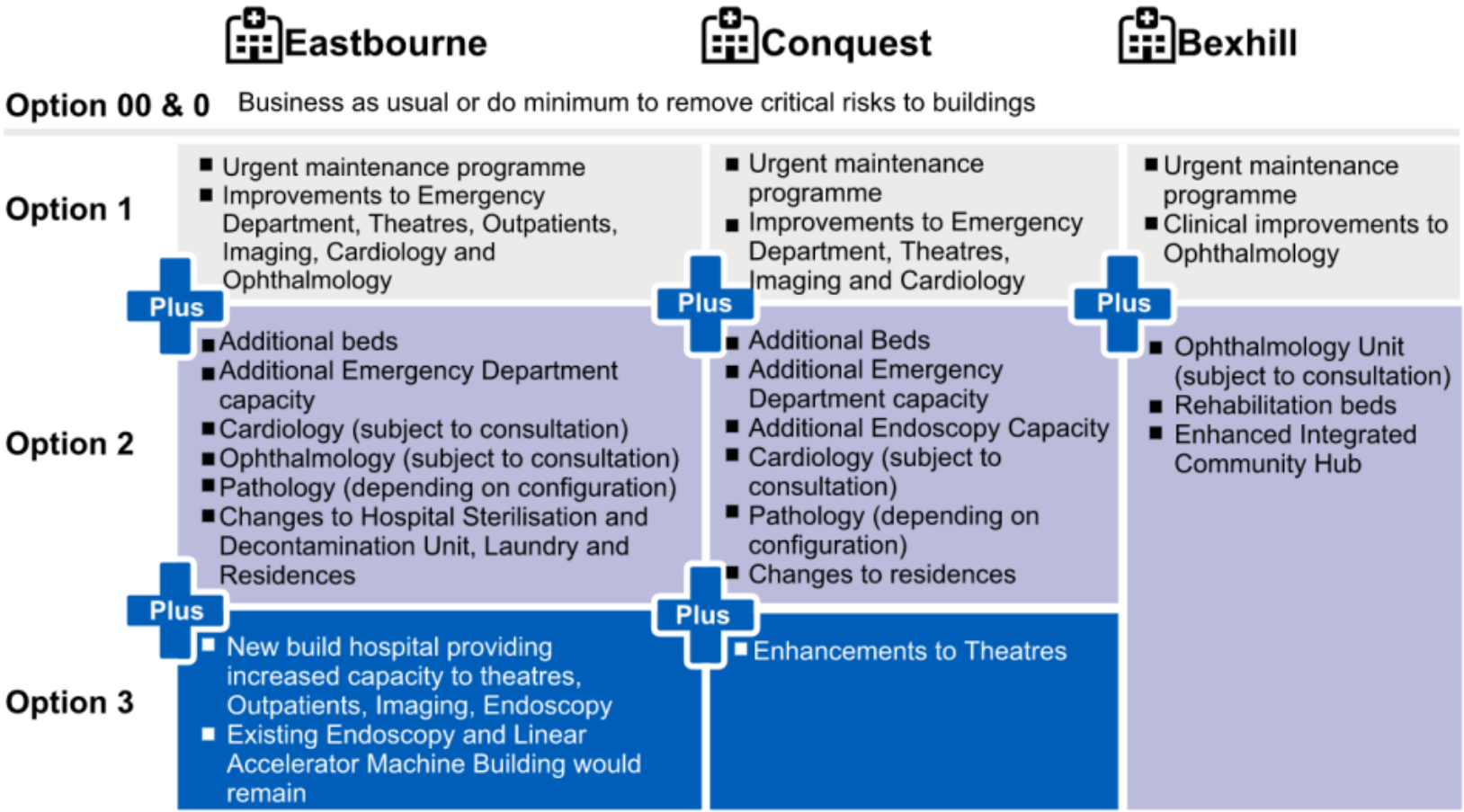
- Submission of FBC for approval *(early 2023)*
- NHS approval of FBC *(expected Summer 2023)*
- Commence construction of main refurbishment/build *(subject to NHS approval – start on site mid-2023)*

2028 – COMPLETION OF BUILD

- Completion of refurbishment / build staged by site

Preferred way forward options

East Sussex Healthcare NHS Trust



Working with local people

East Sussex Healthcare NHS Trust

- We will work with our local population, members of staff and our partners to prioritise where this infrastructure investment is needed most or where it will make the biggest difference
- Since August we have been seeking feedback from key groups as part of our Phase 1 communications and engagement plan
- This initial feedback will be used to test our thinking and help shape our engagement and communications plans further

Early results of initial engagement
Front door listening

East Sussex Healthcare NHS Trust

Throughout Aug and Sept 2020 we asked people visiting our hospitals: *"What would an improved hospital mean to you and your community?"* A total of 96 respondents said:

- Wayfinding (good signage and easy navigation around estate) – 27%
- Appearance (modern fit-for-purpose buildings) – 26%
- Waiting areas (away from public areas) – 24%
- Parking (choice and availability) – 23%

EDGH	Bexhill	Conquest
• Parking nearer to destinations • Improved navigation • Modernised buildings • Private waiting areas • Improved staff facilities (changing rooms and lockers)	• Modern Irvine Unit (rehabilitation) • Improved waiting areas • New catering facilities • Building fabric that matches quality of care provided by staff	• Improved navigation • Modern lifts • Modernised buildings • Welcoming reception area • Improved parking (staff and visitors)

Early results of initial engagement
Online questionnaire

East Sussex Healthcare NHS Trust

On 5 October, we opened a short survey on our website and extranet. A total of 69 staff and 36 members of the public have responded so far.

When people were asked "*Tell us what you want from the redevelopment of our hospitals*".. Responses focused on (from most to least):

- Ward and inpatient design
- Treatment and diagnostic room design
- Front entrance design
- Atmosphere, environment and space
- Design for children and young people
- Location of services
- Accessibility
- Signage and wayfinding
- Transport
- Catering

Early results of initial engagement Independent research

East Sussex Healthcare NHS Trust

During October 2020 a research company held focus groups with a diverse group of independently recruited members of the public, followed by a questionnaire.

Elements that contribute to wellness:

- Calm / peaceful; Fresh Air; Quiet; Nature; Escapism; Comfort; Potential for social contact / communication; Warmth; Light; Freedom; and Space

Elements that contribute to not feeling well:

- Crowds; Busyness; Chaos; Feeling anonymous; Confusion; Cold; and Cramped

How hospitals can support wellness:

- Welcoming reception; Comfortable surroundings; Privacy; Potential for social interaction; Escapism / Ambience; Nature

Site specific feedback:

- Eastbourne - Lack of: outdoor space, elements of nature and disabled parking
- Conquest - Large, confusing and difficult to navigate site

Stakeholder Engagement Next Steps

East Sussex Healthcare NHS Trust

Actions	Timeline
FFT and complaints review (phase 1)	End of November
Publish initial results, FAQs and redeveloped core narrative (phase 1)	End of November
New Engagement HQ questionnaire (phase 2)	End of November
Staff engagement sessions (phase 1)	November/December
Third sector and charity engagement (phase 2)	January
Primary Care engagement (phase 2)	January
Front door engagement (with volunteers) (phase 2)	January
Engagement gap analysis (phase 3)	Early 2021
Develop co design principles (phase 2)	Early 2021
Develop terms of reference for formal stakeholder group (phase 2)	Early 2021

Quality Account 2019/20

Meeting information:			
Date of Meeting:	1st December 2020	Agenda Item:	9
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The Quality Account (QA) is an annual public report to share information on the quality and standards of care and services the Trust provides. It enables the organisation to demonstrate the achievements made and identify key priorities for improvement in the forthcoming year. It is a requirement to publish the Quality Account on the 30th June each year. However, due to the pandemic NHS England put a pause on the process of publishing the Quality account in their 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic' guidance. A subsequent update from NHS England has indicated the Quality Account will now need to be published on the 15th December 2020.

The Quality Account would normally be shared at the Trust's Annual General Meeting but because of the change in schedule it is being shared at the Board meeting. The Quality Account has been reviewed by the Quality and Safety Committee.

The priorities identified for 2019/20 have been achieved and the new priorities for 202/21 are:

- Embedding patient safety
- Infection Control excellence
- Perfecting discharge

The Quality Account has also been reviewed by the Commissioners, Healthwatch and Health and Overview Scrutiny Committee with positive feedback received.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality and Safety Committee 17th September 2020

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

To receive this Quality Account and to be assured on the achievements made in 2019/20.

East Sussex Healthcare NHS Trust

Quality Account 2019/2020

Part 1 – Introduction

Statement of Quality from the Chief Executive

I am delighted to introduce the Quality Account for East Sussex Healthcare NHS Trust (ESHT).

This report summarises the Trust's quality achievements during 2019/20 and is designed to assure our local population, our patients and our partners that we provide high quality clinical care to our patients and service users. It also highlights areas for further improvement and sets out what we are doing to improve, in addition to our quality priorities for 2020/21.

Over the last twelve months we saw continued improvement to the quality of care we provide. Important indicators of the safety of our care improved - such as the number of patients who had a fall or contracted an infection while in our care. At the same time we have improved the screening, identification, and speed of treatment for severe infection and sepsis. These improvements are reflected in the Trust's relative mortality index which is now at its lowest since the measure was introduced.

Patient feedback about our care continues to improve and 98% of people would recommend our services to others. The numbers of complaints we receive are significantly outnumbered by the number of compliments we get and our services continue to be reviewed highly on the national NHS and local Healthwatch websites. We also continue to get positive feedback from those who take part in the CQC inpatient, emergency care, maternity and children and young people surveys.

In November and December 2019 the Care Quality Commission (CQC), the health and care services regulator, undertook their latest inspection of the quality of care and services at the Trust. The results, which were published in February 2020:

- ESHT is rated 'Good' overall, 'Outstanding' for Caring and 'Outstanding' for Effective
- Community Services are rated 'Outstanding' overall, 'Outstanding' for Community Health Services for Adults, 'Outstanding' for Caring, 'Outstanding' for Effective.
- Conquest Hospital is rated 'Outstanding' overall, 'Outstanding' for End of Life Care, 'Outstanding' for Well Led, 'Outstanding' for Caring
- Eastbourne DGH is rated 'Good' overall, 'Outstanding' for End of Life Care

These are excellent results and represent very significant milestones that the organisation has achieved in its recovery from the difficulties of 2015 and ambition of becoming 'Outstanding and Always Improving'

The reputation of our organisation continues to grow and our teams are increasingly being asked to share the work that we are doing with other organisations. We are regularly cited as an exemplar of good practice for the way that we have improved the efficiency and effectiveness of our care for patients.

Towards the end of the financial year, in January 2020, the NHS declared a Level 4 National Incident in response to Covid-19. At the time of writing this report the organisation, along with partner organisations, was in the midst of responding to the pandemic. We are incredibly proud of all our staff and volunteers who have gone above and beyond to ensure we are continuing to provide the best possible care in this unprecedented situation.

The Trust has made good progress towards the priorities we set in the 2019/20 Quality Account, many of which will continue within programmes over this year. All of the priorities identified have been achieved and further progress will be made I the coming year.
We continue to see success for our clinical services as part of the national clinical audit programme, and we are proud that in many clinical areas our results feature in the highest levels of performance in the country.

We know that the key to maintaining and improving the quality of our services, care for our patients and the experience of our staff is listening to feedback and ensuring that we make changes and embed improvements based on the feedback we receive. For our patients this means better two-way communication during every step of their care journey and ensuring that they are fully informed and involved in decisions relating to their care. For members of the public this means ensuring that we embed a culture of experience based co-design when redesigning services or care pathways. For members of staff it means continuing to encourage an open reporting culture so that they feel safe and able to raise concerns. We were pleased to see this reflected in some of the improvements we saw in the NHS staff survey published in March this year.

As ever, our values will underpin everything we do. The real improvements that we have made to patient care and our working environment come from how well we work together, treat each other, care for our patients with respect and compassion, involve others in decisions that affect them, and continually seek to develop and improve ourselves and the services we provide.

We would like to congratulate and thank all of our members of staff, volunteers, Board members and local partners, people and organisations for supporting us to achieve these high standards. These are excellent improvements and ones in which we can all take pride. Taken together they represent a further very significant milestone that the organisation has achieved in its ambition of becoming ‘Outstanding and Always Improving’.

Joe Chadwick-Bell
Chief Executive

About us and the service we provide

We are proud to provide 'Outstanding' care and be a great place to work

At East Sussex Healthcare NHS Trust (ESHT) we provide safe, compassionate and high quality hospital and community care to the half a million people living in East Sussex or visiting our local area.
We are one of the largest organisations in East Sussex with an annual income of £476 million. Our extensive health services are provided by over 7000 dedicated members of staff working from two acute hospitals in Hastings and Eastbourne, three community hospitals in Bexhill, Rye and Uckfield, over 100 community sites across East Sussex and in people's own homes.

In 2020 the Care Quality Commission (CQC), the health and care regulator, rated us as 'Good' overall, and 'Outstanding' for being caring and effective. Our acute hospital at Hastings and our Community Services are also rated 'Outstanding'. Our acute hospital at Eastbourne is rated 'Good'.

Our two acute hospitals have Emergency Departments and provide care 24 hours a day, offering a comprehensive range of surgical, medical, outpatient and maternity services, supported by a full range of diagnostic and therapy services. At Eastbourne hospital we provide a centre for urology and stroke services, while at Hastings we provide a centre for trauma services and cardiology is provided across both sites.
We have around 800 beds and over 112,000 inpatient spells each year. During 2019/20, we saw 136,000 attendances at our Emergency Departments and there were over 400,000 outpatient attendances.

At Bexhill Hospital and Rye, Winchelsea and District Memorial Hospital we offer a range of outpatients, day surgery, rehabilitation and intermediate care services. At Uckfield Hospital we provide day surgery and outpatient care. We also provide rehabilitation services jointly

with East Sussex County Council Adult Social Care from Firwood House in Eastbourne and Bexhill Health Centre.

In the community we deliver services that focus on people with long term conditions living well outside hospital, through our Integrated Locality Teams working with district and community nursing teams. Community members of staff also provide care to patients in their homes and from a number of clinics, health centres and GP surgeries.
To provide many of these services we work in partnership with East Sussex Council, commissioners and other providers across Sussex, as part of a locally focused and integrated health and social care network.

We aspire to provide locally-based and accessible services that are Outstanding and Always Improving and our values shape our everyday work. Working together we drive improvements to care, services and the experience of local people and members of staff.

Our year in numbers

136,000	times our Emergency Departments were used, an increase of 5% on last year
3,029	children born in our hospitals, including 319 children born at the Eastbourne Midwifery Unit
54,000	people had planned surgery; 89% of these were daycases
22,500	cancer referrals were made to us, an increase of 6% on last year
400,000	outpatient appointments were made; nearly 290,000 of these were consultant- led
288,000	X-ray and scans were carried out
7 million	pathology tests were performed

Our Vision, Values and Ambition – to be Outstanding and Always Improving

Our vision, values, priorities and objectives have been embedded across the organisation and made meaningful in our everyday work. They form the foundations for personal objectives, internal communications, and external communications with partner organisations and other stakeholders.

Our Objectives:

- **Safe patient care is our highest priority:** Delivering high quality services that achieve and demonstrate the best outcomes and provide an excellent experience for patients
- **All members of staff will be valued and respected**: Members of staff will be involved in decisions about the services they provide and offered training and development to fulfil their roles and help them progress
- **Our clinical services will be sustainable**: Working with commissioners, our local authority and other stakeholders we will plan and deliver health and care services that meet the needs of our local population now and in the future
- **We will operate efficiently and effectively:** Diagnosing and treating patients in a timely fashion that supports their return to health
- **We will use our resources efficiently and effectively:** Ensuring our services are financially sustainable for the benefit of our patients and their care

ESHT in numbers

NHS
East Sussex Healthcare
NHS Trust

Our staff tell us

- 9 in 10 "My role makes a difference to patients"
- 8 in 10 "Care of patients is ESHT's top priority"
- 8 in 10 "I am satisfied with the quality of care I give"

What patients say

98% recommend our care

Improving quality

- 84% reduction — Grade 3/4 pressure ulcers
- 18% reduction — Patients falling while in our care
- 20% reduction — Sepsis mortality

Demand and access

Same day care

35% Emergency patients seen on the same day

Finances

£45m deficit 2018/19 ⇩ £10m deficit 2019/20

At year end (19/20) we earned an additional payment to finish on a small surplus

Responsive services

"People could access services when they needed them and received the right care in a timely way."

Next steps

- Emergency Departments and Cancer Services are focussed on achieving key access standards
- Community Services are investing in integrated services
- We are building for our future and planning for the significant investment that has been committed to ESHT over the next decade.
- Creating sustainable, long-term services

2018: CQC ratings

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

2020: CQC ratings

Safe	Effective	Caring	Responsive	Well-led	Overall
Good	Outstanding	Outstanding	Good	Good	Good

CQC rates Trust 'Good' overall with 'Outstanding' areas

Trust Overall: 'Good' (was Requires Improvement)
- Safe: 'Good' (was Requires Improvement)
- Effective: 'Outstanding' (was Requires Improvement)
- Caring: 'Outstanding' (was Good)
- Responsive: 'Good' (was Requires Improvement)
- Well-led: 'Good' (was 'Good')

Community Services:
- Community: adult services 'Outstanding' (was Requires Improvement)
- Community: End of Life Care 'Good' (was Requires Improvement)
- **Overall**: 'Outstanding' (was Requires Improvement) and 'Outstanding' for Effective and Caring

Conquest:
- Children and Young people: 'Good' (was Requires Improvement)
- End of Life Care: 'Outstanding' (was Requires Improvement)
- Outpatients: 'Good' (was Requires Improvement)
- **Overall** 'Outstanding' (was Requires Improvement) and 'Outstanding' for Caring and Well-led

Eastbourne DGH:
- Children and Young people: 'Good' (was 'Requires Improvement')
- End of Life Care: Outstanding (was Requires Improvement)
- **Overall** 'Good' (was Requires Improvement)

'Outstanding' for care

"Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from patients was consistently very positive and that staff went the extra mile."

'Outstanding' for effective care

"Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care."

Outstanding practice recognised in the report

In Community Adult Services there were exceptional pathways through which patients seamlessly transitioned to receive the services they need. Staff worked together cohesively in the best interest of patients.

Following the introduction of advanced care plans for care home residents, the Trust saw a dramatic reduction in hospital admissions. This was an exceptionally effective outcome for patients.

There was a culture centred on the needs of patients at the end of their life with staff committed and passionate about the end of life care they provided.

The outpatients service at Conquest Hospital demonstrated a strong visible patient-centred culture.

The development of the multi-disciplinary diabetic foot clinic showed how medical and nursing staff worked together to improve patient care in response to feedback.

'Outstanding' community

"Those delivering care worked together to benefit patients, whose care and treatment was seamless and uninterrupted. They consistently supported each other to provide good care and communicated effectively with other agencies."

'Outstanding' End of Life Care

"The End of Life Care service truly respected and valued their patients as individuals and empowered them to be partners in their care"

2015: CQC ratings

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

2017: CQC ratings

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	**Requires improvement**

Some of our achievements in 2019/2020

We are proud of our many innovations and improvements including:

Eastbourne Midwifery Unit increases number of births

The increasingly popular Eastbourne Midwifery Unit reported its busiest year to date with a 15.6% increase in the number of births on the previous year. This included a 57.5% increase in first time mothers birthing at the unit. Half of all the births at the Unit were in the relaxing water bath.

Reduction in amputation rates

The introduction of multidisciplinary diabetic foot clinics over a six month period resulted in a 70% reduction in the amputation rate for patients with diabetic complications.
We are now performing lower than the national average for diabetic related amputations, having previously been a significant outlier. The clinics have brought together a dedicated team of specialist vascular and diabetic doctors, specialist nurses and podiatrists all in one place to provide the best possible care for patients with diabetic foot problems. It means patients no longer have to attend for multiple appointments as they are now seen in one clinic by multiple specialists.

Psychological care for Critical Care Patients

The first full-time clinical psychologist working in Critical Care in the South of England was employed at the Trust to provide psychological care for patients in the Critical Care Unit and after their stay as recommended by the government paper published in 2012 'No Health without Mental Health'. This highlighted the need for mental health services to have parity of esteem with physical health services.

New community outreach service

A new community outreach service was implemented to screen for and treat Hepatitis C amongst substance misuse clients in the community. This has had a positive impact, with an increase in the number of people testing for the illness and receiving treatment.
The service is provided jointly with the local drug and alcohol service and was set up following recent medical advances which mean most patients can now be cured of Hepatitis C with oral medication that has no significant side effects.

Prestigious Award for Health Visiting service

The Health Visiting service with the support of East Sussex County Council's Children's Centres, have been awarded the prestigious Baby Friendly Award from UNICEF (United Nations Children's Fund). The award recognises public services that protect, promote and support breastfeeding and strengthen mother-baby and family relationships.

New Urology Investigation Suite

A new £1.3 million Urology Investigation Suite, offering patients a dedicated one-stop urology clinic and an enhanced experience, was opened at Eastbourne District General Hospital. The new development provides a modern, fit for purpose unit that will significantly reduce the time taken to diagnose cancer and other urological conditions. It has ten outpatient clinic rooms fitted with some of the latest diagnostic investigation equipment, £500k of which was donated by the Friends of Eastbourne Hospital. The new unit provides double the capacity of the old one helping to meet the ever increasing demand that currently stands at 7,000 patients a year being treated in the

New MRI Suite at Conquest Hospital
A new MRI (Magnetic Resonance Imaging) Suite was officially opened by Her Royal Highness the Princess Royal. A plaque was unveiled to mark the opening and she met some of those who generously donated and raised money to fund the purchase of two new MRI scanners, including the Friends of Bexhill and Conquest Hospitals, as well as visiting staff in the hospital.

Wayfinding signage at Eastbourne District General Hospital
New wayfinding signage was installed which divides the hospital into five coloured zones and three Levels. The principle is to direct patients to their "service address" via four progressive elements - the entrance (denoted by a letter), the zone (denoted by a colour), the level (denoted by a number) then the department or ward i.e. letter, colour, number, name. Patients' letters inviting them to an appointment test or procedure now includes these four progressive elements.

Patient feedback on cancer care
Care of cancer patients by the Trust was highly praised in a national survey of patients who were diagnosed with the disease. The National Cancer Patient Experience Survey, now in its eighth year, was completed by over 500 local patients. They were asked to rate their care overall on a scale of 1 to 10. Patients in East Sussex rated their care as 8.8 out of 10. Cancer care for Haematology and Lung patients scored particularly well with scores above the national averages.

Trust awarded for commitment to patient safety by the National Joint Registry
The Trust was named a National Joint Registry (NJR) Quality Data Provider after successfully completing a national programme of local data audits, on the performance of hip, knee, ankle, elbow and shoulder joint replacement operations. In order to achieve the award hospitals are required to meet a series of six ambitious targets during the audit period.

High definition MRI heart scans
The new MRI scanner at the Conquest Hospital is able to produce an image of the heart in great detail which previously was not possible with the old MRI scanner. An MRI heart scan is used to monitor heart disease, evaluate the heart's anatomy and function investigating the blood supply to the heart, heart muscle conditions, damage to the heart muscle and heart valve disease.

Opening of Expanded Same Day Emergency Care Unit
A newly expanded £900k Same Day Emergency Care unit at the Conquest Hospital provides emergency care for patients who don't require an overnight stay in hospital. The Unit now has a much larger dedicated area with 8 treatment cubicles and 3 treatment rooms for assessments and procedures offering patients greater privacy and dignity. It also offers patients rapid access to diagnostic tests and review by hospital consultants in one place.

National award for reducing infection rates in joint replacement surgery
A unique collaboration involving the Trust and 29 other organisations to drive forward improvements for patients having hip and knee replacements won a top national award. The programme called QIST (Quality Improvement for Surgical Teams) aims to reduce infection rates from MSSA (Methicillin Sensitive Staphylococcus Aureus) for patients undergoing joint replacement surgery. This initiative was named 'Infection Prevention and Control Initiative of the Year' at the 2019 Health Service Journal Patient Safety Awards; by working as a collaborative it has helped more than 16,000 patients to date across the country to receive an effective patient safety intervention.

Our partnerships and collaboration

The Trust continues to work closely with our local commissioners, Eastbourne, Hailsham and Seaford, Hastings and Rother and High Weald, Lewes Havens CCGs and East Sussex County Council to further develop and deliver integrated health and care services for our local population. Working as an alliance with commissioners, primary care and the local authority we are working towards integration of our health and care services; so we can demonstrate the best use of resources to meet the health and social care needs of the people of East Sussex.

The Sussex and East Surrey Sustainability and Transformation Partnership (STP) enable us to work in a bigger network. This enables us to plan how our patients can access specialist services that we cannot provide locally, such as major trauma services and specialist cancer services.

As part of a national network, there is a local Healthwatch in every local authority area in England. Healthwatch East Sussex works with the public of East Sussex to ensure that health and social care services work for the people who use them. Their focus is on understanding the needs, experiences and concerns of people of all ages who use services and to then speak out on their behalf. Their role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work and decision making. They do this by gathering people's experiences and identifying issues that are important to them and, when addressed, which will make services better for everybody. This year Healthwatch undertook a great deal of activity at ESHT, including teams of volunteers observing our care of patients as part of their listening tour and separately over a 24 hours period. The feedback supports us with the continuing improvement of our processes.

Purpose of the Quality Account and how it was developed

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.

In addition to the mandatory elements of the Quality Account we have engaged with staff, patients and public, our commissioners and other stakeholders to ensure that the account gives an insight into the organisation and reflects the improvement priorities that are important to us all.

Part 2 – Priorities for Improvement and statements of assurance from the Board of Directors

Part 2.1 – Priorities for Improvement in 2020/21

Our Quality Strategy (September 2020) outlines the improvements required to achieve the Trust's ambition to become an outstanding and always improving organisation and describes the main improvement schemes we will be working on to ensure that we are able to deliver our ambition.

Prior to the Covid-19 pandemic, the Trust had identified three priority projects for 2020/21. However, as the pandemic progressed it was acknowledged that two of the projects could not be progressed in 2020/21. Therefore, the Trust identified two new priorities but due to constraints as a result of Covid-19, these could not be consulted upon with the public.

Table 1: Priorities for improvement in 2020/21

Quality Domain	Priorities for improvement 2020/21
Patient Safety **Clinical Effectiveness** **Patient Safety**	1. Embedding Patient Safety
Patient Safety **Clinical Effectiveness**	2. Infection Control Excellence
Patient Safety **Clinical Effectiveness** **Patient Experience**	3. Perfecting Discharge

1. Embedding Patient Safety

Why this has been chosen as priority

The Trust has robust systems in place to report, investigate, identify learning and develop actions to reduce the possibility of the same or similar incidents occurring. However, there remains a challenge to collate evidence that demonstrates, if changes have been made, that they have they led to measureable and sustainable risk reduction.

The aim of this priority is to identify methodology that will measure and support the effectiveness of the actions taken forward and their impact on reducing the risk of further incidents.

What we are going to do

- Review the serious incident investigations root cause analysis (RCA) reports and subsequent actions from the previous 12 months
- Identify overdue actions yet to be implemented and identify what barriers are preventing the actions being completed
- Work with clinical teams to develop methodology that will support them in how to evidence the impact of the actions on reducing the risk of further patient safety incidents
- Apply new methodology to 2 areas of patient safety and assess whether methodology is being applied correctly and consistently, and if it is whether it is providing the necessary data from which the Trust can measure the effectiveness of actions and the impact on risk
- From the 12 month RCA report review and utilising guidance in the new draft Patient Safety Incident Response Framework) identify themes to be investigated further
- Identify changes in practice in response to reducing future risk

What will success look like?

- By reviewing the serious incident RCA reports as a whole collection of information rather than individual incidents, new learning will indicate how actions in the future could be identified to ensure that the risk of further incidents is reduced
- All overdue actions will have been completed with evidence provided
- Methodology for evidencing the effectiveness and impact of actions on improvement (or lack of) in areas of concern for patient safety will have been developed and tested
- Themes for undertaking investigations as part of the new Patient Safety Incident Response Framework will have been identified

How we will monitor progress

- Data on serious incidents, actions and themes and themes is reported to the Quality and Safety Committee bimonthly
- Progress of this priority (particular areas of focus) specifically will be provided to the Quality and Safety Committee bimonthly including presentation on the methodology developed
- Data and information as outputs of this priority will be shared with clinical teams within the appropriate governance and risk meetings.

2. Infection Control Excellence

Why this has been chosen as priority

There has recently been the introduction of a national requirement for Trust to have a Board Assurance Framework for Infection Prevention and Control (BAF-IPC). The purpose of the BAF is to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks. Although the BAF-IPC is not mandatory it is considered to a helpful assurance tool. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can be used to assure trust boards.

The BAF-IPC will be adopted as the key policy for infection prevention and control and implemented in the Trust during 2020/21.

What we are going to do

- Finalise the BAF-IPC template to ensure it is capturing all relevant detail
- Identify key gaps in the BAF-IPC and develop actions plans to address them
- Monitor infection rates and identify and incorporate emerging themes
- Complete serious incident RCA investigation reports into outbreaks and identify learning with appropriate actions

What will success look like?

- The BAF-IPC will be updated and reported on monthly via a number of forums with oversight by the Quality and Safety Committee
- Areas for improvement will have been identified and action plans in place to support improvement
- Learning from outbreak serious incidents will identified on the BAF-IPC and taken forward to ensure high standard of practice is maintained ensuring patient and staff safety
- Trust will be compliant with all national guidance
- The trust will achieve low levels of hospital transmission in relation to national rates.

How we will monitor progress

- The BAF-IPC will be reviewed monthly at the Trust Infection Prevention and Control Group with escalation via the Patient Safety and Quality Group
- There will be oversight on the progress of the priority by the Quality and Safety Committee bimonthly.
- Annual reporting to the Board

3. Perfecting Discharge

Why this has been chosen as priority

Data from the national inpatient survey, our own internal complaints and inpatient questionnaires highlight a number of areas regarding communication and information provided to patients regarding the discharge process as an area where we can make improvements.

Last year as part of the Quality Account Patient Experience Priority 120 patients were surveyed about their experience of involving patients in making decisions about their care, and the information provided to them. The Trust recognises that there are a number of areas in the patient journey where communication could be improved and these surveys identified communication at the point of discharge could be improved.

The changes to the Trust's discharge processes during the Covid-19 pandemic has contributed to an increased focus with short actions being taken and longer term plans being developed. A Multidisciplinary Strategic Discharge Improvement Group has been established to take the plans forward.

A quality improvement approach will be adopted to identify the specific areas to target, test new approaches and ensure improvements are sustained.

What we are going to do

- Provide oversight of themes, trends, lessons learned and areas of best practice that support the divisions to facilitate safe, high quality multidisciplinary and timely planning of discharges and improve the patient experience.
- From data analysis work streams have been identified as areas of focus (communication, process, medication and training and education).
- The strategic group will meet monthly to report back on the work streams progress
- We will gain feedback from those who received the revised process/ communication to identify areas for improvement and develop action plans to implement changes, using a quality improvement approach.
- Seek ongoing feedback from patients/carers/relatives about how well the discharge process is meeting their needs

What will success look like?

- Patients receive high quality (safe, effective, timely, experience) discharge.
- Patients/carers/relatives are comprehensively informed and understand about their care needs and follow-up actions
- Improved satisfaction of patients/relatives/ carers feeling informed during the discharge process.
- Improved the score for each question in section 9 of the National Inpatient Survey by 1 point.
- To obtain the evidence of how the changes made have impacted on patient experience and share this information across the Trust.
- Expected Dates of Discharge are met as planned
- Reduced unplanned admission
- Discharge communication with GP is accurate and complete

How we will monitor progress

- Progress from the discharge workstreams will be reported to the Multidisciplinary Discharge Improvement Group.
- Escalation of issues and barriers will be to the Recovery and Restoration Board
- The Quality and Safety Committee will be provided with a progress report bimonthly.

Part 2.2 – Statements of Assurance from the Board of Directors

Services provided and income

During 2019/20 East Sussex Healthcare NHS Trust provided and/or sub-contracted 76 NHS services.

East Sussex Healthcare NHS Trust has reviewed all the data available to them on the quality of care in all 76 of these NHS services.

The income generated by the NHS services reviewed in 2019/20 represents 100% of the total income generated from the provision of NHS services by East Sussex Healthcare NHS Trust for 2019/20.

Participation in Clinical Audit and National Confidential Enquiries

Clinical audit is used within East Sussex Healthcare NHS Trust to aid improvements in the delivery and quality of patient care, and is viewed as a tool to facilitate continuous improvement. Clinical audit involves the review of clinical performance against agreed standards, and the refining of clinical practice as a result. The importance of this is also described in the ESHT Quality Strategy (2019).

The National Clinical Audit Patient Outcomes Programme (NCAPOP) is a set of national clinical audits, registries and confidential enquiries which measure healthcare practice on specific conditions against accepted standards. These projects give healthcare providers' benchmarked reports on their performance, with the aim of improving the care provided. The Trust is fully committed to supporting and participating in all applicable NCAPOP studies.

East Sussex Healthcare NHS Trust follows a comprehensive and focused annual Clinical Audit Forward Plan which is developed in line with the Trust's strategy and quality agenda. The Forward Plan is formulated through a process of considering both national and local clinical audit priorities for the year ahead.

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust was eligible to participate in during 2019/20 are detailed below.

National Audit and National Confidential Enquiries Programme

During 2019/20, 58 national clinical audits and 5 national confidential enquiries covered relevant health services that East Sussex Healthcare NHS Trust provides.

During that period, East Sussex Healthcare NHS Trust participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Details of the national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust was eligible to participate in during 2019/20 can be found in Appendix 2.

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, *and for which data collection was completed during 2019/20*, are listed in Appendix 3, 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.

The Trust also participated in seven additional (non-mandated) national audits in 2019/20 which can be found in Appendix 4.

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)

NCEPOD issued four reports in 2019/20:

- 'Mental Healthcare in Young People and Young Adults' was published in September 2019.
- 'Pulmonary Embolism: Know the Score' was published in October 2019.
- 'Acute Bowel Obstruction: Delay in Transit' was published in January 2020.
- 'Long Term Ventilation: Balancing the Pressures was published in February 2020.

Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK

The Women and Children's division continues to report:

- All late foetal losses between 22+0-23+6 weeks gestational age showing no signs of life, irrespective of when the death occurred.
- Terminations of pregnancy – resulting in a pregnancy outcome from 22+0 weeks gestation onwards.
  Any late fetal loss, still birth or neonatal death resulting from a termination of pregnancy should be reported, however the requirement is to only complete the initial notification. Completion of the full surveillance is not required and these deaths will not be supported for review using the Perinatal Mortality Review Tool.
- Antepartum Stillbirth – a baby is delivered at or after 24th week showing no signs of life and known to have died before the onset of care in labour.
- Intrapartum Stillbirth – A baby delivered at or after 24th week of pregnancy showing no signs of life and known to have been alive at the onset of care in labour.
  (MBRRACE do not split into Antepartum and Intrapartum - the requirement is 'still births from 24/40 gestation, showing no signs of life' irrespective of when the death occurred).
- Early Neonatal death - 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) who died after 7 completed days.
- Late neonatal Death - 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) who died after 7 completed days but before 28 completed days after birth.
- Surviving siblings in a multiple pregnancy - any live born baby who lives beyond 28 days as part of a multiple pregnancy, resulting in at least 1 late fetal loss, still birth or neonatal death.
  (Notification only, surveillance not required)

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 2019/20 include:

- Amniotic Fluid Embolism (0 cases reported)
- Anti-thrombin in Pregnancy (1 case reported)
- Protein C Deficiency in Pregnancy (3 cases reported)
- Cirrhosis in pregnancy (0 cases reported)
- Diabetic Ketoacidosis (DKA) in Pregnancy (1 case reported)
- Extremely pre-term, pre-labour rupture of membranes (6 cases reported)
- Fontan and Pregnancy (0 cases reported)
- Peripartum Hyponatraemia In Pregnancy (1 case reported)
- Pregnancy Following Bone Marrow Transplant (0 cases reported)
- New Therapies for Influenza (1 case reported)
- Covid-19 in Pregnancy (0 cases reported)

Successes in National Audit

A number of national audit reports published throughout 2019/20 confirm that the Trust is performing above the national average in many clinical areas and is achieving (or exceeding) best practice clinical standards, delivering consistently good clinical outcomes for our patients.

Trauma and Research Network (TARN) National Audit

This year the National Major Trauma Networks Conference was held in London. Opening key speech was delivered by Professor Chris Moran who presented some national TARN data. Representatives from the Sussex Trauma Network were delighted to note that our Network is rated as having the highest level of excess survivors following major trauma. This is a great reflection not only of the clinical care delivered by all involved in patient care across Sussex from “Roadside to Rehabilitation” but also of the fantastic work of our TARN coordinators.

The data is analysed and adjusted to reflect the quality and accuracy of TARN submissions before national comparisons are made. Here at ESHT we have come on leaps and bounds with our TARN data. This was recognised nationally with the TARN Coordinator Kelly Tuppen being awarded TARN coordinator of the year award in 2019.

National Joint Registry

The Trust has been named a National Joint Registry (NJR) Quality Data Provider after successfully completing a national programme of local data audits, on the performance of hip, knee, ankle, elbow and shoulder joint replacement operations.

Mr Guy Selmon – Clinical Lead, Karin Knowles – Trauma Pathway Facilitator/Practice Educator, Ben Goring – Quality and Improvement Coordinator

The NJR collects high quality orthopaedic data in order to provide evidence to support patient safety, standards in quality of care, and overall cost effectiveness in joint replacement surgery. The ‘NJR Quality Data Provider’ certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety and reward those who have met registry targets in this area. In order to achieve the award, hospitals are required to meet a series of six ambitious targets during the audit period 2017/18. One of the targets which hospitals are required to complete is compliance with the NJR’s mandatory national audit aimed at assessing data completeness and quality within the registry.

The NJR Data Quality Audit investigates the accurate number of joint replacement procedures submitted to the registry compared to the number carried out and recorded in the local hospital Patient Administration System. The audit ensures that the NJR is collecting

and reporting upon the most complete, accurate data possible across all hospitals performing joint replacement operations, including Conquest Hospital and Eastbourne DGH. NJR targets also include having a high level of patients consenting for their details to be included in the registry and for demonstrating timely responses to any alerts issued by the NJR in relation to potential patient safety concerns, if necessary.
Mr Guy Selmon, Clinical Lead, Trauma and Orthopaedics Unit said: "Improving patient safety is of the upmost importance and something all staff take very seriously. We fully support the National Joint Registry's work in facilitating improvement in clinical outcomes and governance for the benefit of joint replacement patients and we're delighted to be awarded as an 'NJR Quality Data Provider' for the second consecutive year".
Debra East, Service Manager for Trauma and Orthopaedics said: "We are immensely proud that we have been recognised for the second consecutive year and awarded the National Quality Data Provider 2018/19. This is a combined effort with clinical and administrative teams coming together to ensure that the data we collate is accurate and managed in a timely manner."

National Joint Registry Medical Director, Mr Tim Wilton, said: "Congratulations to colleagues at East Sussex Healthcare NHS Trust. The Quality Data Provider Award demonstrates the high standards being met towards ensuring compliance with the NJR and is often a reflection of strong departmental efforts to achieve such status.
"Registry data now provides an important source of evidence for regulators, such as the Care Quality Commission, to inform their judgements about services, as well as being a fundamental driver to inform improved quality of care for patients."
Mr Matthew Porteous, Chair of the NJR Data Quality Committee, added: "It is clear that for surgeons and patients alike, the necessity for having accurate and complete data is an absolute requirement. The Quality Data Provider Award continues to go from strength to strength and highlights the number of hospitals who are now fully engaged with the NJR's data completeness programme."

Full details about the NJR's Quality Data Provider certificate scheme can be found online at: www.njrcentre.org.uk

National Clinical Audit Reports in 2019/20

The reports of 27 national clinical audits were reviewed by the Trust in 2019/20. The Trust scrutinises each set of results to benchmark the quality of care provided, identify successes for celebration and / or identify any risks for mitigation. Recommendations for local improvement and change are considered and tracked via a central clinical audit action plan.

Five of these completed national clinical audits are detailed below with the associated actions that the Trust intends to take (if required) to improve the quality of healthcare provided.
Full details of all mandated national clinical audits and Trust specific results are available online via: https://www.hqip.org.uk/

National Cardiac Audit Programme

Report ref. and name: National Cardiac Audit Programme (NCAP) 2019 Annual Report

Date of publication: 12th September 2019 (reporting on 2017-18 data)

The National Cardiac Audit Programme 2019 Annual Report covers over 300,000 records across five clinical areas: Heart Attack, Percutaneous Coronary Interventions (PCI), Heart Failure, Adult Surgery *(not applicable for audit at ESHT)* and Congenital Heart Disease *(not applicable for audit at ESHT)*. It highlights quality improvement opportunities under the themes of the need for timely care, the need for specialised care and the need for evidence-based care delivered equitably.

Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)

The Myocardial Ischaemia National Audit Project (MINAP) is a domain within the National Cardiac Audit Programme (NCAP) that contains information about the care provided to patients who are admitted to hospital with an acute coronary syndrome (heart attack).

Key Results

Management of patients admitted to hospital with NSTEMI, with respect to involvement of a cardiologist, admission to a specialist cardiac ward and, for those eligible, the proportion who receive coronary angiography during admission:

Conquest	97.61%	83.73%
EDGH	91.84%	74.83%

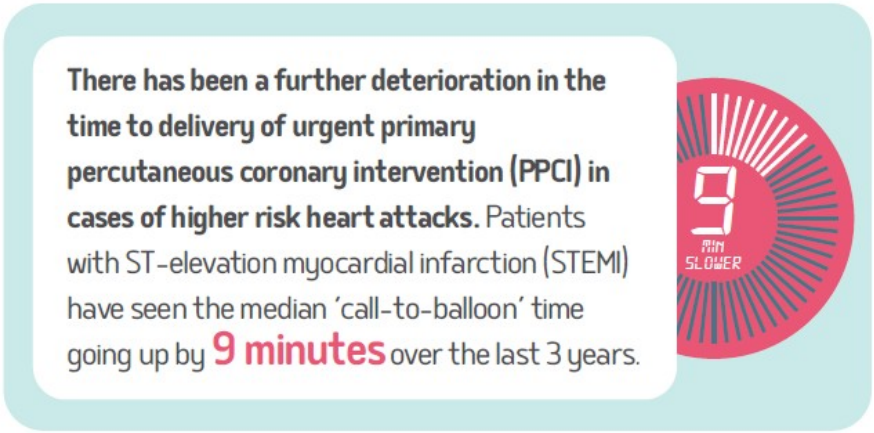
Performance of hospitals with respect to prescription of secondary prevention medication at time of discharge home to patients with either STEMI or nSTEMI. Performance is not reported when there are fewer than 20 eligible patients:

Conquest	100.00%
EDGH	99.15%

Delays to treatment reported by those hospitals providing primary PCI for patients admitted directly ('Direct') and those transferred ('Transfer') from another hospital with STEMI:

	Eligible pts who received pPCI within 90 mins of arrival at Heart Attack Centre (door to balloon)	Median of door to balloon	Eligible pts who received pPCI within 150 mins of calling for help (call to balloon) including those admitted directly or transferred to Heart Attack Centre	Median of call to balloon	Eligible pts who received pPCI within 150 mins of calling for help (call to balloon) with direct admission to Heart Attack Centre
Hospital	**DtB90 (%) National standard**	**DtB Median (minutes)**	**CtB 150 ALL (%)**	**CtB Median (Minutes)**	**CtB 150 Direct (%)**
National Standard	**100%**	**-**	**75%**	**-**	**75%**
National Average	**89.7%**	**41**	**70.7%**	**122**	**70.7%**
Conquest	**76.74%**	**49**	**70.13%**	**127.5**	**73.24%**
EDGH	**82.50%**	**53**	**68.06%**	**127**	**67.61%**

National Overview



National recommendations and local outcomes:

1) Hospitals not achieving the current national or BCIS '*Door to Balloon'* standards should undertake a clinical pathway process review and identify areas where delays can be avoided. Advice should be sought from centres where such work has resulted in the meeting of current standards.
   OUTCOME - Cardiology Transformation underway supported by the 'Getting it Right the First Time (GIRFT) initiative recommendation (2020) to single site services.
2) All hospitals and ambulance trusts should ensure that local service delivery times for Angiograph and PCI for patients with NSTEMI are reviewed and areas of delay are identified.
   OUTCOME - Improved communication with the South East Coast Ambulance Service (SECamb) to involve the service in our local pathway. SECamb attended a recent Cardiology Nurse Practitioner Team day and as a result the Trust now has a SECamb contact to answer any specific reasons for delay.
3) Hospitals not achieving the targets for access to specialist care should undertake a review of staffing structures and clinical protocols and are also advised to learn from other centres that provide the best care.
   OUTCOME - Medical Staffing is on the Trust's Risk Register.
4) All hospitals should ensure that all appropriate heart attack and heart failure patients are referred for cardiac rehabilitation and that such rehabilitation services are appropriately staffed.
   OUTCOME – Staffing levels have now been improved across our Cardiac Rehabilitation Teams to ensure continuation of care for all patients who require input

Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)

The National Audit of Percutaneous Coronary Intervention (PCI) is a continuous audit that collects information about all percutaneous coronary intervention procedures performed in all NHS hospitals and the majority of private hospitals in the UK. The NAPCI assesses the process of PCI care and speed of the PCI delivery as well as the patient outcomes for example complication rates, or mortality.

Key Results

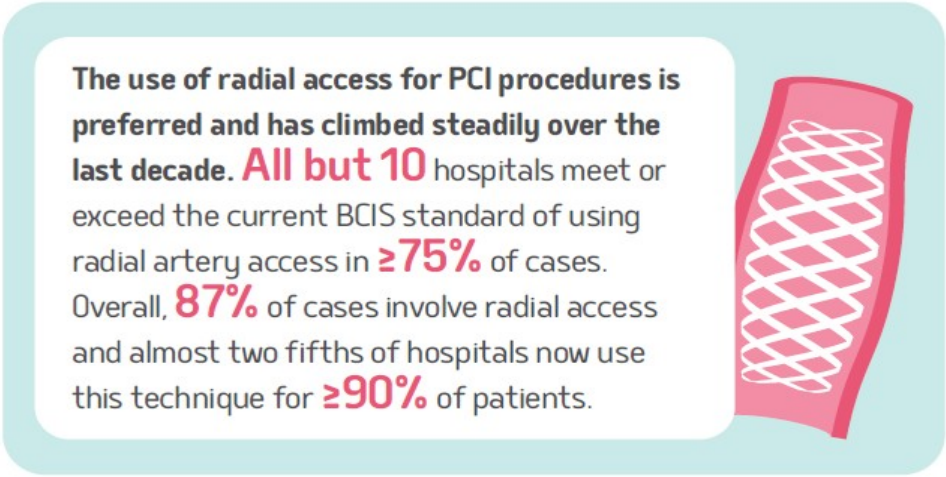
Day Case Procedures, Thrombectomy & Use of Drug Eluting Stents (DES):

Hospital	Elective same day discharge (%)
National goal	75%
Conquest	68.64%
EDGH	72.73%

Door to Balloon (DtB):

Hospital	DtB within 60min (%)
National Standard	75%
National Average	76.8%
Conquest	62.26%
EDGH	50.82%

National Overview



Radial Artery Access:

Hospital	Radial artery access (%)
National standard	75%
National average	87.2%
Conquest	71.28%
EDGH	65.32%

National recommendations and local outcomes:

1) Hospitals not achieving the BCIS target for the use of radial artery access should set this as a quality target, supported by the necessary leadership and training.
   OUTCOME – The Trust's 'femoral only' Operator has recently retired which will improve our compliance with the BCIS Recommended target for radial artery access in future rounds of the audit.
2) Operators with low rates of radial artery access, unless justified by their case mix, should attend educational and training courses or be proctored in the technique.
   OUTCOME – A Senior Operator with excellent clinical outcomes has been identified as the Trust's trainer for Junior Doctors in femoral access moving forward. This individual will hold training/education sessions regarding radial access and proctor the technique at ESHT to facilitate higher rates of compliance against the BCIS target.

Heart Failure

The National Heart Failure Audit (NHFA) deals with a specific and crucial phase in the patient journey. It reports on the characteristics of patients admitted with acute or sub-acute HF, the in-hospital investigation and care, the treatment given and the discharge planning and follow-up which is offered.

Key Results

Hospital name	Received echo %	Cardiology inpatient %	Input from consultant cardiologist %	Input from specialist %
National Standard	90	60	-	85
National Average	87.7	4	56.7	82
Conquest	100	41.1	89.6	100
EDGH	100	66.9	91.9	100

National Overview

Access to specialist care for patients suffering a higher risk heart attack or with heart failure is generally good. 96% of NSTEMI and 82% of heart failure patients are seen by specialist teams. There is much more variability in the case of NSTEMI patients and those with heart failure who are not admitted to cardiac wards.

National recommendations and local outcomes:

1) All hospitals should ensure that all heart attack and heart failure patients have equal access to specialist care, regardless of which type of ward they are admitted to.
2) Hospitals not achieving the targets for access to specialist care should undertake a review of staffing structures and clinical protocols and are also advised to learn from other centres that provide the best care
3) All hospitals should ensure that all appropriate heart attack and heart failure patients are referred for cardiac rehabilitation and that such rehabilitation services are appropriately staffed
4) Hospitals not achieving the 60% target of offering patients with HFrEF (and without established contraindications) should undertake a review of the clinical pathway to identify opportunities to improve performance, including learning from hospitals providing the best care. In particular, the focus of this, should be on increasing the use of MRA's
5) A reasonable goal of 80% of all patients, without contraindications, to be offered all three disease modifying drugs

OUTCOME - Acute Heart Failure guideline encompassing all national recommendations has been written and agreed with Consultant Cardiologist body. Guideline is now in use.

National Audit of Breast Cancer in Older Patients

Report ref. and name: National Audit of Breast Cancer in Older Patients 2019 Annual Report

Date of publication: 12th September 2019 (reporting on January 2014 – December 17 data)

The National Audit of Breast Cancer in Older Patients (NABCOP) aims to evaluate the care provided to, and subsequent outcomes for, women diagnosed with breast cancer aged 70 years or over, comparing this with a younger cohort of women diagnosed between 50 and 69 years to study any age-related treatment variations.

Key Results

Completeness of Data Upload by information type:

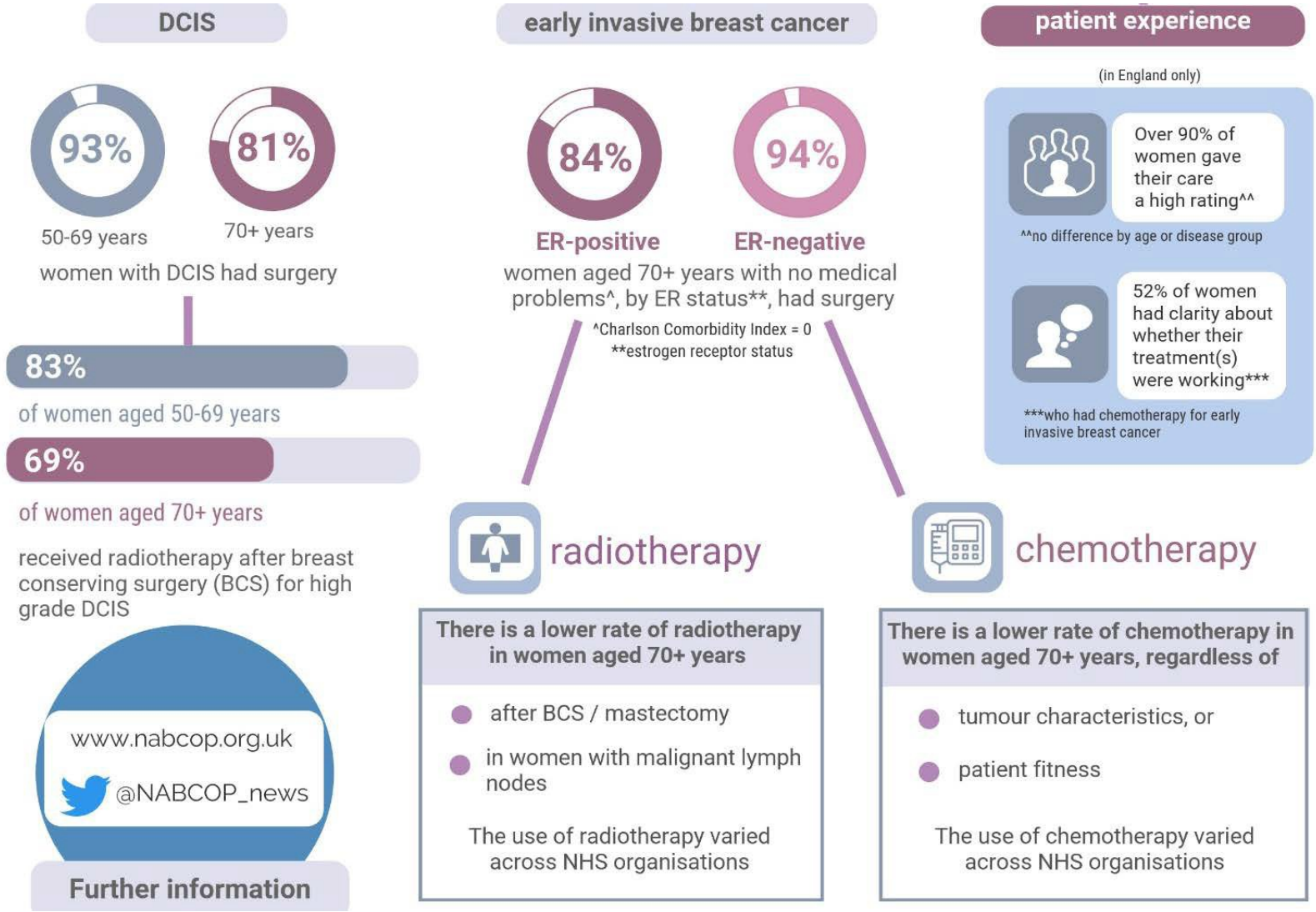
	All pts diagnosed in 2017 ->	Laterality	CNS contact	WHO PS	DCIS tumours in 2017 ->	Non-invasive grade	ER status	Whole tumour size	HER2 status
50-69 yrs	75	100%	80%	69%	4	100%	75%	0%	0%
70+ yrs	106	99%	66%	58%	3	100%	67%	0%	0%

	Invasive tumours in 2017 ->	Invasive grade	Tumour stage	Nodal stage	Metastases stage	Stage	ER status	HER2 status	Whole tumour size	PR status
50-69 yrs	71	99%	94%	94%	100%	100%	96%	96%	63%	45%
70+ yrs	103	100%	90%	82%	84%	84%	84%	84%	46%	25%

Trust Summary:

	East Sussex Healthcare NHS Trust		All NABCOP NHS Organisations	
Triple diagnostic assessment in a single visit	50-69 years	70+ years	All 50-69	All 70+
*TDA Yes (Strict criteria)**	7%	16%	66%	67%
*TDA Yes (Relaxed criteria)**	86%	81%	81%	82%
Women seen by a breast CNS/named key worker [only women with data on CNS contact]				
CNS contact reported as "Yes"	98%	97%	96%	94%
Surgical treatment for DCIS				
Total having surgery (observed)	93%	Unknown	93%	81%
Total having surgery (adjusted)	94%	Unknown	93%	81%
Surgical treatment for early invasive breast cancer				
Total having surgery (observed)	70%	88%	73%	90%
Total having surgery (adjusted)	70%	90%	73%	90%
Women who receive RT to the breast/post-mastectomy [only women with invasive EBC who had surgery]				
RT after BCS	92%	61%	91%	84%
RT after mastectomy	81%	65%	67%	60%
Women who receive chemotherapy plus trastuzumab [only women with HER2-positive invasive EBC who had surgery]				
Total having chemotherapy + trastuzumab (observed)	86%	36%	69%	36%
Total having chemotherapy + trastuzumab (adjusted)	81%	39%	69%	36%
Women who receive chemotherapy [only women with newly-diagnosed metastatic breast cancer]				
Total having chemotherapy (observed)	78%	10%	59%	24%
Total having chemotherapy (adjusted)	71%	14%	59%	24%

National Overview



Local Action Plan:

Local Recommendation	SMART Action Point	Deadline	Comments / action status
The total number of patients diagnosed for both sites in 2017 was 181. It is felt that this may be too low. Numbers to be checked.	Specialty to review the total number of patients diagnosed in 2017.	August 2019	**Complete** – ESHT data confirms the following: 2016: 323 Cancer patients were treated cross-site 2017: 370 (Conq-170 / EDGH-200) 2018: 449 (Conq-205 / EDGH-244) Data is not always fully uploaded to the NABCOP portal in time for the national data extraction, the Trust have no control over this (this process is managed by NABCOP)
Review the recording of ER Status, NABCOP have reported a lower than expected Trust result.	The audit lead will investigate the data discrepancies.	August 2019	**Complete** - A local audit was undertaken which confirms that both main hospital sites evidenced a 100% recording of ER status for patients.
NABCOP recommend that each organisation should identify a clinician who is responsible for reviewing and checking data returns.	Audit lead to identify a clinician to review and check data returns.	August 2019	**Complete** – The Audit Lead will take on this role as required.
NABCOP recommends that there is consistent assessment and recording of comorbidity and frailty	The Conquest site took part in the trial of frailty assessment forms from NABCOP.	August 2019	**Complete** – Rolled out cross site.

National Non Invasive Ventilation Audit

British Thoracic Society

Report ref. and name: National Non Invasive Ventilation 2019 Annual Report

Date of publication: 4th September 2019 (reporting on February 2019 – March 2019 data)

The aim of the BTS audit programme is to drive improvements in the quality of care and services for patients with respiratory conditions across the UK. The BTS Non-Invasive Ventilation Audit seeks to identify where improvements could be made in this area to align practice to BTS Quality Standards and other guidance.

Audit Participation	Institutions	Submissions
Conquest Hospital	1	13
Other Institutions	156	3 466
Total	**157**	**3 479**

The median (IQR) number of submissions per institution was 20 (13-29).

Resultis Summary		Conquesti Hospitial	National resultis
Patient Characteristics and Diagnosis		n = 13	n = 3479
Gender	Male	46%	44%
	Female	54%	56%
Age	Median (IQR)	72 (63-77)	72 (64-80)
Diagnosis	COPD	54%	67%
	Obesity/Hypoventilation	8%	8%
	Chest wall/Neuromuscular	0%	3%
	Cardiogenic pulmonary oedema	23%	7%
	Other	15%	13%
	No data / Not recorded	0%	1%
First pre-NIV CO2	Median kPa (IQR)	8.8 (7.1-10.5)	9.2 (7.5-11.1)
Last pre-NIV CO2	Median kPa (IQR)	8.8 (7.0-11.7)	9.3 (7.8-11.1)
Respiratory rate pre-NIV	Median (IQR)	29 (20-32)	24 (20-30)
Initial Management			
NIV within 60 minutes of last pre-NIV blood gas	Yes	63%	50%
Respiratory rate at 2 hours NIV	Median (IQR)	22 (20-26)	21 (18-25)
Outcomes			
What plan was made	Discharged from hospital off NIV	61.54%	56.37%
	Transferred to home ventilation centre or discharged with home NIV by treating centre	15.38%	14.66%
	Death (respiratory cause)	15.38%	22.02%
	Death (non-respiratory cause)	.00%	4.17%
	No data / Not recorded	.00%	.20%
	Other	7.69%	2.59%

Audit Participation	Institutions	Submission
Eastbourne District General Hospital	1	1
Other Institutions	156	3 46
Total	**157**	**3 47**

The median (IQR) number of submissions per institution was 20 (13-29).

Resultis Summary		Eastibourne Districti General Hospital	National resultis
Patient Characteristics and Diagnosis		n = 13	n = 3479
Gender	Male	31%	44%
	Female	69%	56%
Age	Median (IQR)	72 (63-74)	72 (64-80)
Diagnosis	COPD	85%	67%
	Obesity/Hypoventilation	8%	8%
	Chest wall/Neuromuscular	0%	3%
	Cardiogenic pulmonary oedema	0%	7%
	Other	8%	13%
	No data / Not recorded	0%	1%
First pre-NIV CO2	Median kPa (IQR)	8.8 (7.0-11.0)	9.2 (7.5-11.1)
Last pre-NIV CO2	Median kPa (IQR)	9.2 (7.9-11.8)	9.3 (7.8-11.1)
Respiratory rate pre-NIV	Median (IQR)	24 (20-28)	24 (20-30)
Initial Management			
NIV within 60 minutes of last pre-NIV blood gas	Yes	67%	50%
Respiratory rate at 2 hours NIV	Median (IQR)	22 (18-24)	21 (18-25)
Outcomes			
What plan was made	Discharged from hospital off NIV	69.23%	56.37%
	Transferred to home ventilation centre or discharged with home NIV by treating centre	7.69%	14.66%
	Death (respiratory cause)	15.38%	22.02%
	Death (non-respiratory cause)	7.69%	4.17%
	No data / Not recorded	.00%	.20%
	Other	.00%	2.59%

National Overview

1. Compared to the last audit, an increased proportion of patients treated with acute non-invasive ventilation (NIV) had COPD, the indication with the strongest evidence. We saw a decreased proportion of patients who were treated with NIV despite no clearly documented indication. This suggests improved patient selection in line with the evidence base for NIV.
2. 50% of patients treated with NIV started NIV treatment within 60 minutes of the blood gas that defined the need for NIV. Clinician responses indicate a reduced perception of treatment delay in comparison to prior audits.
3. Acute NIV was successful in resolving respiratory acidaemia for 76% of patients treated, in comparison to 69% in the last audit (2013).
4. Inpatient mortality was 26%. It has reduced from 34% in 2013 and represents the first time that mortality has improved since the first BTS audit in 2010.
5. Only 74% of organisations reported that they have sufficient capacity to deliver the routine acute NIV service.
6. Only 52% of organisations had a nursing lead and 34% had a physiotherapy lead for their acute NIV service.

Local Action Plan

Local Recommendation	SMART Action Point	Deadline	Comments / action status
To start NIV in A&E to avoid delay to patient care	• Agreement with Outreach team to start NIV in A/E • Training for A/E Resus medical staff • Two NIV ventilators and a selection of facemasks on a dedicated NIV trolley	January 2020	In view of Covid, NIV will be started on Baird W We have a dedicated Side room with negative p which is kept reserved for potential patients. A Business plan has been completed for a Che Physiotherapist to assist with the NIV set up as all Chest Physiotherapy on Baird ward.
To ensure appropriate numbers of nursing staff on Baird ward Conquest Site at all times to facilitate transfer to a Respiratory ward from A/E	Meeting with Chief Executive and subsequent Business case to ensure that: 1. The levels and number of nursing staff are appropriate for NIV according to BTS criteria (1 nurse to 2 patients) 2. Four NIV ventilators and selection of face masks are available on the Conquest Site Respiratory Ward at all times	January 2020	Progress delayed due to Covid Pandemic.
To provide a home NIV clinic at the Eastbourne Site to enable patients to continue NIV after discharge and prevent hospital readmission	Complete and submit a Business case for additional Home ventilators and face masks Start Home NIV clinic Eastbourne site linked to Conquest Home NIV service	February 2020	**COMPLETE** – in place.

Local Clinical Audit Reports in 2019/20

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.

The reports of 70 local clinical audits were reviewed by the Trust in 2019/20. The Trust scrutinises each set of results to benchmark the quality of care provided, identify successes for celebration and / or identify any risks for mitigation. Recommendations for local improvement and change are considered and tracked via a central clinical audit action plan.
Three of these locally completed clinical audits are detailed below with the associated actions that the Trust intends to take (if required) to improve the quality of healthcare provided.

Emergency Department: Silver Trauma - An audit of the Management of Major Trauma in Older People in a Trauma Unit Emergency Department (4556)

**** JOINT WINNER OF THE 2019/20 ESHT CLINICAL AUDIT AWARDS****

Background - Trauma is a common cause of morbidity and mortality for all age groups. The TARN (Trauma Audit and Research Network) report from 2017 suggests that older patients are often prone to suffering severe traumatic injuries from low energy mechanisms (for example, falling from standing). Globally, the proportion of elderly people is increasing; moreover Sussex has a greater number of over 65 year olds than in other parts of the country.

With the development of the major trauma centres in the UK, many resources in managing the traumatically injured patients have shifted away from other hospital settings, whilst at the same time, such emergency departments are managing more of these patients.

National data suggests older patients with traumatic injuries are less likely to be manged by trauma teams, wait longer for imaging, are seen by more junior staff members and are less likely to be transferred to specific trauma centres. We would like to see if this is the case at the Conquest Hospital, and if so how can we improve the care we provide?

Aims and objectives - We will analyse data from patients presenting to the Conquest Hospital with severe, traumatic injuries (using the ISS score system) to determine if older patients (those over 65) are treated any differently by the emergency department than younger patients with similar injuries. Additionally in doing so we will assess our compliance to best practice national guidance.

Standards measured against

Source of clinical Standard	Name of guideline	Date of guideline	Clinical Standard	Exceptions
NICE	Head injury: assessment and early management (CG176)	Updated September 2019	100% of adults who have sustained a head injury and have one of the noted risk factors **have a CT head scan performed within 1 hour** of the risk factor being identified	**None**
NICE	Senior doctors managing trauma; Major trauma: service delivery NICE guideline (NG40)	February 2016	100% of patients are pre-alerted by paramedics to Emergency Department staff	**None**
TARN	Major Trauma In Older People	2017	100% of patients, who have sustained a head injury, should receive senior clinician input, regardless of their age.	**None**

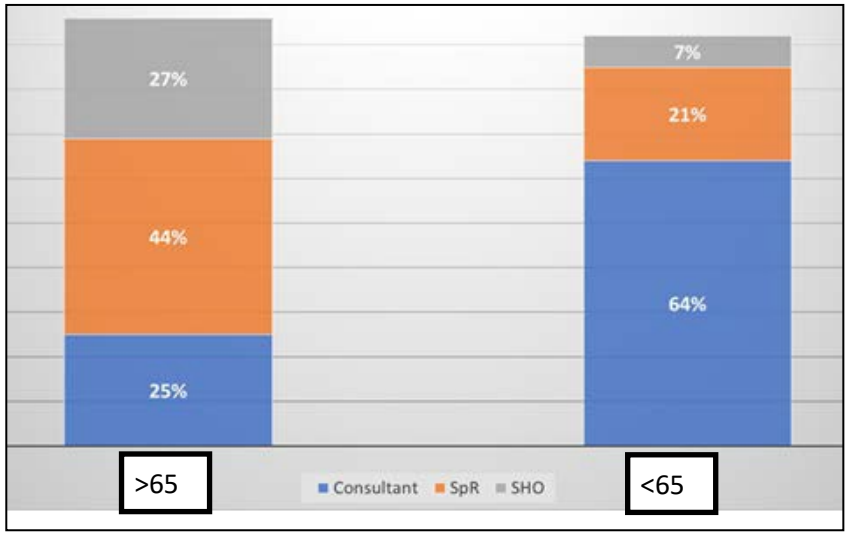
Key Results

- Patients over the age of 65 with these injuries are far more likely to be treated by a junior doctor without any senior input than younger patients. National guidance states that **all** such patients should have senior input.

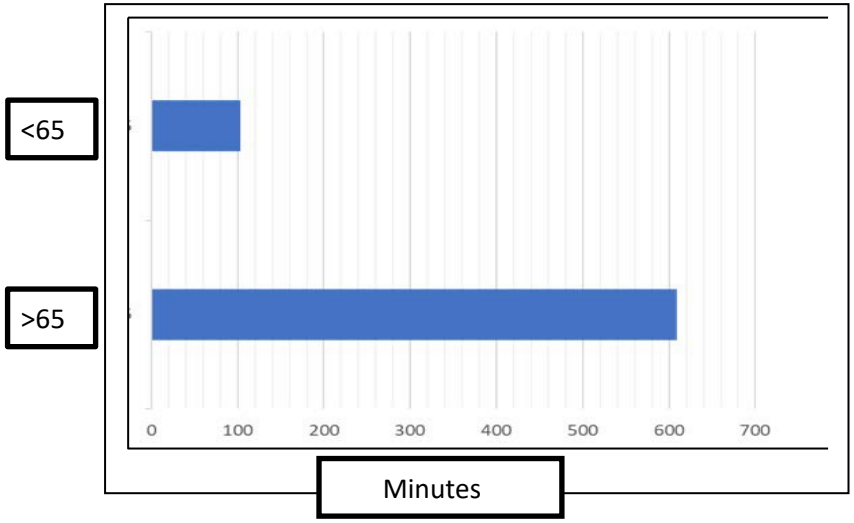
- Patients over the age of 65 waited much longer (an average of 609 minutes) for a CT scan in comparison to 103 minutes (average) for those under 65. National guidelines recommend that a CT scan is performed **within 1 hour.**

- Mortality was 0% for patients below age of 65 and 6% for patients above age 65 at 30 days.

Seniority of Doctors Managing the patient



Average Time to CT (minutes)



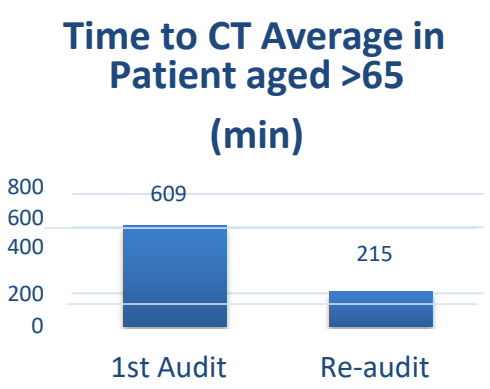
Lessons Learnt

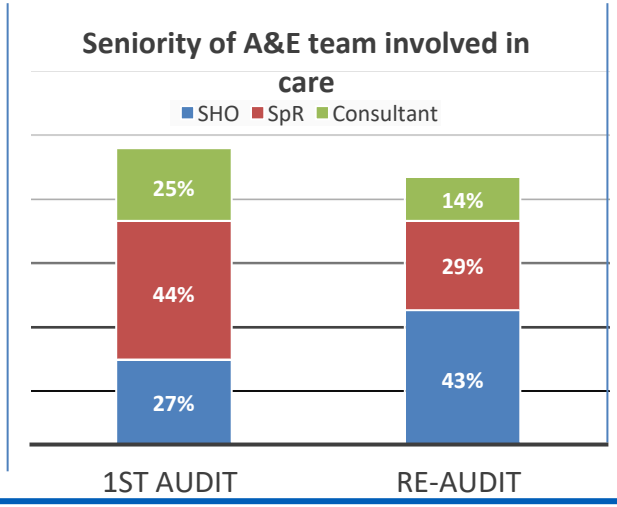
- The results of this local audit match the patterns seen in other traumatic injury management studies across the country.
- Awareness that elderly patients frequently suffer serious traumatic injuries from low energy transfer mechanisms (predominantly falling from a standing position).
- In younger patients, significant traumatic injuries more commonly affect males; however in patients over the age of 65 traumatic injuries affect both genders equally.
- A multi-disciplinary team approach is needed to improve the care we provide following a traumatic injury; we must engage the junior doctors, senior doctors, nurses, healthcare assistants, receptionists, paramedics and radiographers.
- Senior Emergency Department doctors must assess all patients who fall from a standing position and expedite CT scans as and when they are deemed clinically appropriate, in order to ensure compliance with best practice national guidance.

Actions following the audit

Local Recommendation	SMART Action Point	Deadline	Comments / action status
Teaching session to all ED SHOs about management of trauma in elderly patients	Session will be added to SHO teaching programme	31/03/19	**Complete** - well received.
Discussion with nursing staff during handovers about identification and escalation of elderly trauma	Discussion with nursing staff during handovers about identification and escalation of elderly trauma	31/03/19	**Complete** - Discussed with nursing staff over multiple handover sessions.
Posters to be displayed in ED, 'Conquest Silver Trauma Triage Tool' with an aim to identify patient with possible traumatic injury, for them to be seen rapidly by senior ED doctor or trauma team and if needed for imaging to be organised promptly.	Posters to be displayed in ED, 'Conquest Silver Trauma Triage Tool' with an aim to identify patient with possible traumatic injury, for them to be seen rapidly by senior ED doctor or trauma team and if needed for imaging to be organised promptly.	31/03/19	**Complete** - Multiple posters have been printed and displayed around the ED.
Audit to be presented in A&E local audit meeting	Audit to be presented in A&E local audit meeting	31/03/19	**Complete** - Presented at Conquest ED Meeting.
Re-audit 3 months following intervention	Re-audit 3 months following intervention	01/05/19	**Complete –** Re-audit undertake.

Re-Audit Results





Conclusions

Intervention has led to **significant improvements** in 'Time to CT' for patients over the age of 65, though the Trust is not yet meeting the gold standard of one hour. The re-audit also surprisingly evidenced reduced senior involvement, with poorer results shown that in the original audit, highlighting the need for continuing education on these best practice standards.

Breast Surgery: ARTISS: Day-case Drain-less Mastectomy (4459)

** JOINT WINNER OF THE 2019/20 ESHT CLINICAL AUDIT AWARDS**

Background – The Length of Stay (LOS) in Breast Surgery was last audited in our unit in 2011. This audit found the average LOS to be 5 days, when the new national standard was 23 hours. By 2018, the LOS locally had improved to 23 hours, but the national standard had now become Day-case. The reasons for delayed discharge in patients with drains include increased burden on community nurses, patient choice and social issues relating to this area's elderly population. The use of suction drains in breast surgery is decreasing; complications associated with drains include surgical site infection, drain failure and post-operative pain. Alternative to drains include "quilting" of skin flaps and adhesive tissue glues. Our unit decided to trial the use of ARTISS – a fibrin sealant spray that negates the use of suction drains, thereby enabling a faster recovery and shorter LOS, and is designed to reduce the formation of post-operative seroma.

The implementation of this new technique is to facilitate a reduction in length of stay for mastectomy patients and to demonstrate that drain-free mastectomies are possible using ARTISS.

Aims and objectives -

1. To reduce the Length of Stay (LOS) in Mastectomy patients in accordance with national guidelines.
2. To prospectively audit the Length of stay and post-operative complications associated with ARTISS: including wound infection, rate of seroma formation and rate of haematoma requiring return to theatre.

Standards measured against

Source of clinical Standard	Name of guideline	Date of guideline	Clinical Standard	Exceptions
Getting it Right First Time (GIRFT)	GIRFT Review	2018	100% of mastectomies should be performed as a Day-case, as clinically viable.	**As clinically viable.**

Key Results - We achieved a Day-case rate of **41%** (14/34 cases) of which six patients developed seromas requiring aspiration & one was re-admitted 7 days later with a haematoma requiring evacuation.

Of the 20 delayed discharges, 13 were due to patient choice (of which 8 had an axillary drain after ALND), two due to post-operative nausea/vomiting, one due to a blue dye reaction, and 4 due to a bilateral mastectomy procedure being performed.

Lessons Learnt - Reducing the length of stay for patients is possible when new techniques and innovations are found to enhance patient recovery and experience.

Actions following the audit

Local Recommendation	SMART Action Point	Deadline	Comments / action status
Share the results of this audit with colleagues at EDGH with a view to reducing the LOS across both sites	Share the audit report across the division. Present at the Breast Audit Meeting in July 2019	June 19 July 19	**COMPLETE** - Audit report and results shared with EDGH colleagues at AGM 6th June.
Discuss future use of ARTISS spray on both sites – some clinicians may prefer other methods to reduce LOS	Discuss at audit meeting in July 2019 if not before	July 19	**COMPLETE** - Discussed at the Breast – Cross Site AGM 6th June: All clinicians will now trial ARTISS.
Continue to use ARTISS spray at Conquest and conduct a further audit to see if LOS has reduced further	Current practice to continue Plan date for future audit	Ongoing Jun 19	**COMPLETE** – Current practice is continuing, Re-Audit completed and reported upon.
Discuss omitting the drain following axillary lymph node clearance procedures	Discuss at audit meeting in July 2019 if not before	July 19	**COMPLETE** - Discussed at the Breast – Cross Site AGM 6th June: All clinicians will now trial ARTISS.

Respiratory: Oxygen Prescription and Delivery on Baird Ward (4444)

Background – This audit was initiated during the preparation for our ward to deliver an NIV service and in response to the poor results from previous oxygen prescription and delivery audits both locally and nationally, and additionally to evaluate the effectiveness of series of educational events and a change in the communication between the night nursing team and the medical team's morning hand over meeting.

The 2015 BTS oxygen audit identified the following concerns in the National audit results:
1. 42.5% of patients receiving supplemental oxygen had no valid prescription, despite 70% of hospitals having a policy of setting a target saturation range for all patients at the time of admission to hospital.

2. Only 69% of patients with a prescribed target range had a saturation within the intended range. 9.5% of patients were below the target range and 21.5% were above the target range.

3. 8.8% of patents using oxygen were found to be at risk of iatrogenic hypercapnia due to being above their target range by more than 2% despite recognised hypercapnic risk (prescribed target range of 88-92% or less).

4. Oxygen saturation was reliably documented during observation rounds (104% of expected frequency) but oxygen was signed for on only 28% of drug rounds.

The Paper "Oxygen Therapy for acutely ill medical patients: a clinical practice guideline", published in the BMJ in October 2018 discussed the current problem of over prescription and delivery of oxygen to patients and the risk of the harm that this can cause to patients who are sensitive to the effects of oxygen (Respiratory failure due to COPD, Obesity hypoventilation and chest wall deformity).

Aims and objectives - The objective was to create a safer clinical environment in which to care for patients with respiratory failure and to start a non-invasive ventilation support service. With the addition of better patient education, this would enable Baird ward to achieve the National BTS guideline targets for oxygen prescription.

Key Results - Our initial audit showed that only 11 out of 28 patients (39%) had an oxygen prescription and that of the patients receiving oxygen 4 out of 9 patients (44%) were receiving too much oxygen, increasing their risk of prolonged hospital stay and risk of respiratory failure requiring unnecessary admission to intensive care.
In January 2018 I introduced the oxygen prescription check to our morning handover meeting; this increased the percentage of patients with an appropriate target oxygen prescription from 39% to 86%. This measure also increased the accuracy of the oxygen delivery to meet the oxygen target range. The number of patients who were receiving oxygen and who were within the oxygen target range increased from 5 out of 9 (55%) to 4 out of 5 and then 4 out of 6 (66%).

The oxygen report card was altered in April to encourage the night staff to consider altering their oxygen delivery to meet the target oxygen prescription range before the morning handover meeting. This measure increased the correct oxygen delivery to 100% and 80% on two subsequent audits. The final audits confirmed a sustained improvement in target oxygen prescription to 100%.

Source of clinical Standard	Name of guideline	Clinical Standard	Audit Results
BTS Oxygen prescription	Oxygen Prescription National Improvement Guideline	90% of patients using oxygen to have oxygen signed for at the most recent drug round	**May 2019 100% compliance**
BTS Oxygen prescription	Oxygen Prescription National Improvement Guideline	95% of patients using oxygen to have a valid prescription with target prescription saturation range	**May 2019 100% compliance**
BTS Oxygen prescription	Oxygen Prescription National Improvement Guideline	100% of nursing staff and medical staff to be trained in the safer use of oxygen according to the local Trust /Health board oxygen policy	**May 2019 100% compliance**

Lessons Learnt - This audit has illustrated the many factors which need to be taken into consideration when attempting to improve oxygen prescription and the delivery of oxygen to patients on a respiratory ward. The lessons learnt include:

1. The importance of commitment by the consultant team leading the daily ward to encourage and teach the more junior members of staff.

2. The doctors in training recognising the importance of the change in practice and acting on the overnight oxygen report during the daily ward rounds.

3. The importance of having a system by which the night nursing staff can be accountable for the oxygen that they are delivering and to have a communication tool which can be used to communicate this information to the day team.

4. Finally the audit showed the importance of engaging with our patients and their relatives to ensure a sustained improvement in practice both in hospital and in the community.

Actions following the audit

Local Recommendation	SMART Action Point	Deadline	Comments / action status
Deliver educational events for all nursing staff and doctors in training	Monthly dedicated Educational sessions on the importance of oxygen prescription and delivery	Aug 19	**COMPLETE** - Approved by the Education office with consultant job plan time and space in the education department allocated for the training.
The Baird team of night staff to continue to complete the oxygen delivery report card for the morning handover meeting and the medical staff to act on the results by prescribing oxygen and giving advice for alteration of the flow rates to ensure that each patient is reaching their target. The Trust board and head of nursing to consider introducing this communication aid to other wards	The Trust to consider asking the night teams on Baird ward to continue to complete the oxygen report cards and to consider introducing its use on other wards such as EAU and care of the elderly	Aug 19	**COMPLETE** – This is now established practice on Baird Ward.
The patient information cards to be available to all patients within the Trust.	This information card has been created by the BTS. The communication team and Board approve and encourage its use within the Trust Provide laminated cards for each patient	Sept 20	**PARTIALLY COMPLETE** – a card is in place but needs to be updated.
The Baird team of doctors and nurses to receive a certificate from the Trust to confirm their involvement with this successful audit and encouragement from the Trust to continue the good work that has been demonstrated. Please consider our team for the Trust Audit awards.	The audit team to create a certificate for all member of the Baird team of nurses and doctors in training as well as the consultants working on the ward.	Aug 19	**COMPLETE** – distributed.

Participation in Clinical Research

National studies have shown that patients cared for in research active NHS Trusts have better clinical outcomes. Participation in clinical research demonstrates our commitment to improving the quality of care that we offer and to making a contribution to wider health improvement.

The Health Research Authority (HRA) defines research as 'The attempt to derive generalisable or transferable new knowledge to answer questions with scientifically sound methods'.

The number of patients receiving relevant health services provided or sub-contracted by East Sussex Healthcare NHS Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1460 participants. This is an increase from the previous year where 956 patients were recruited to participate in research studies in 2018/19.

At the beginning of this year, the Trust pledged to recruit 476 patients into trials, which was based on there being reduced capacity within the clinical research team to support this activity. The team have exceeded expectations by working collaboratively with speciality teams across the Trust, and assisting new teams to develop research activity.
We have also developed and maintained a mixed portfolio of high recruiting observational studies, as well as those that recruit smaller numbers but are highly interventional.

The clinical research team work closely with specialist teams, supporting Principal Investigators, Clinical Nurse Specialists and Allied Health Professionals in a number of specialities. The Trust is currently conducting over sixty clinical research studies and supporting research activity within several clinical fields including: oncology, cardiovascular, gastroenterology, infectious diseases including sexual health, mental health, children, orthopaedic surgery, musculoskeletal (MSK) including physiotherapy and rheumatology, surgery, renal disorders, injuries and emergencies, health services research, neurological, and anaesthesia.

At the time of writing, in Q4, Trusts have been instructed by NIHR to cease opening all new studies other than those involving COVID-19 research. Many studies have informed the Clinical Research Team that recruitment to their current studies must cease.
We are therefore working to open and recruit to various COVID-19 studies only, both interventional and observational.

We are maintaining a remote follow up activity by telephone, for current oncology and cardiovascular studies.
When COVID-19 study requirements subside, we plan to open studies in critical care, emergency medicine and respiratory medicine and aim to increase diabetes research activity.

We will also continue to participate in a Health Service Research programme – Quality Improvement in Surgical Teams (QIST) which is now in its second phase regarding Hb Optimisation. This is a whole system change in enabling pre op patients to receive iron infusion prior to surgery.

Achievements 2019/20

- NIHR Value for Money metrics have improved over 2019/2020. This is the extent to which CRN funding offers value for money. It is a per patient metric that has fallen

over succeeding years, meaning that the Clinical Research team offer better value for money and is currently a competitive rate of £67.35 per patient. This has fallen from a previous VFM of £137 in 18/19. (National VFM = £82)

- The core team have redesigned the Clinical Research contribution to the Trust extranet. This aims to be more user-friendly and have more interesting information about the studies being undertaken within ESHT.
- The research team are taking part in social media, sharing content with ESHT twitter feed. This aims to ensure that patients and staff are more aware of the studies being supported across ESHT.
- The core team have located spaces around the Trust to advertise research study opportunities, as well as sign up to Dementia Research, and Patient Research Ambassador roles.

Commissioning for Quality and Innovation (CQUIN)

A proportion of the East Sussex Healthcare NHS Trust's income in 2019/20 was conditional on achieving quality improvement goals agreed by the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

East Sussex Healthcare NHS Trust, like 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 1.25% of the Trust standard contract value and 1.25% for Specialised Services commissioned through NHS England. If milestones and goals are not fully achieved, a proportion of CQUIN monies may be withheld.

During 2019/20 East Sussex Healthcare NHS Trust undertook five national schemes, three specialised service schemes and four public health schemes agreed with NHS England.

Exceptional circumstances in Q4 meant that CQUINs were suspended to pour resource into managing Coronavirus 19. Therefore national agreement was reached for CQUIN payment The table below demonstrate benchmarking against the delivery standard.

Table 2: CQUIN priorities 2019/20

	Scheme	Outcome
National	**CCG1a** Adherence to national antibiotic guidance: Lower UTI in older people	Partially Achieved
	CCG1b Antibiotic prophylaxis in elective colorectal surgery	Achieved
	CCG2 Staff Flu Vaccinations	Achieved
	CCG3 Alcohol & Tobacco, Screening & offering Advice	Achieved
	CCG7 Three high impact actions to prevent Hospital	Achieved
	CCG11a Same Day Emergency Care; Pulmonary Embolus	Achieved

	CCG11b Same Day Emergency Care; Tachycardia with AF	Achieved
	CCG11c Same Day Emergency Care; Community Acquired Pneumonia	Achieved
Specialised Services (NHSE)	PSS1 Medicines Optimisation	Achieved
Public Health (NHSE)	Diabetic Eye Screening Programme	Achieved
	CHIS- Child Health Information Service	Achieved
	Secondary Care Dental: Referral Management and Triage	Partially Achieved*
	RTT Reporting	Achieved*
	Secondary Care Dental: Participation in Dental MCN	Achieved*
	SMSKPE – Improving access times for patients referred into ESHT from SMSKPE with simple mechanical low back pain	Achieved
	SMSKPE – Improving service design for OA Hip and OA Knees	Achieved

* Awaiting confirmation of outcome from commissioners

Further details of the agreed goals for the following 12 month reporting period are available electronically at: https://www.esht.nhs.uk/wp-content/uploads/2019/05/Commissioning-for-Quality-and-Innovation-CQUIN.pdf

Statements from the Care Quality Commission

East Sussex Healthcare NHS Trust is registered with the Care Quality Commission (CQC) to carry out eight legally regulated activities from 16 registered locations with no conditions attached to the registration. The Trust has not participated in any special reviews or investigations by the CQC in the reporting period.

In November and December 2019 the CQC carried out inspections of some services at the Conquest Hospital, Eastbourne District General Hospital, and some Community Adult Services. A full report was published in February 2020 and can be viewed at https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ7767.pdf

Children's and Young Peoples services and End of Life Care at both the Conquest Hospital and Eastbourne District General Hospital were inspected along with the Outpatients' departments at the Conquest Hospital. In the Community, services for adults and End of Life Care were also inspected and in addition a Trust wide Well-led inspection and Use of Resources was also undertaken.

The overall rating for the Trust was **GOOD**.

Adult Community Services and End of Life Care were rated **OUTSTANDING** overall.
The Conquest Hospital was rated as **OUTSTANDING.**

Eastbourne District General Hospital was rated **GOOD** overall, with End of Life Care services being rated as **OUTSTANDING.**

The Use of Resources Inspection which was undertaken by NHS Improvement was rated as Requires Improvement. The review noted that the Trust had exited special measures for finance in 2019 and highlighted the Trust's good productivity in several areas. However, the information available at the time of the assessment showed that despite improvements, the trust's costs remained higher than the national median and there were still opportunities to improve the use of resources.

The CQC found no breaches that justified regulatory action, no requirement notices were issued and no enforcement actions taken.

A number of 'should do' actions were recommended to improve on service quality many of which have been completed with the remaining being worked on.
The areas inspected and new ratings are outlined below however as the inspection did not cover all of the services a number of those that were not inspected (particularly at Eastbourne) still carry the results overall of inspections that were conducted in 2018 and 2016.

Overall Ratings (Arrows indicate progress since last report)

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Feb 2020	Outstanding ↑↑ Feb 2020	Outstanding →← Feb 2020	Good ↑ Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Feb 2020	Outstanding ↑↑ Feb 2020	Outstanding ↑ Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Outstanding ↑↑ Feb 2020
Community health inpatient services	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Community end of life care	Good ↑ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Overall*	Good ↑ Feb 2020	Outstanding ↑↑ Feb 2020	Outstanding ↑ Feb 2019	Good →← Feb 2020	Good →← Feb 2020	Outstanding ↑↑ Feb 2020

Ratings for Conquest Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Outstanding Jun 2018	Good Jun 2018
Medical care (including older people's care)	Good Jun 2018	Good Jun 2018	Outstanding Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Surgery	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Outstanding Jun 2018	Good Jun 2018
Critical care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Maternity	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Services for children and young people	Requires improvement → ← Feb 2020	Good → ← Feb 2020	Good → ← Feb 2020	Good ↑ Feb 2020	Good → ← Feb 2020	Good ↑ Feb 2020
End of life care	Good → ← Feb 2020	Good ↑ Feb 2020	Outstanding ↑ Feb 2020	Outstanding ↑ Feb 2020	Outstanding ↑↑ Feb 2020	Outstanding ↑↑ Feb 2020
Outpatients	Good ↑ Feb 2020	Not rated	Outstanding ↑ Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Overall*	Good ↑ Feb 2020	Good → ← Feb 2020	Outstanding ↑ Feb 2020	Good ↑ Feb 2020	Outstanding ↑↑ Feb 2020	Outstanding ↑↑ Feb 2020

+Services for Urgent and Emergency services, Medical care, Surgery, Critical care, and Maternity were not inspected in 2019, the ratings relate to the inspection in 2018 and 2015.

Ratings for Eastbourne District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Requires improvement Jun 2018
Medical care (including older people's care)	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Surgery	Good Oct 2016	Good Oct 2016	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016
Critical care	Good Oct 2016	Good Oct 2016	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016
Services for children and young people	Good ↑ Feb 2020	Good → ← Feb 2020	Good → ← Feb 2020	Good ↑ Feb 2020	Good → ← Feb 2020	Good ↑ Feb 2020
End of life care	Good → ← Feb 2020	Good ↑ Feb 2020	Outstanding ↑ Feb 2020	Outstanding ↑↑ Feb 2020	Outstanding ↑↑ Feb 2020	Outstanding ↑↑ Feb 2020
Outpatients	Good Jun 2018	Not rated	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Good ↑ Feb 2020	Good ↑ Feb 2020	Good → ← Feb 2020	Requires improvement → ← Feb 2020	Good → ← Feb 2020	Good ↑ Feb 2020

+Services for Urgent and Emergency services, Medical care, Surgery, Critical care, and Outpatients were not inspected in 2019, the ratings relate to the inspection in 2018 and 2016.

The full reports and ratings are available at www.cqc.org.uk/provider/RXC

Data Quality

Good quality information ensures effective delivery of patient care and is essential for quality improvements to be made.

During 2020/21 we will support improvement in data quality by:

- Working collaboratively with divisions to identify areas for data quality improvement and determine actions to overcome long term data issues. This includes addressing issues with new systems and services that have been introduced to the Trust, such as Nervecentre.
- Continuing to ensure training materials and scripts are accurate and support good data quality practice
- Continuing to validate correct attribution on the Patient Administration System of GP Practice through the national register (SPINE)
- Continuing to undertake regular audit of completeness of NHS Numbers to ensure continued progress
- Continuing to 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

NHS Number and General Medical Practice Code Validity –

East Sussex Healthcare NHS Trust submitted records during April 2019 to March 2020 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8 for admitted patient care
- 99.9% for outpatient care
- 98.8% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 99.9% for accident and emergency care

Data Security & Protection Toolkit attainment levels

The Data Security and Protection Toolkit (DSPT is an online performance tool developed by NHS Digital to support organisation to measure their performance against the National Data Guardian's data security standards. The Care Quality Commission uses the results to triangulate their findings.

All health and social organisations, including ESHT, are mandated to carry out self-assessments of their compliance against the DSPT assertions. The Trust is required to evidence 44 assertions over the following ten standards:

1. Personal confidential data
2. Staff responsibilities
3. Training
4. Managing data access
5. Process reviews
6. Responding to incidents
7. Continuity planning
8. Unsupported systems
9. IT protection
10. Accountable suppliers

ESHT's DSPT assessment score for 2019/20 was submitted with 116 pieces of evidence provided and all standards graded as met. This is a self-assessment, but is reviewed by our auditors to provide assurance of accuracy to the Trust. The Trust's internal auditors report gives 'reasonable assurance' that the Trust's submission is robust for 2019/20.

Clinical Coding Error Rate

East Sussex Healthcare NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 96.21%

Clinical Coding is the translation of medical terminology written in the patient's notes by healthcare professionals, to describe a patient's presenting complaint or problem, diagnosis and treatment into a coded format which is nationally and internationally recognised.

To ensure accuracy of clinical coding a number of internal audits are undertaken in addition to an external Data Security and Protection Toolkit (DSPT) Audit conducted by a Clinical Classifications Service Registered Auditor.

Results of the DSPT Audit

We have achieved advisory level in primary diagnosis, secondary diagnosis and secondary procedure fields and achieved mandatory level in primary procedure field. Attainment levels are summarised in table 3 below.

Table 3: Levels of attainment – percentage accuracy targets for Acute Trust

Levels of attainment – percentage accuracy target areas	Mandatory	Advisory
Primary diagnosis	≥ 90%	≥ 95%
Secondary diagnosis	≥ 80%	≥ 90%
Primary procedure	≥ 90%	≥ 95%
Secondary procedure	≥ 80%	≥ 90%

Table 4: Overall Audit Results Summary – November 2019/20

Overall Audit Results Summary (203 FCEs)

Primary Diagnosis Correct	Secondary Diagnosis Correct	Primary Procedure Correct	Secondary Procedure Correct	Unsafe to Audit
97.04%	93.35 %	97.17%	97.28%	0

East Sussex Healthcare NHS Trust achieved an overall accuracy percentage of 96.21% highlighting 3.79% error rate.

In conclusion, the general standard of Clinical Coding was noted as very good with national standards for clinical coding being followed well.

- Relevant and mandatory secondary diagnoses and secondary procedures were omitted due to lack of indexing and data extraction skills.
- Some of the errors were due to the poor state of the clinical notes and inconsistencies in documentation
- Staff vacancies and a greater number of trainees is the contributory factor for some of the errors.
- Clinician awareness in coding terms and in recording co-morbidities is limited.

East Sussex Healthcare NHS Trust will be taking the following actions to improve data quality:

- Management will immediately feedback the audit findings and refresh coders on the National Coding Standards where the standards have not been followed.
  - Improve the quality of case notes and the timely availability of electronic notes on Evolve by implementing robust Health records policies
  - Fill the vacancies with trained coders
  - Increase engagement and awareness with clinicians across all specialities.
  - Implement regular internal audits and encourage senior staff to gain an approved auditor status.

Learning from Deaths

Since 2017/18, there has been a national drive to improve the processes Trusts have in place for identifying, investigating and learning from inpatient deaths.

Most deaths are unavoidable and would be considered to be 'expected', however there will be cases where sub-optimal care in hospital may have contributed to the death. The Trust is keen to take every opportunity to learn lessons to improve the quality of care for our patients and families, and is committed to fully implementing the national guidance on learning from deaths.

The Trust policy for the review of deaths ensures there is a robust process for identifying, reviewing and learning from deaths, and outlines the roles and responsibilities of staff involved in that process.

Number of patients who died

Between January and December 2019, 1804 East Sussex Healthcare NHS Trust patients died. Table 6 summarises the number of deaths which occurred in each quarter of that reporting period:

Table 6: Number of deaths per quarter (January 2019 to December 2019)

Reporting period	Number of deaths
Q4 2018/19: January 2019 to March 2019	486
Q1 2019/20: April 2019 to June 2019	433
Q2 2019/20: July 2019 to September 2019	385
Q3 2019/20: October 2019 to December 2019	500
Total: January 2019 to December 2019	**1804**

Number of case record reviews or investigations

By 14/05/2020, 1640 case record reviews and 118 investigations have been carried out in relation to the 1804 deaths included in table 6. In 99 cases, a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out, is summarised in table 7.

Table 7: Number of case record reviews or investigations per quarter (January 2019 to December 2019)

Reporting period	Number of case record reviews or investigations
Q4 2018/19: January 2019 to March 2019	462
Q1 2019/20: April 2019 to June 2019	411

Q2 2019/20: July 2019 to September 2019	351
Q3 2019/20: October 2019 to December 2019	435

4 representing 0.22% of the patient deaths between January and December 2019 are judged to be more likely than not to have been due to problems in the care provided to the patient. The numbers relating to each quarter is outlined in table 8.

Table 8: Estimated deaths per quarter considered likely to have been avoidable (January 2019 to December 2019)

Reporting period	Number of patient deaths considered likely to be avoidable	Percentage of the patient deaths considered likely to be avoidable
Q4 2018/19: January 2019 to March 2019	1	0.21%
Q1 2019/20: April 2019 to June 2019	1	0.23%
Q2 2019/20: July 2019 to September 2019	1	0.26%
Q3 2019/20: October 2019 to December 2019	1	0.20%

These numbers have been estimated using the Royal College of Physicians National Structured Judgement Review methodology in conjunction with internal Serious Incident investigations, Amber Investigations, Complaints, Inquests and Quarterly Mortality Review Audits.

Reviews and investigations which relate to deaths in the previous reporting period

20 case record reviews and 2 investigations were completed after 20/05/2019 which relate to deaths in the previous reporting period (January 2018 to December 2018).

0 representing 0.00% of the patient deaths in the previous reporting period, which were reviewed or investigated after 20/05/2019, are judged more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Royal College of Physicians National Structured Judgement Review methodology in conjunction with internal Serious Incident investigations, Amber Investigations, Complaints, Inquests and Quarterly Mortality Review Audits.

Our revised estimate of the number of deaths reported in the previous reporting period (January 2018 to December 2018) judged more likely than not to have been due to problems in the care provided to the patient, remains the same.
There were 3 representing 0.16% of the patient deaths between January and December 2018 judged more likely than not, to have been due to problems in the care provided to the patient.

Seven Day Hospital Services

The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall there are ten clinical standards for 7DS, of which four clinical standards have been made priorities for delivery by NHS England (NHSE) and NHS Improvement (NHSI).

The priority clinical standards are:

- **Standard 2 – Time to first consultant review.** Patients wait no longer than 14 hours to initial consultant review after admission
- **Standard 5 – Access to diagnostic tests.** Patients get access to diagnostic tests with a 24 hour turnaround for non-urgent patients. For urgent patients this drops to 12 hours, and for critical patients, one hour.
- **Standard 6 – Access to consultant-directed interventions.** Patients must have timely 24 hour access, 7 days a week to specialist, consultant-directed interventions
- **Standard 8 – Ongoing consultant-directed review.** Patients with high-dependency care receive twice daily consultant review and those patients admitted to hospital in an emergency will receive daily consultant directed review

Providers of acute services have been required to submit a self-assessment survey on compliance against delivery of the 7DS standards to NHS England since 2016. In November 2018, a new *Seven Day Hospital Services Board Assurance Framework* was introduced by NHS England and NHS Improvement process for providers to record a single consistent report for the dual purpose of assurance from their own boards and national reporting.

We have made substantial progress over the last year and now have evidence indicating that we are compliant with all four core standards.

Rota Gaps

As an organisation that employs and hosts NHS trainee doctors, the Trust has in place two Guardians of Safe Working Hours (GOSWH) to champion safe working hours for junior doctors. Our GOSWHs are based on each of our acute hospital sites, one at Conquest Hospital in Hastings, and one at the Eastbourne District General Hospital. The roles are independent from the Trust management structure and are supported by the British Medical Association (BMA) to:

- Act as champions for safe working hours for junior doctors and students
- Support exception reporting, monitoring and resolving rota gaps
- Oversee compliance with the safeguards set out under the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

The aim of the GOSWH role is to provide assurance to doctors and employers that doctors are able to work within safe working hours. The GOSWH is there to champion and support junior doctors to deliver this. Where the system fails a set process allows early reporting (exception reporting) to occur which is aimed at giving doctors the confidence that improvement will be made. The GOSWHs provide quarterly and annual reports to the People and Organisational Development (POD) group, and are also involved in the meetings in table 8.

Table 8: Meetings attended by the GOSWH

Group	Frequency
People and Organisation Development (POD) Group	Quarterly
Trust Local Faculty Group (LFG)	Every 4 months
Oversight Group Meeting	Every 4 months
Junior Doctors Forum	Quarterly
Junior Doctors Inductions	Three times a year
CEO Junior Doctors Forum	Every 4 months
Local Negotiating Committee	Monthly

Each year the Trust is given an allocation of junior doctors from the Deanery; the doctors are then allocated to the clinical divisions within the Trust. If the Trust has not been allocated sufficient doctors to fill a rotation, rota gaps are escalated to the division's clinical leads and service managers are made aware if a gap affects their service. The division approaches any current doctors who have expressed an interest to stay on at the Trust at the end of their rotation to help with filling rota gaps. Subsequently if there are still gaps in the rotation the vacant posts will be advertised or filled using locum or bank staff.

Two new NHS roles – Doctors assistant and a Physician associate have been appointed to and are now helping to cover ward areas.

Staff who speak up

In its response to the Gosport Independent Panel Report, the Government committed to the legislation requiring all NHS Trusts in England to report annually on staff who speak up (including whistle blowers).

How staff can speak up
All staff at ESHT are encouraged to raise and share concerns and much work has been done to promote raising concerns and the freedom to speak up. The Trust has a positive incident reporting culture in place and staff are encouraged to report any patient safety concerns or incidents through DATIX (or through an alternative method if they are without computer access). All incidents are reviewed within Governance meetings and investigated and feedback given to the staff member.

ESHT was named as one of the most improved Trusts in the National Guardian Freedom to speak up Index publication:

- The Trust has a Freedom to Speak Up; Raising Concerns (Whistleblowing) policy
- Staff are actively encouraged to raise concerns with their line manager, Supervisor or Clinical lead to enable support, review, and where appropriate, timely actions and feedback to take place. If staff are not reassured they can escalate in line with Raising concerns guidance.

- The Trust has an independent Speak Up Guardian who encourages and supports staff to confidentially raise concerns through their line managers and leadership team. If staff feel unable to raise concerns through usual reporting routes the Freedom to Speak Up Guardian (FTSUG) is a confidential impartial support for all staff. The Trust encourages staff to raise and share concerns as part of everyday business. Staff are thanked for raising and sharing concerns to improve patient safety and culture.
- The role of the Speak Up Guardian is promoted through meetings, team huddles, the staff induction process, regularly circulated newsletters, and a range of materials and information is available on the Trust extranet.
- The Speak Up Guardian is contactable by email, on the telephone and through social media. Contact is offered face to face on and off-site to suit the needs of the staff member.

Staff can report something they are concerned about either to:

- their line manager
- their professional lead
- Staffside, or other union representative
- Speak Up Ambassador – an individual who has had training in raising concerns and can signpost staff to resources and support or the FTSUG
- Speak Up Guardian
- The Risk Management team
- The Trust's Executive Director responsible for Whistleblowing
- The Trust's Non-Executive Director responsible for Whistleblowing

All of these people have been trained in receiving concerns and will give you information about where you can go for more support. If for any reason an individual's concern has not been resolved and all internal options have been exhausted; the concern can be raised with external bodies, listed on the Speak Up Guardian page of the extranet.

How feedback is given to those who speak up

A requirement from the National Guardian office is to seek feedback and that is "*would you speak up again*" where possible, this is asked and recorded:

- Concerns, including feedback and follow ups are monitored via a database, subject to staff consent.
- Feedback is routinely sought from staff who have raised concerns to ensure that they have not suffered detriment as a result of speaking up and any learning can be captured.

How we ensure staff who speak up do not suffer detriment

- Fear of reprisal is discussed and it is recognised that it is may not be easy to speak up in certain posts or areas. The Speak Up Guardian reports to the Chief Executive, and staff are reassured with this reporting line. Any concerns of reprisal would be raised immediately and can be managed down a formal route. Records are made of staff who feel that they have faced reprisal and this is escalated appropriately.
- Patient safety concerns are escalated to the appropriate leads by the Speak Up Guardian, if required, and followed up for reassurance and any learning shared
- Monthly meetings are held between the Guardian and HR Managers within the Clinical Divisions to review any behaviour related reported incidents for bullying, harassment and discrimination - this enables partnership working and appropriate action to be taken efficiently. Sharing of any learning is also discussed.
- The Speak Up Guardian is visible and regularly visits difference areas across the Trust to discuss organisational values, behaviour and the process for managing concerns. Speaking up forms part of the 'Well led' domain for CQC.

- Staff engagement, Human Resources and the Speak Up Guardian are jointly responsible for providing and reviewing specific training for managers and leads to manage concerns regarding bullying and harassment.
- The Speak Up Guardian regularly meets with and has access to / support from the Trust's Executive team. Any recurrent themes and concerns are discussed to triangulate actions and ensure learning.

Staff Survey 2019 Results

NHS Staff are invited annually to take part in the NHS Staff Survey. This is a survey completed by staff to gather views on staff experience at work around key areas including:

- Appraisal and development
- Health and wellbeing
- Staff engagement and involvement, and
- Raising concerns.

Staff engagement and staff survey

Research demonstrates that those organisations with high levels of staff engagement also have better patient outcomes/experience. In 2019, 3642 staff members at ESHT took part in the survey between October and December 2019 either a through postal or online questionnaire. This constituted an overall response rate of 52%, compared with a national response rate of 48% for similar organisations.

The results of our Staff Survey are shared with our staff members to agree which areas they would like to work together to bring about improvement. Progress is monitored regularly through quarterly Pulse surveys.

Based on the feedback that we have received, we have identified four corporate priorities that link to the key findings and recommendations from the Staff Survey 2019:

1. To continue to support staff wellbeing with specific focus on improving both physical and mental health
2. To continue to ensure a Positive and Inclusive culture where all staff can flourish at work
3. To continue to emphasise the need to act on concerns raised by patients in order to build on improved trends
4. To understand any particular hotspots within each division linked to violence, bullying and aggression and develop a range of interventions to improve staff experiences

Living our Values

Our Trust values were developed by our staff and shape our beliefs and behaviours, and are fundamental to how we undertake our everyday work. The importance of positive behaviours is led by our Chief Executive and senior team and is regarded as everyone's responsibility. We have spent time with different staff groups in order to develop and refresh our behavioural framework which outlines the behaviours we expect to see and those which are deemed unacceptable. We will continue to focus on Equality Diversity and Inclusion supporting our diverse workforce to flourish and thrive at work. We have hosted engagement sessions with various staff groups including from Black Asian and ethnic minority, the output have resulted in the development of our Courageous conversations and Ambassador Programmes, we have also developed a range of support for staff who are COVID vulnerable which offer a safe space for staff to focus on their physical and emotional wellbeing. Our values continue to underpin how we work together and we will seek to ensure that they underpin the lived experience of all staff at work.

Leadership Development
The Trust recognises the importance of an Organisation being well led and the impact it has on Patient Outcomes and Experience, Performance, Culture and Retention of a High Calibre workforce.
Our Leadership Pathway outlines the leadership, management and coaching development provided for aspiring, new and experienced leaders from all staff groups and provides continual professional development for those staff in Leadership roles.

During the past year we have continued to add to the Leadership pathway with a particular emphasis on working in teams, supporting opportunities for our leaders to learn and work with colleagues across systems and the development of a High Potential Programme. The trust has also been working in partnership with Henley Business School to provide an MA in Leadership for 48 of our leaders.

The impact of our Leadership Development programmes has contributed to the continued improvement in the Trust being well led and our Staff Survey results.

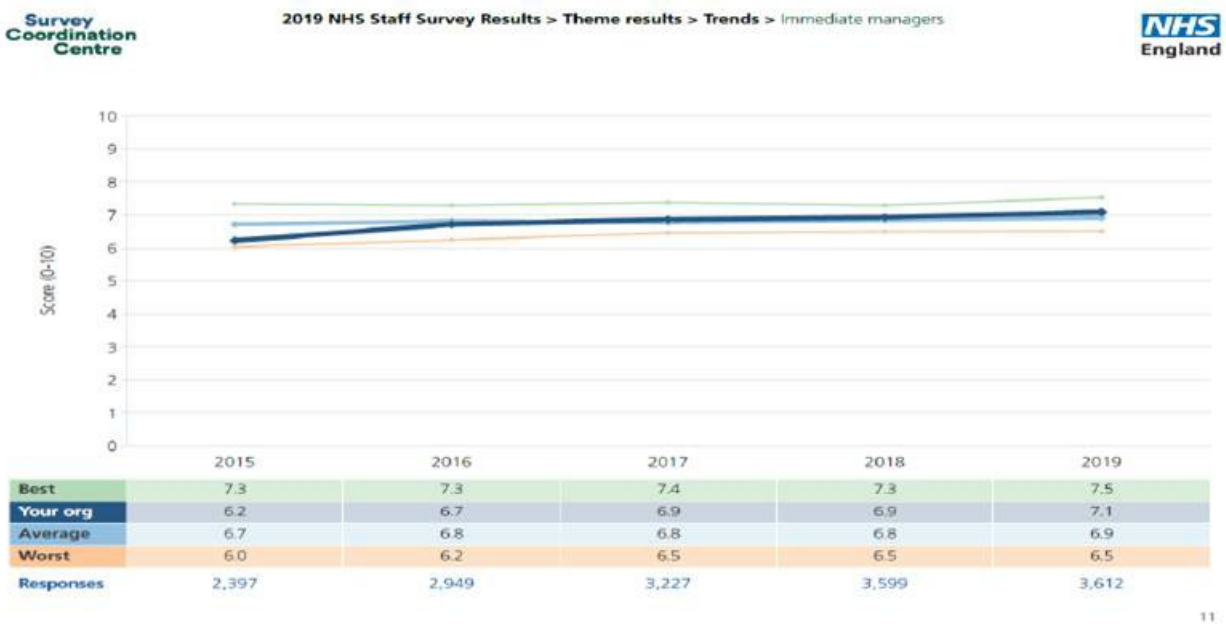


Table 9 below outlines the range of leadership development opportunities available at ESHT and number of leaders who have attended

Table 9: Leadership development programmes at ESHT

Programme Name	Number of staff that have attended training
First Line Managers *Development of core leadership skills including effective communication as a manager and managing organisational change*	108
Leading Service/Leading Excellence *Refreshing core and advanced leadership skills including: leading self, leading others, understanding change, leading into the future*	135

High Potential Programme **Developing aspiring directors with the skills to be able to lead at a Board level**	11
Coaching **Providing 1-1 coaching for staff on a range of development needs**	87
Foundations in Coaching A two-day programme for staff in roles where they have the opportunity to coach others. The 'Foundation Programme in Coaching Skills' gives people the opportunity to learn and practice the skills of coaching conversations and introduce frameworks to use to making sure these conversations are focused and effective, helping to make our staff feel listened to, supported and empowered to deliver their responsibilities. Taking a coaching approach improves staff motivation, quality of work and aids retention.	32
Team development **Bespoke sessions are designed and delivered to support team performance.**	700
External and National Leadership Programmes.- e.g. Edward Jenner programme, Stepping up Programme, Rosalind Franklin **Development of enhanced leadership and strategic development skills**	180

Health and Wellbeing

The emotional and physical wellbeing of our staff is really important to us and we launched our staff Health and Wellbeing strategy in 2019 which outlines seven key priorities to help us support staff wellbeing. Some of the work delivered to date:

- **Care First Employee Assistance programme**
  The Service has been extremely well utilised during the year with 487 instances of support being provided as a result of 225 members of staff making contact with Care first for the first time. This enhanced service supports staff to stay well and flourish in the working environment.
- **Physical wellbeing** – Wellbeing Clinics for COVID Vulnerable staff were delivered providing time and space with a wellbeing advisor.
  Staff have been offered the opportunity to improve their physical wellbeing with Men's health campaigns, Pilates, lunch break walks, take a break campaign, staff discount at local fitness centres and support for those staff who want to use healthy alternatives to travel to work.
- **Emotional wellbeing** – All of our staff have access to a range of support including pastoral support, counselling and psychology services , Schwartz round and various training events e.g. Compassion without Burnout workshops, Menopause demystified Mindfulness and Art of Relaxation sessions and a range of online webinars.
- **Time to Talk**- 250 staff supported in a safe space via telephone delivered during COVID with focus on their emotional wellbeing
- **Employee support** – 200 staff have been supported with a range of issues linked to flexible working, childcare and financial wellbeing, this support has been critical to staff retention.

The investment in leadership development, improving staff engagement and involvement, promoting and supporting staff wellbeing has contributed to the Trust working towards becoming Good overall and outstanding for Care in our recent CQC report. We have continued to develop a positive safety culture for both our staff and patients as well as making a number of improvements linked to patient experience and outcomes. We are demonstrating ongoing improvement in staff retention especially for staff groups such as nursing. Over the past four years our Staff Survey results have continued to improve. The survey and the staff family and friends test has highlighted that staff feel better supported by their line managers with improvements linked to quality of appraisal, and working in teams. More staff than ever have also said they would recommend ESHT as a place to work.

Part 3 - Review of Quality Indicators and our Priorities for Improvement in 2019/20

Part 3.1 – Our Priorities for Improvement in 2019/20

The Trust identified four quality improvement priorities for 2019/20 to contribute towards the delivery of our Quality and Safety Strategy. Overall the Trust has fully delivered and achieved the objectives for four priorities in 2019/20.

This section describes the significant work that has been undertaken at ESHT to deliver on our quality improvement priorities over the past year, and sets out how we will continue to work on delivering the aims of each of our improvement priorities, where there is still room for improvement to be made.

Table 10: Priorities for improvement 2019/20

Quality Domain	Quality Improvement Priority 2019/20		Status
Patient Safety	1.	Continue to improve the management of the deteriorating patient	Achieved
Clinical Effectiveness	2.	Improve compliance against the 7 day working standard for ongoing consultant-directed review	Achieved
	3.	Continued implementation and development of the Excellence in Care Programme	Achieved
Patient Experience	4.	Improve communication so that patients feel better informed about their care and treatment	Achieved

Patient Safety Improvements 2019/20

1. Continue to improve the management of the deteriorating patient

Why we chose this priority

Early detection and treatment of physiological deterioration has been shown to improve the clinical outcome for patients. In 2019/20 we committed to further improve our escalation processes to ensure consistent early recognition of deterioration so that patients are assessed and treated with ongoing care planned appropriately.

The TEP tool was introduced across the Trust from 1 April 2019, and therefore the priority was to ensure the TEP tool was embedded into clinical practice and used consistently as an aid to improve management of deterioration and document individualised goals of care. The new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process was also launched in April and would support this process and the ongoing work regarding End of Life Care.

Our aims

- To increase the number of patients who have a Treatment Escalation Plan in place following MET/SET call (baseline zero as new process)
- Reduction in the number of cardiac arrests associated with un-recognised deterioration in the preceding 12 hours("failure to rescue")
- Reduction in avoidable surgical admissions to Critical Care Unit(s)

How have we done?

Revised and improved escalation pathway developed and implemented
We ran a number of workshops across the Trust inviting all members of our multi-disciplinary teams that contribute to the care of Deteriorating Patients to assist us with developing an improved escalation pathway at ESHT. These workshops were attended by doctors and nurses from the Emergency Department, Critical Care and Acute/General Medicine.

Discussion and feedback during the sessions helped us to identify a common theme regarding communication of plans about escalation. Although there were many different ways within the Trust of communicating about escalation plans, knowledge and awareness of the processes was variable. In addition there was no standardised means of documentation and often decisions regarding "what happens next" were not addressed or effectively communicated.

To address these challenges, we have introduced the following:

- We developed a standardised ESHT Treatment Escalation Plan (TEP) that provides a tool for clear and consistent documentation in every ward area. The development process for the TEP involved introducing the new tool initially to one area (Critical Care Outreach Team) and using quality improvement methodology, was amended and shaped by feedback from the teams that were using it. We widened our trial area to include more clinical areas, and the final version of the TEP was introduced across the Trust at the beginning of April 2019.
- From the data collected following emergency calls, there has been an achievement of a TEP being in place for all patients. During the Covid-19 pandemic, the TEP has

been seen less often but there has been an increase in REPSECT forms which has been appropriate.
- We have also developed a new in-house Deterioration Assessment Response and Treatment (DART) training course, which focuses on ensuring our nursing teams have the skills and competencies to recognise the Deteriorating Patient and act rapidly.

Reducing cardiac arrests associated with suboptimal management of physiological deterioration
During January 2020, a week long engagement event, took place highlighting the deteriorating patient and the policy. Every ward visited by the Critical Care Outreach team with support from the Chief Executive, Medical Director and the Director of Nursing. Posters were provided for each ward with flow diagram for escalation. Via meet and greet sessions, key messages were given to help further embed the process, to discuss the use of the Situation Background Assessment and Recommendations (SABR) tool and what work the ward need to do so the staff were empowered to take action.
All cardiac arrests were reviewed to assess the 24 hour period prior to the arrest and review if escalation occurred e.g. was NEWS of ≥5 escalated to Critical Care Outreach and patient seen by doctor. Where there was a NEWS ≥9, was there an emergency call made. Data has demonstrated that there has been a reduction in cardiac arrests and reduction in failure to escalation rate.
The proportion of cardiac arrests where there was evidence of deterioration in the preceding 24 hours which was not escalated was 17% between April 2019 and March 2020, compared with 20.48% between April 2018 and March 2019. Our Critical Care Outreach team continue to monitor this indicator and will develop plans to support improvement where required.

Improving the recognition and management of Sepsis in our acute hospitals
As part of the recognition of the deteriorating patient, compliance with the sepsis screening tool has been monitored. Compliance with sepsis screening was good at the beginning of the financial year but during winter and with the Covid-19 pandemic, there has been a slight drop in compliance. This has been affected by the Covid-19 pandemic as it triggers the sepsis protocol automatically and so there is confusion about completing the screening tool. This will be reviewed to see what lessons can be learnt and taken forward.

Revised and improved AKI pathway
A new policy has been developed and it was due to be launched on World Kidney Day in March but due to the Covid-19 crisis, it was cancelled. Further consideration is being given as to how further improvement can be progressed. Despite this, the data collected shows improvement in length of stay and mortality rates for AKI stages 1, 2 and 3.

Further improvements identified for 2020/21

The new patient safety module on Nervecentre (a new electronic observation system) which is being implemented during 2020/21 will have the ability to allow the seamless transfer of observation to a doctor automatically. It will provide an alert system in real time, including deteriorating urine output from an electronic fluid chart, so that immediate action can be taken.

Our work to improve the recognition and management of sepsis and AKI also continues, and includes:

- AKI recognition and management tool and pathway flowchart written. Will require support from QI team to introduce across Trust.
- AKI electronic alerting system to be developed.
- Focus on fluid balance charts and AKI alerting based on urine output measurements

- Targeted pharmacy review for high-risk groups
- Rolling educational programme for ward based staff
- Consider business case for AKI specialist nurse for Trust one day per week; educational/clinical/audit work
- Ensure appropriate discharge advice for all inpatients with AKI (suggest 'Think Kidneys' patient advice leaflet)

Clinical Effectiveness Improvements 2019/20

2. Improve compliance against the 7 day working standard for ingoing consultant-directed review

Why we chose this priority

The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall there are ten clinical standards for 7DS, of which four clinical standards have been made priorities for delivery by NHS England (NHSE) and NHS Improvement (NHSI). Improvement in delivery against the four priority 7DS clinical standards was identified as an improvement priority in 2018/19 and 2019/20, and the Trust has made progress in improving delivery against the four priority 7DS clinical standards.

Standard 8 related to ongoing review of inpatients after the initial consultant assessment, recognising that patient outcomes and length of stay improvement with greater ongoing senior input. Patients in critical areas (ITU and HDU) should be reviewed twice daily by a consultant. Those in other inpatient areas should be reviewed once daily. However, these consultant reviews may be formally delegated to another team member. Some inpatients (e.g. patients in rehabilitation or medically stable patients awaiting packages of care or placement in residential care) may not need regular daily medical review unless their condition changes or nursing staff have concerns. In such patients, this should be specified in the patient record.

Our self-assessment of compliance against the 7DS standards in February 2019 indicated that the Trust had not met the standard overall for ongoing consultant-directed review (clinical standard 8), with particular challenge at weekends in a number of specialities where the formalised arrangement for consultant cover does not include a consultant-led ward round. Documentation of need for medical review and delegation of consultant review was also found to be variable across specialities and wards, and remains poor in some.

Our aims

- To ensure progress continued on delivering the standard for ongoing consultant-directed review during weekdays and weekends, so that the Trust can deliver on its aim to meet all priority standards by 2020/21
- Nerve Centre (live bed state system) to be used across the Trust to maintain the record of board round decisions
- The review needs of individual patients are determined, agreed, documented and reassessed regularly at ward rounds or the daily board round.

How have we done?

We have made substantial progress over the last year and now have evidence indicating that we are compliant with all four core standards.

Standard 2 – time to first consultant review

- Since November 2018, we have monitored the rate of review within 14 hour standard, by ward, on a monthly basis as part of the "Excellence in Care" programme. This is a sample of between 400-460 inpatients each month. Apart from a slight dip in weekend performance in September, overall compliance with Standard 2 has been above the 90% since November 2018.

Month	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
Weekday %	94.6	95.1	92.8	92.9	90.3	93.9	96.0	93.4	91.8	93.7	92.0	92.9
Weekend %	90.5	90.3	94.0	94.0	94.2	88.0	91.0	96.9	98.1	92.7	92.6	100

We were unable to separate weekday and w/e performance in the Excellence in Care tool in April 2019 but did do a separate audit of w/e performance April-May 2019 which indicated 90.5%.

Standard 5– Access to consultant-directed diagnostics

- The only outstanding element to this standard last year was the availability of emergency endoscopy The Trust wide 24/7 emergency endoscopy rota went live on 19th Aril 2019, so we are now fully compliant with this standard.

Standard 6– Access to consultant-directed interventions

- With the advent of the trusts 24/7 GI bleed rota on 15th April 2019 we became fully compliant with this standard.

Standard 8 – Ongoing consultant-directed review

- In 2018 our self-assessment of compliance against standard 8 indicated that the Trust was not complaint overall.
- Some specialties have been challenged in achieving this. ENT, in particular, has a recognised severe shortage of consultant staff. This has been mitigated by employment of locum consultants and use of very senior and experienced non-consultant staff (Associate Specialists) to provide consultant level advice.
- Since 2019, there has been an ongoing programme of education and information, resulting in great improvements in consistency of daily board rounds, the documentation of patient reviews and of the delegation of review.
- We audited this standard across both the acute hospitals in March 2020. The audit indicates that we are now compliant with this standard:
- Twice daily review was 100% in our ITUs and HDUs throughout the week
- Once daily review overall was 96.0% and at weekends was 92.2%.

Further improvements identified for 2020/21

Introduction of the Nerve Centre (live bed state system) across the Trust, initially planned from spring 2019, has been substantially delayed and was due to be re-launched in August 2020. However the current COVID-19 pandemic may cause further delays. When fully operational, this will support real time tracking of patients, their review within 14 hours, support the processes of review delegation, effective handover between shifts provide patient and task lists for medical staff, and provide a robust mechanism for monitoring performance against this clinical standard.

3. Continued implementation of the Excellence in Care Programme

Why we chose this priority

The overall aim of the Excellence in Care programme is to provide one source of robust key performance information to enable ward teams to monitor consistency in care and identify areas for improvement. It is in essence a dashboard with four specific domains (of which Quality and Safety is one) and consists of a large number of Key Performance Indicators (KPIs). The priority for 2019/20 was to ensure that the Essential Care Standards for all domains within the dashboard are clearly defined, and that teams are supported to implement improvements. Considerable technical support was required due to a change in focus and also a change in the software used for the programme.

Our aims

- Provide support and training to our ward teams and departments to use the information to make improvements, highlight risks and celebrate success.
- Agree standards for all domains with the domain leads.
- Align the KPIs to the standards.
- Confirm the data source of information that will be automatically populated into the dashboard.
- Amend the audit questions to reflect the KPIs and provide staff with data that they can use for improvement.
- Agree the number of audits required per clinical area.
- Agree phase 2 areas to include following the initial roll out.
- New format dashboard to be developed and launched
- Heads of Nursing, matrons and team leaders will have received an Introduction to Quality Improvement training session
- Each division will have completed at least three Quality Improvement projects by the end of the year

How have we done?

All in-patient areas are now auditing against a total of 35 new Essential Standards and revised metrics. Staff are them able to use the data to identify areas for improvement. Other teams outside of the phase 1 scope such as Paediatrics and District Nursing have created their own bespoke Essential Standards which are all available on the Trust Intranet. Their Excellence in Care data, together with Critical Care's, are now integrated into the main EIC dashboard. A standard operating procedure and audit guidance notes have also been developed for those areas not in scope.

Between April 2019 and March 2020, a total of 70 senior nursing and midwifery leads (including heads of nursing, matrons and team leaders) attended a training session on quality improvement (QI). A detailed breakdown is summarised in the table below. Of the 70 members of staff that attended the introduction to QI session:

- 42 have attended a 1 hour pop-up awareness session providing an introduction to QI
- 24 have progressed to attend a half or one day session
- 4 have completed the 5 day QSIR Practitioner course which covers a range of QI principles and techniques to enable those that attend the course to lead their own quality improvement projects

In addition to the senior nursing and midwifery leads that were trained, a further 118 nurses and midwives were also trained in QI during 2019/20.

Total senior nursing leads (including heads of nursing, matrons and team leaders) trained in QI in 2019/20

Course name	Heads of nursing, matrons and team leads	Staff nurses and midwives	Grand Total
POP-UP (1 hour awareness session)	42	79	121
BITESIZE (half day session)	3	9	12
QSIR FUNDAMENTALS (1 day intro to QI)	21	22	43
QSIR PRACTITIONER (5 day programme)	4	8	12
Grand Total	**70**	**118**	**188**

During 2019/20, a total of 73 divisional quality improvement projects were initiated at ESHT and supported by the Trust quality improvement team. These projects ranged from small scale changes initiated at a local level by clinical, operational and corporate teams, through to Trust strategic programmes of work. Of the QI projects that were initiated in 2019/20, 41 are still being actively worked through.

Divisional QI projects initiated in 2019/20

Division	Number of QI projects initiated	Number of active QI projects in April 2020
Diagnostics, Anaesthetics and Surgery	12	8
Medicine	12	8
Women, Children and Sexual Health	14	7
Out of Hospitals	18	9
Urgent Care	2	1
Corporate	15	7
Total	**73**	**41**

Further improvements identified for 2020/21

Excellence in Care will continue to be embedded into practice which will help to support and grow the culture of quality improvement within ESHT. The way that the dashboard is presented will continue to evolve under the leadership of the Information Management team. Processes will continue to be reviewed so that staff can easily triangulate the Excellence in Care quality data with that of workforce data and performance.

4. Improve communication so that patients feel better informed about their care and treatment

Why we chose this priority

Data from the national inpatient survey, our own internal complaints and inpatient questionnaires highlight a number of areas regarding communication and information provided to patients where we can make improvements. This includes how we involve patients in making decisions about their care, and the information provided to them.

The Trust recognises that there are a number of areas in the patient journey where communication could be improved. The priority for 2019/20 was to work with patients and staff to review the current systems in place and identify the opportunities to re-design and improve how we communicate with patients. This will include improving the experience of patients with communication barriers, so that they are fully informed and involved in decisions relating to their care.

Our aims

- To analyse our existing data and information to identify areas to focus our improvement work
- To complete patient and carer engagement events linked to our areas of focus, to gather feedback on how we can improve
- To identify key areas for improving how we communicate and involve patients and carers in their care and treatment, and have initiated improvement plans in key areas

How have we done?

We have reviewed the current systems we have in place for gathering patient and service user feedback, and analysed existing information, including the National Inpatient Survey's to identify and refine areas to focus our improvement work on.

A short survey was designed focusing on communication during the discharge process and those patients who had been an inpatient within the previous 6-8 weeks were targeted, either face to face or on the telephone. This also allowed us and the patients to expand on views or opinions they had.

We used the feedback gathered to prioritise areas to focus on and took these suggestions to an engagement event during quarter 4.

Further improvements identified for 2020/21

During 2020/21, we will work with two wards to review the current patient information provided to patients who are discharged home. We will look to redesign the format in which the information is shared to include some of the suggestions made by patients. This will be shared with our Patient Experience Volunteers who can provide an expert opinion on the documents. During the quarter 3 of 2020/21, we will use the revised patient information to give to patients when they are discharged home and during quarter 4 we will gain feedback on how this information has been received.

Part 3.2 - Sign up to Safety pledges

In last year's Quality Account, we also committed to improving the quality and safety of care we provide and continuing to drive improvement through the following 'Sign up to Safety' pledges for 2019/20.

Our progress and achievement for these areas is outlined below:

Sign up to Safety – Reduce patient falls

Our aim was to reduce the number of falls to no more than 5 falls per 1,000 bed days; during 2019/20 the number of falls per bed days was 5.5 per 1000 bed days. There were 1453 falls incidents reported in 2019/20, compared to 1514 reported in 2018/19. There has been an increase in the number of serious incidents relating to falls, 21 serious incidents (severity 4 falls) were reported in 2019/20, compared with 9 reported in 2018/19. The Trust acknowledges that there is still more to do to reduce harm, and this remains one of our priority areas for improvement in 2020/21.

Sign up to Safety – Reduce pressure ulcers

ESHT have continued to reduce the number of category 3 and 4 pressure ulcers. In 2018/19 we reported a 76% reduction. In 2019/20 this had increased to an 87% reduction over the previous 3 years. Our focus on category 2 pressure ulcers shows that the number of incidents reported has remained static, however, the themes identified through the regular deep dive investigations have been used to inform the training programme for 2020/21. This year we have also reviewed how we code pressure ulcers, so that we are in line with national guidance and can accurately monitor the care we provide to our patients.

Sign up to Safety - Improving Sepsis recognition and treatment

Our work to improve sepsis recognition and treatment continues and remains a priority for the organisation and was included in the priority for the management of the deteriorating patient. Compliance with the sepsis tool has overall been good with some challenges occurring in winter and also during the Covid-19 pandemic. Covid-19 has been an automatic trigger for sepsis and so there has been confusion as to whether the sepsis tool requires completion. A review will be undertaken to assess these challenges and develop a trust wide approach to suing the sepsis tool during a pandemic.
As part of the Trust's programme to digitalise all documentation, sepsis screening will be part of a module being introduced within a new digital system.

Sign up to Safety - Duty of Candour (DoC)

2019/20 the Patient Safety team continues to monitor this area and report on progress through the Governance key performance indicators. We have not achieved the ambitious goal we had set ourselves back in 2018/19. We have achieved to date DoC verbal 75% and written 79%. The patient safety team continue to support the Divisions and staff that need to complete this aspect.
The Patient Safety team are continuing to offer Duty of Candour training sessions throughout the year on both acute hospital sites for all staff that work in the community and acute areas. The team will also provide bespoke training on request.
To achieve our ambitious 100% level of compliance we continue to work collaboratively with colleagues across the Trust.

Sign up to Safety - Reduced mortality rates

We have achieved our goal to reduce the Trust Summary Hospital Mortality Index (SHMI) to 0.97. A series of actions have been taken to achieve this, as highlighted on page 87 and actions continue to be taken.

Sign up to Safety - Improve patient experience

Our response rate for the Friends and Family Test (FFT), has decreased for our Emergency Departments from 14% (January 2019) to 7.5% (January 2020) and our recommendation score is 96% (January 2020). However our Inpatient response rates have increased from 42% (January 2019) to 44.1% (January 2020) and our recommendation score is 98% (January 2020). We continue to drive and explore new options of collecting this feedback from our patients. This is monitored and tracked through our Patient Experience and Engagement Steering Group.

Sign up to Safety 2020/21

The Sign up to Safety campaign came to a close at the end of March 2019. Although the national campaign has finished, Trusts have been encouraged to continue with the improvement work they had started. To achieve this, the falls improvement work will be monitored and reported by the Falls Steering Group. Pressure ulcer improvement will be monitored and reported through the Pressure Ulcer Review Group. Duty of Candour improvement will be monitored by the Patient Safety and Quality Group and reported by the Patient Safety Team. Sepsis improvements will continue to be monitored and reported through the Clinical Outcomes Group.

Part 3.3 – Review of our Quality Indicators

Amended regulations from NHS Improvement require Trusts to include a core set of quality indicators in the Quality Account. The data source for all indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC).

The Trust performance for the applicable quality indicators are set out below.

Patient Safety Indicators

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.

Indicator	ESHT 16/17	ESHT 17/18	ESHT 18/19	ESHT 19/20 (April 2019 to Dec 2019)	National average (Acute Trusts)	Best performer (Acute Trusts)	Worst performer (Acute Trusts)
Percentage of admitted patients risk-assessed for Venous Thromboembolism (VTE)	96.77%	95.83%	95.90%	**94.96%**	95.40%	100.00%	71.84%

Source: NHS Digital

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

1. Compliance is now recorded on the Trust's Excellence in Care Quality dashboard which is allows wards to review their data monthly and take action where required.
2. Compliance data is reviewed at Divisional and Specialty levels through the Integrated Performance Review process.
3. Implementation of the ePMA system which will support with risk assessment compliance and the prescribing of appropriate thromboprophylaxis treatment
4. Conducting Root Cause Analysis of patients who have died with VTE in parts 1a, b or c of the death certificate to support learning, improvement and adherence to NICE VTE Prevention Guidance (CG92)
5. Review of Non-fatal Hospital Acquired Thrombosis cases within 6 weeks of a surgical procedure highlighted in reports from CKHS and raising an RCA investigation where appropriate.
6. New Standing Operating Procedure for VTE admitted trauma patients

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.

Indicator	ESHT 15/16	ESHT 16/17	ESHT 17/18	ESHT 18/19	ESHT 19/20	National average	Best performer	Worst performer
Rate of C. difficile Infection per 100,000 bed days (aged 2 or over)	19.2	17.6	15.4	20.1	16.7	14.0	0.0	91.0

Source: ESHT 18/19 data is from the Public Health England (PHE) Healthcare Acquired Infections (HCAI) Data Capture System. All other data is from NHS Digital. At the time of writing this report 19/20 data was not available.

***Clostridioides difficile* Infection (CDI) mandatory surveillance 2019/20**

The way that organisations are required to report CDI has significantly changed to include prior healthcare exposure. The changes to the CDI reporting algorithm for financial year 2019/20 are:

• adding a prior healthcare exposure element for community onset cases
• reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For the first time, CDI cases diagnosed within 48hrs of admission (community onset infections) are now attributed to the acute trust and classed as community onset healthcare associated (COHA), if the patient has been an inpatient in the previous 4 weeks. This change is to take account of the patient's prior healthcare exposure. It will increase the numbers of reportable infections for acute trusts.

Cases are now considered hospital onset after 48hrs of admission and not 72hrs as in previous years. ESHT reported 51 cases against a limit of 40 for 2018/19. For 2019/20, the limit for ESHT increased to 68, to take into account this change and the patients with prior healthcare exposure (COHA). The annual report for CDI data for 2019/20 has not yet been published by PHE who have advised that the reporting is delayed until December 2020 due to the COVID-19 pandemic.

According to the PHE data capture system, the rate of CDI for ESHT is16.7 for 2019/20 however publication of the annual surveillance report has been postponed until December 2020 and therefore this rate have not been confirmed. Equally, the national performance date for 2019/20 is not yet available.

A total of 51 cases are attributed to ESHT for 2019/20. While this is the same number as the previous year it is well below the limit of 68 set and represents a significant improvement because prior healthcare cases are now included. The improvement is likely due to improved compliance with infection control, antimicrobial prescribing and environmental decontamination.

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

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

Indicator – NRLS Data	ESHT 19/20	National Average	Best Performers	Worst Performers	ESHT 18/19	ESHT 17/18
	01/04/19 – 30/09/19	01/04/19 – 30/09/19	01/04/19 – 30/09/19	01/04/19 – 30/09/19	01/04/18 – 30/09/18	01/04/17 – 30/09/17
Rate of patient safety incidents reported per 1000 admissions	38.03 (4594 incidents reported)	49.8 (6276 incidents reported)	103.8 (11620 incidents reported)	27.8 (1392 incidents reported)	40.68 (4870 incidents reported)	43.02 (5339 incidents reported)
% of patient safety incidents reported that resulted in severe harm or death – This is the National and Reporting and Learning system Data between 01/04/2019 and 30/09/2019	Severe 0.46% (21 incidents)	Severe 0.2%	Severe 0.2%	Severe 1.2%	Severe 0.23% (11 incidents)	Severe 0.13% (7 incidents)
	Death 0.02% (1 death)	Death 0.1%	Death 0.1%	Death 0.7%	Death 0.02% (1 incident)	Death 0.0% (No incidents)

East Sussex Healthcare NHS Trust has taken the following actions to improve the number and rate, and so the quality of services by:

- The management of investigation of severe and serious incidents continues to be centralised and is embedded in the Trust with an ongoing improvement in the quality of investigations.
- Serious incidents are all managed in accordance with national legislation and timescales.
- Amber and Serious incidents are monitored by the Weekly Patient Safety Summit
- Actions resulting from serious incidents and amber investigations continue to be monitored with updates on the number outstanding provided to the Patient Safety & Quality Group.
- Work is underway with regards to auditing completed actions to ensure that they have been embedded in clinical practice.

Clinical Effectiveness Quality Indicators

Summary Hospital-level Mortality Indicator (SHMI)
Risk Adjusted Mortality Index (RAMI)

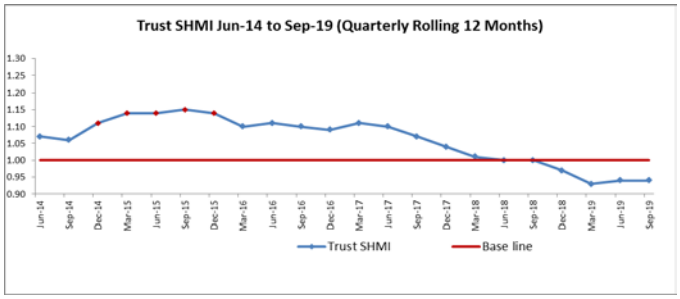
East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

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

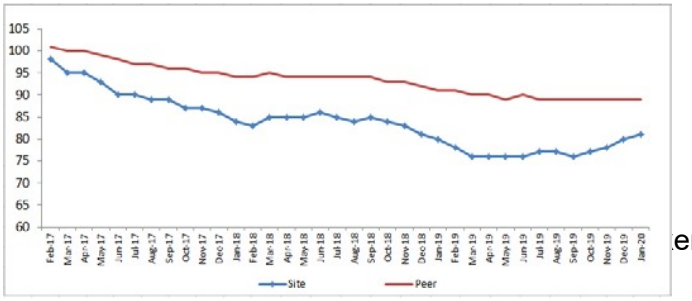
Indicator	ESHT Jan 14 - Dec 14	ESHT Jan 15 – Dec 15	ESHT Jan 16 – Dec 16	ESHT Jan 17 - Dec 17	ESHT Jan 18 - Dec 18	ESHT Jan 19 - Dec 19
SHMI value	1.11	1.14	1.09	1.04	0.97	0.97
Banding	1 (higher than expected)	1 (higher than expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)
% of patient deaths with palliative care coding by speciality and/or diagnosis	21.6	17.7	18.9	22.7	31.99	35.28

Source: NHS Digital

Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



Risk Adjusted Mortality Index (RAMI)



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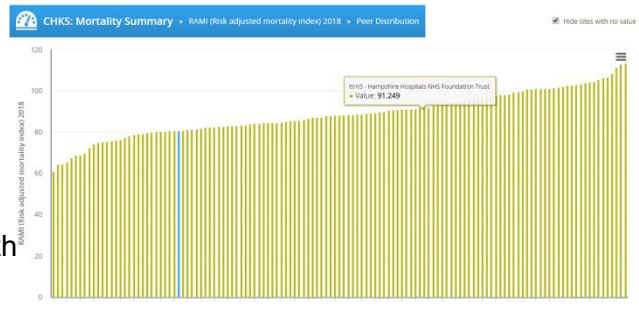
RAMI v Peer This shows our position nationally against other acute trusts



- Recruiting Consultant staff in our emergency units and acute medicine departments so we can provide optimum care when patients are acutely ill, with consultant presence on MAU every day for around 12 hours.
- Increasing the number of doctors resident at night.
- Increasing provision of ambulatory emergency care (AEC), with the new AEC unit at Eastbourne having opened in 2018 and the new AEC facility at Conquest in 2019. This has allowed streaming of patients from A&E to the most appropriate assessment area, with resulting more rapid senior input.
- Further improving the recognition and rapid treatment of Sepsis, both at admission and in inpatients, both of which have contributed towards reducing the mortality indicators across the year.
- Improving recognition of Acute Kidney Injury (AKI).
- Providing timely senior decision making at ward level through multidisciplinary daily board rounds, led by the consultant.
- Improving handover for acute teams. We have also purchased Nerve Centre: a handover, task allocation, and patent tracking tool. The first components of this are currently being introduced and others rolled out across the hospitals.
- Increasing recognition of frailty, with specific documentation of this in the Integrated Patient Document (IPD).
- Implementing a 24/7 acute GI bleeding service.
- VitalPAC is used across acute inpatient areas to identify patients whose observations are deteriorating. The system is used to record and share the information ensuring clinicians have full visibility of a patient's observations and can respond at the earliest opportunity. The system was upgraded this year with new functionality available including NEWS2, fluid management charts and falls assessment.
- The Trust's Deteriorating Patient Improvement Group (DPIG) has introduced RESPECT forms and Treatment escalation plans (TEP) allowing greater clarity on ceilings of care and treatment escalation.
- Overview of Trust mortality indicators is provided by the Clinical Outcome Group (COG) which is chaired by the Medical Director. The group also drives improvement in a number of workstreams to improve outcomes for patients.
- An additional quarterly review group reviews the case notes of all deaths graded at M&M review as having poor quality of care, deaths involving serious clinical incidents or complaints, to re-assess avoid ability and promote learning.
- Moving to an independent Medical Examiner system has been delayed due to delays in appointing the National Lead Medical Examiner, and the Regional ME, but we have now interviewed locally and will go live with the new system in 2020.
- The Trust Board is sighted on our mortality performance with formal quarterly reporting of "Learning from deaths", which includes the number of avoidable deaths.
- Improving clinical coding of patient information to ensure mortality indicators are based on accurate clinical information.

Patient Reported Outcome Measures /Scores (PROMS)

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

All NHS patients having hip or knee replacement 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 from patients on the reported outcome of their surgical intervention and compare themselves to other Trusts nationally.

NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

Indicator	Index	ESHT 14/15 Adjusted Average Health Gain	ESHT 15/16 Adjusted Average Health Gain	ESHT 16/17 Adjusted Average Health Gain	ESHT 17/18 Adjusted Average Health Gain	ESHT 19/20 Adjusted Average Health Gain
Patient Reported Outcome Measures Adjusted Average Health Gain Hip Replacement (primary)	EQ-5D	0.45	0.46	0.50	0.44	0.36
	EQ-VAS	11.49	12.53	14.54	16.98	10.60
	Oxford Hip Score	22.58	23.38	22.85	22.70	21.75
Patient Reported Outcome Measures Adjusted Average Health Gain Knee Replacement (primary)	EQ-5D	0.31	0.33	0.33	0.38	0.23
	EQ-VAS	5.28	2.17	4.81	9.61	5.71
	Oxford Knee Score	16.38	16.76	16.32	17.62	12.71

Source: NHS Digital - PROMS Score Comparison Tool/CSV Data Pack.

2018/19 PROMS data not available

The NHS Digital Score Comparison Tool is based on modelled records which are the number of records where both the pre- and post-*operative* questionnaires have been completed, the questionnaire pair has been successfully linked to a record of hospital inpatient activity and key data items used in the case-mix adjustment methodology have valid values recorded.

ESHT have raised queries with both Quality-Health who are responsible for the PROMS data and NHS digital as the linkage achieved by NHS digitally is significant low and this therefore impacts on the information available to the Hospital for their patient outcomes. For data finalised from the period of April 2018 to March 2019, it is reported that there were 519 procedures eligible, that ESHT supplied 691 pre-operative questionnaires, therefore representing a participation rate of 133.1%, however only 287 procedures were linked, representing a 41.5% linkage rate. NHS Digital and Quality-Health are currently investigating this data.

East Sussex Healthcare NHS Trust will continue to take the following actions to improve the rate and therefore the quality of its services by:

- Reviewing and sharing the data through our divisional Quality and Governance mechanisms.

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.

Indicator	ESHT 16/17	ESHT 17/18	ESHT 18/19	ESHT 19/20	National Average	HES Acute Peer 5th Percentile	HES Acute Peer 95th Percentile
Emergency readmissions to hospital within 30 days of discharge Age 0-15	13.60%	13.57%	14.87%	13.50%	12.03%	5.01%	17.51%
Emergency readmissions to hospital within 30 days of discharge Age 16+	12.75%	14.03%	15.54%	15.41%	14.01%	11.62%	16.83%

Source: NHS Digital

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

- Building on work from the previous year, we have expanded the 'enhanced discharge' meetings to twice weekly. The meetings involve social care and community colleagues to avoid unnecessary readmissions
- Creating a readmissions dashboard which divisions use to identify trends and themes underlining readmissions which is presented to Executive Directors quarterly at the divisional Integrated Performance Reviews (IPR)
- Holding daily operational executive calls to identify system issues and put actions into place to support effective discharge home
- Ensuring crisis response teams support patients at home for 72 hours post discharge to prevent them requiring readmission and ensure they settle fully at home

Patient and Staff Experience Indicators

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.

Indicator	ESHT 2015	ESHT 2016	ESHT 2017	ESHT 2018	ESHT 2019	National average *For acute and community Trusts*	Best performer	Worst performer
Percentage of staff who would recommend the Trust to friends or family needing treatment	54%	62%	65%	67.3%	**69.1%**	69.9%	90.5%	48.8%

Source: NHS Digital

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

- Analysing the NHS Staff Survey results and using the information to identify key priorities for the whole organisation to focus on. To deliver those priorities effectively across the Trust, each division was tasked to create and implement action plans, giving local control and enabling staff to make effective change.

- Using staff FFT results as a source of intelligence to inform and signpost to areas for improvement in staff working life, wellbeing, conditions and work environment. Staff responses are also monitored three times a year through an internal Pulse survey mechanism.
- Launching a Leadership Pathway to develop and support aspiring, new and experienced leaders from all staff groups, including providing continual professional development for those staff in leadership roles.

The Staff Engagement and Wellbeing Team are working with the Strategy, Innovation and Planning Team to promote Quality Improvement (QI) sessions aimed at all members of staff, to increase awareness and develop capability for continuous improvement across the Trust.

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.

Indicator	ESHT 16/17	ESHT 17/18	ESHT 18/19	ESHT 19/20	National Average 2019/20	Best Performer 2019/20	Worst Performer 2019/20
Responsiveness to inpatients' personal needs. CQC National Inpatient survey score	66.5%	67.3%	67.2%	66.3%	67.1%	84.2%	59.5%

*CQC National Inpatient survey was published in June 2020.

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

- For the 2018 results, the questions with the lowest scores were reviewed
- The results of the 2017 survey was provided to teams for areas of improvement to be addressed
- The results were used alongside other feedback as part of the data collection for deep dives into clinical areas where further support may have been indicated
- The 2019 survey results have been published and the recommendations are:
    - Ensure support is given to patients who require help when washing.
    - Ensure patients have enough privacy when discussing conditions or treatments.
    - Explore ways of improving feedback received within section 10 "feedback on care and research".
    - Set up a Quality Improvement Project to improve discharge arrangements.
    - Share the results within the trust.
    - Present the results and action plan at Patient Safety and Quality Group.

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

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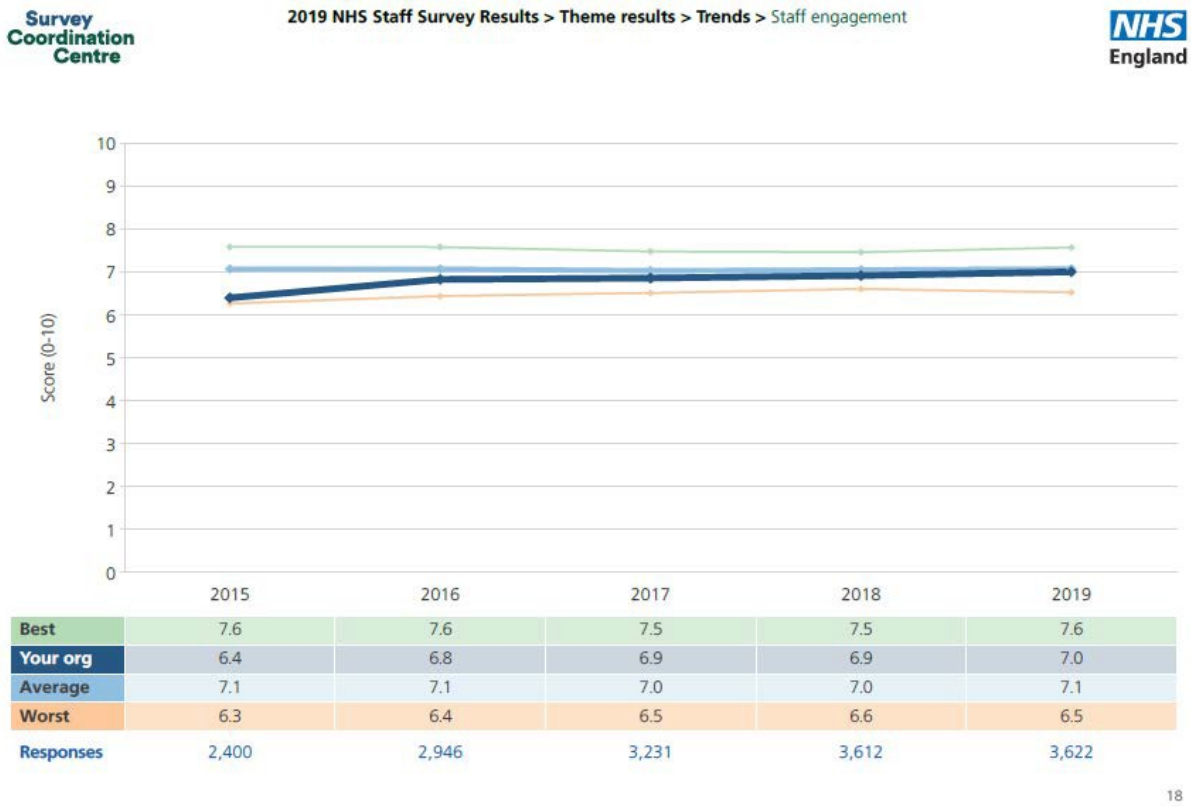
Source: NHS Digital



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Annexes

Annex 1: Statements from the Commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Statement from Commissioners

The Trust has continued to improve the quality and safety of services provided to the residents of East Sussex during 2019/20.
This Quality Account demonstrates improvement in a range of outcomes for the population who access services at ESHT. The Trust has continued to improve its safety culture with key highlights including:

- All relevant recommendations into the “Gosport War Memorial Hospital: The Report of the Gosport Independent Panel (2018)” reviewed and implemented where required;
- A 20% decrease in Sepsis related mortality;
- An 84% decrease in Pressure Ulcers (Grade Three and Four);
- An 18% in patient falls taking place whilst under the care of the Trust;
- A 98% Friends and Family Test (FFT) response;
- Significantly positive patient experience feedback in relation to cancer care; and,
- Improved number of births taking place at the Eastbourne District General Hospital (EDGH) Midwifery Led Unit (MLU).

The 2020/21 Quality Account priorities will ensure the Trust Board is able to seek assurance on the experience of people who are accessing the services provided by the Trust. The Commissioners would like to work with the Trust to improve the quality and safety of services offered to the residents of East Sussex, including the areas outlined below:

- Implementing recommendations based upon the findings of the Staff Survey (2019);
- Improving access and waiting times in relation Ophthalmology services;
- Ensuring that the Trust is effective in undertaking 52 week and 104 day wait clinical harm breach reviews;
- Continue to learn from Serious Incidents;
- Support the national requirement for Trusts’ to have a Board Assurance Framework for Infection Prevention and Control (BAF-IPC);
- Supporting the Trust response to the Patient Safety Incident Response Framework (2019) and,
- Managing the Trust response to COVID 19 as part of the wider Sussex Health and Care Partnership (SHCP).

Overall the CCG has seen evidence of significant quality improvements being made within the Trust during 2019/20. This has been emphasised by the favourable Care Quality Commission (CQC) report published during February 2020 which saw the organisation rated overall as “Good” with “Effective” and “Caring” domains being rated as “Outstanding”.

The commissioners are therefore pleased to endorse this quality account and we look forward to continuing an effective working relationship so we can all drive forward improvements for our local populations during 2020/21.
Yours sincerely,

Allison Cannon
Chief Nursing Officer
On behalf of Sussex NHS Commissioners

Statement from Healthwatch East Sussex

Healthwatch East Sussex remains committed to providing a public statement following the review of the ESHT Annual Quality Account. We feel it is crucial that NHS services can demonstrate to local communities and stakeholders through publishing a Quality Account, which sets out the status, quality and any changes in the services they deliver. However, Quality Accounts remain largely inaccessible for the public and patients to review in a meaningful way and we offer our support to ESHT to address this in future years.
Our approach is to focus on the priorities achieved and agreed going forward and how they reflect what patients tell Healthwatch about their experiences.
The most noticeable achievement for the Trust during the year (2019/20) was achieving an overall rating of 'Good' following its CQC inspection with 'Outstanding' areas awarded in End of Life Care, Effective Care and Community Services. This was a great cause for celebration amongst the community and staff alike and evidenced the improvement journey the Trust publicly committed to and must continue to pursue to achieve an overall rating of 'Outstanding'.
The Quality Account also highlights that demand on the Trust's services is increasing in many departments, which presents further challenges for the Trust in sustainably and consistently delivering high quality services, whilst also managing the increase in demand.
A key priority the Trust achieved in 2019/20 was improving communications with patients so they feel better informed about their care and treatment, positively impacting on the overall patient experience. Excellent communication skills are vital to ensuring better outcomes but also nurture satisfaction and contribute to improving the overall patient experience.
Through our continued engagement with the Trust's Patient Engagement Teams, we will continue to monitor the improvement of communication with patients, families and carers. Whilst it is positive for the Trust to be able to report achievements, and we welcome that, communicating with patients, families and carers does remain one of the most reported themes to Healthwatch where improvements are still required.
As part of the monitoring we undertake on behalf of patients and the public, we will work collaboratively with the Trust to improve patients' experiences in Emergency Departments as new ways of working are developed and come online.
Looking forward to 2020/21, with the unknown outcomes from the impact of a global pandemic, the priorities the Trust has identified are paramount in combating the spread of Coronavirus:

- Embedding Patient Safety
- Infection Control Excellence; and
- Perfecting Discharge

The introduction of the Board Assurance Framework for Infection Prevention and Control, whilst not mandatory, would be a welcome introduction and it is a commitment Healthwatch can monitor as it develops. We will continue to liaise with the Trust on strengthening the relationship with the Executive Board and non-executive members for the coming year, and will continue to share evidence and insight through locally commissioned projects that will assist the Trust in perfecting Hospital Discharge.

John Routledge Executive Director
East Sussex Community Voice (ESCV) delivers Healthwatch East Sussex

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

HOSC has welcomed the Trust's continued positive engagement with the Committee as evidenced by the attendance of the Chief Executive and other senior officers at each meeting.

We extend our congratulations to the staff of ESHT for achieving an overall rating of 'good' from the Care Quality Commission (CQC) following their last inspection. This is a considerable improvement compared to where the Trust was in 2015 and shows that all the hard work and dedication of staff has paid off. We do hope to see continued improvement over the next year or more, and see the Trust achieve its goal of an 'outstanding' CQC rating when it is next inspected.

We were particularly concerned by the culture of bullying and harassment that the CQC uncovered during its 2015 inspection of the trust. However, over the last few years we have seen strong evidence that the senior management team has improved ESHT's organisational culture. We welcome the trust's achievement of a good rating in the well-led domain as evidence of this improvement.

The removal of ESHT from quality and financial special measures over the past two years is to be commended. The forecast of achieving financial balance for 2020/21 should also be seen as a considerable achievement, given the financial issues the Trust has endured for several years. Combined with the considerable capital investment the Trust has been allocated, we hope this will result in more improvements to the care provided to patients in East Sussex in the years to come.

The Trust appears to have adapted to the Covid-19 pandemic as well as can be expected and we hope to see it weather the storm over the next few months. The Committee hopes that, as the second wave intensifies over winter, the trust is able to continue to deliver a degree of elective surgery to patients whilst maintaining strong infection control measures. If it is necessary to move certain services offsite for a temporary period of time, HOSC would expect these to be returned to normal as soon as is reasonably practicable.
The Committee also expects to hear formal proposals from the trust over the next year on its plans for its Cardiology and Ophthalmology services.

Despite seeing many considerable improvements to the Trust, HOSC is committed to its role as a 'critical' friend of the Trust and will continue to hold it to account for its performance on behalf of East Sussex residents.

The HOSC extends its thanks to the outgoing Chief Executive of ESHT, Dr Adrian Bull, and wishes him well in his retirement. We look forward to working with the new Chief Executive, Joe Chadwick-Bell, over the coming year.

2019/20 Quality Priorities
HOSC welcomes the Trust's achievement of all four of its Priorities for Improvement 2019/20.

The Committee is glad to see that compliance with sepsis screening was good at the beginning of the year. The drop in compliance due to Covid-19, however, is hopefully a short term issue and we hope that the review of the sepsis protocol will resolve it.
We also welcome the achievement of delivery against the four priority 7 Day Hospital Services (7DS) standards, particularly Standard 8 – ongoing consultant-directed review – which had not yet been achieved this time last year. We note that the audit was completed in March 2020 and hope that Covid-19 has not disrupted the compliance rate, or if it has that it can be restored in short order.

ESHT identifies the introduction of the Nerve Centre live bed state system as key component of achieving further improvements in many of these Quality Priority areas into 2020/21, due to its ability to support real time tracking of patients. We said last year we hoped to see it in place and note that it has been delayed, and will potentially delayed further due to Covid-19. We restate here our hope it is in place as soon as reasonably practicable and hope to see evidence of its success.

2020/21 Quality Priorities
We understand that ESHT has had to amend its Quality Priorities for 2020/21 in light of the impact of Covid-19.

The inclusion of a priority around infection control excellence would seem to be an important self-assessment tool in the Trust's response to Covid-19. We hope to see the Board Assurance Framework for Infection Prevention and Control (BAF-IPC) in place in the coming months. We also hope that it is able to show evidence of the performance of the trust and identify areas where it needs to improve. We hope this will help to ensure the Trust achieves low levels of hospital transmission compared to national rates.

As the Trust identifies, improving communications with patients around the discharge process will help reassure them and provide a better patient experience overall. We hope to see the Trust Improve communication with patients and be able to provide evidence– such as through the National Inpatient Survey – that patients have improved satisfaction levels. We hope that the Trust's achievement of these priorities will put it in a strong position to achieve its goal of being an outstanding and improving organisation.

Councillor Colin Belsey
East Sussex Health Overview and Scrutiny Committee

Annex 2: 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

Mrs Joe Chadwick-Bell
Chief Executive

DATE

Steve Phoenix
Chairman

DATE

Annex 3: Independent Practitioner's Limited Assurance Report on the Quality Account

As part of the 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic' guidance from NHS England/NHS Improvement, there is no requirement for independent assurance for the Quality Account 2019/20.

Appendices

Appendix 1 – Integrated Performance Report

Safety and Quality

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-19	Mar-20	Var	2018/19	2019/20	Var		
Total patient safety incidents reported	M	917	794	-13.4%	11961	11569	-3.3%	964	
% Patient safety incidents with no harm or near miss	70.0%	79.4%	76.3%	-3.1%	81.8%	79.3%	-2.5%	79.3%	
Number of Patient safety incidents with no harm or near miss (1)	M	728	606	-16.8%	9784	9171	-6.3%	764	
Number of Patient safety incidents with low harm (2)	M	180	180	0.0%	2037	2211	8.5%	184	
Number of Patient safety incidents with moderate harm (3)	M	6	7	16.7%	107	130	21.5%	11	
Number of Patient safety incidents causing severe harm or death (4&5)	M	3	1	-66.7%	33	56	69.7%	5	
% Patient safety incidents causing severe harm or death	0.0%	0.3%	0.1%	-0.2%	0.3%	0.5%	0.2%	0.5%	
Number of Serious Incidents	M	4	3	-1	45	68	23	6	
Number of Never Events	0	0	0	0	1	4	3	0	
Number of medication administration incidents	M	34	15	-55.9%	373	237	-36.5%	20	
Total falls	M	140	121	-13.6%	1508	1442	-4.4%	120	
Number of no-harm falls	M	105	87	-17.1%	1109	1043	-6.0%	87	
Number of minor/moderate falls	M	35	33	-5.7%	391	378	-3.3%	32	
Number of major falls	0	0	1	1	8	21	13	2	
Number of catastrophic falls	0	0	0	0	0	0	0	0	
All patient falls per 1000 Beddays	5.5	6.3	6.0	-0.3	5.7	5.4	-0.30	5.0	
All patient falls with harm per 1000 Beddays	M	1.6	1.7	0.1	1.5	1.5	-0.01	1.4	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	2.0	2.7	35.2%	2.2	2.3	4.1%	2.3	
Number of grade 2 pressure ulcers	M	44	54	22.7%	565	588	4.1%	49	
Number of grade 3 to 4 pressure ulcers	M	1	1	0	8	14	6	1	
Pressure ulcer assessment compliance	M	89.8%	96.8%	7.0%	82.7%	96.1%	13.4%	96.1%	
VTE Assessment compliance	95.0%	96.6%	94.4%	-2.2%	95.9%	95.0%	-0.9%	95.0%	
Number of MRSA Cases	0	1	0	-1	2	3	1	0	
Number of Cdiff cases	4	2	5	3	51	50	-1	4	
Number of MSSA cases	M	4	1	-3	18	21	3	2	
Emergency Re-Admissions within 30 days	10.0%	11.3%	15.0%	3.7%	10.9%	14.0%	3.1%	14.0%	
Crude Mortality Rate	M	1.5%	1.9%	0.4%	1.4%	1.5%	0.1%	1.4%	
HSMR (CHKS)	M								
SHMI (NHS Digital)	M								
Number of complaints received	M	47	33	-29.8%	557	583	4.7%	49	
Inpatient FFT response rate	45.0%	48.7%	38.6%	-10.1%	44.1%	43.7%	-0.4%	43.7%	
Inpatient FFT score	96.0%	97.5%	98.8%	1.2%	97.5%	97.7%	0.2%	97.7%	
A&E FFT response rate	22.0%	6.8%	7.6%	0.8%	5.3%	6.2%	0.8%	6.2%	
A&E FFT score	88.0%	90.7%	96.9%	6.2%	92.5%	93.7%	1.2%	93.7%	
Outpatient FFT Score	M	96.2%	98.2%	1.9%	97.5%	97.7%	0.3%	97.7%	
Maternity FFT response rate	45.0%	16.9%	26.5%	9.6%	14.7%	24.6%	9.9%	24.6%	
Maternity FFT score	96.0%	97.4%	95.2%	-2.3%	97.2%	97.0%	-0.1%	97.0%	
Accommodation and Moves									
Mixed Sex Accommodation breaches - patients affected	0	37	89	52	1009	984	-25	82	
All ward moves	M	2264	1863	-17.7%	27562	26509	-3.8%	2209	
Night ward moves	M	409	367	-10.3%	5035	5066	0.6%	422	

Leadership and Culture

TRUST													
WORKFORCE CAPACITY	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend line
Budgeted fte	7054.8	7026.4	7031.9	7070.5	7065.2	7123.4	7211.8	7209.5	7226.2	7246.8	7247.3	7247.9	
Total fte usage	6754.9	6650.6	6659.1	6655.8	6701.7	6784.6	6799.4	6898.3	6880.2	6880.6	6963.0	7057.7	
Variance	-299.9	-375.8	-372.9	-414.7	-363.5	-338.8	-412.4	-311.2	-346.0	-366.2	-284.4	-190.2	
Substantive vacancies	670.6	700.6	677.8	722.7	688.1	685.2	743.9	672.6	690.2	670.6	646.4	612.9	
Fill rate	90.2%	89.7%	90.1%	89.5%	90.0%	90.2%	89.5%	90.5%	90.2%	90.5%	90.9%	91.3%	
Bank fte usage (as % total fte usage)	8.0%	7.1%	7.0%	7.2%	7.5%	7.8%	7.4%	7.6%	7.6%	7.4%	7.9%	8.3%	
Agency fte usage (as % total fte usage)	1.3%	1.4%	1.2%	1.4%	1.4%	1.4%	1.4%	1.6%	1.3%	1.4%	1.5%	1.9%	
Turnover rate	11.0%	10.8%	10.7%	10.4%	10.3%	10.4%	10.4%	10.1%	9.9%	10.0%	10.1%	10.1%	
Stability rate	0.9	0.9	0.9	91.2%	91.0%	91.2%	89.4%	91.7%	91.9%	91.6%	91.5%	91.7%	
SICKNESS ABSENCE	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend line
Annual sickness rate	4.2%	4.3%	4.3%	4.4%	4.4%	4.4%	4.4%	4.4%	4.5%	4.5%	4.5%	4.6%	
Monthly sickness rate (%)	4.1%	3.9%	4.1%	4.6%	4.5%	4.1%	4.4%	4.8%	5.0%	5.0%	4.7%	4.9%	
Short term sickness (<28 days)	54.4%	46.4%	44.8%	44.2%	43.7%	56.0%	47.1%	47.1%	44.8%	50.8%	51.2%	50.2%	
Monthly long term sickness (28 days+)	45.6%	53.6%	55.2%	55.8%	56.3%	44.0%	52.9%	52.9%	55.2%	49.2%	48.8%	49.8%	
MANDATORY TRAINING & APPRAISALS	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend line
Appraisal rate	78.7%	78.1%	77.0%	78.6%	78.6%	79.5%	79.6%	79.3%	79.8%	79.2%	79.4%	78.8%	
Fire	87.5%	87.9%	88.0%	89.0%	89.9%	89.7%	90.5%	90.2%	89.9%	89.7%	89.0%	88.1%	
Moving & Handling	92.4%	92.6%	92.5%	92.6%	92.7%	91.3%	90.2%	91.3%	90.9%	89.9%	89.8%	89.5%	
Induction	94.1%	98.2%	92.6%	90.9%	91.8%	92.4%	94.4%	91.0%	92.0%	88.6%	96.5%	96.2%	
Infec Control	91.7%	91.8%	91.9%	92.0%	92.6%	91.8%	92.3%	92.0%	91.3%	91.2%	90.4%	90.4%	
Info Gov	79.8%	80.5%	81.6%	82.8%	83.6%	84.3%	86.3%	87.2%	86.9%	86.7%	87.5%	86.9%	
Health & Safety	88.8%	90.2%	90.8%	91.4%	91.3%	91.5%	92.3%	92.9%	92.9%	93.0%	93.0%	93.3%	
MCA	74.9%	73.6%	73.9%	73.6%	76.8%	74.5%	74.5%	75.8%	75.9%	76.2%	76.6%	76.2%	
DoLs	72.3%	71.0%	72.1%	71.9%	71.9%	72.1%	72.1%	73.1%	73.7%	74.3%	74.2%	74.2%	
Safeguarding Vulnerable Adults	88.4%	87.5%	88.2%	87.7%	87.9%	87.3%	87.3%	90.0%	90.1%	90.1%	90.3%	89.8%	
Safeguarding Children Level 2	89.2%	87.6%	88.9%	89.1%	88.6%	88.5%	88.5%	87.0%	88.8%	89.0%	89.1%	88.8%	

Appendix 2 – National Clinical Audit and National Confidential Enquiries Programme

National clinical audits and national confidential enquiries we were eligible to participate in during 2019-2020.

National Confidential Enquiries	**ESHT Eligible**	**ESHT Participation**
Maternal, newborn and infant and perinatal mortality (MBRRACE-UK)	**Y**	**Y**
Child Health Clinical Outcome Review Programme	**Y**	**Y**
NCEPOD – Dysphagia in Parkinson's Disease	**Y**	**Y**
NCEPOD – In hospital management of out of hospital cardiac arrest	**Y**	**Y**
NCEPOD – Acute Bowel Obstruction	**Y**	**Y**
National Clinical Audit	**ESHT Eligible**	**ESHT Participation**
Adult Community Acquired Pneumonia	**Y**	**Y**
Mandatory Surveillance of Bloodstream Infections and C. Diff infection	**Y**	**Y**
National Audit of Care at the End of Life	**Y**	**Y**
UK Parkinson's Audit	**Y**	**Y**
National Audit of Seizures and Epilepsies in Children & Young People (Epilepsy 12)	**Y**	**Y**
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	**Y**	**Y**
National Maternity and Perinatal Audit (NMPA)	**Y**	**Y**
Neonatal Intensive and Special Care (NNAP)	**Y**	**Y**
National Endocrine and Thyroid national audit	**Y**	**Y**
Adult Critical Care Audit (Case mix programme - ICNARC)	**Y**	**Y**
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	**Y**	**Y**
FFFAP – Inpatient Falls	**Y**	**Y**
FFFAP – National Hip Fracture Database	**Y**	**Y**
National Joint Registry (NJR)	**Y**	**Y**
National Gastrointestinal Cancer Audit Programme	**Y**	**Y**
National Audit of Breast Cancer in Older Patients (NABCOP)	**Y**	**Y**
National Prostate Cancer Audit	**Y**	**Y**
National Lung Cancer Audit (NLCA)	**Y**	**Y**
Perioperative Quality Improvement Programme (PQIP)	**Y**	**Y**
Surgical Site Infection Surveillance Service	**Y**	**Y**
Major Trauma (TARN)	**Y**	**Y**
National Audit of Coronary Angioplasty / PCI	**Y**	**Y**
Cardiac Rhythm Management (CRM)	**Y**	**Y**
National Heart Failure Audit	**Y**	**Y**
Acute Coronary Syndrome / Acute MI Audit (MINAP)	**Y**	**Y**
National Audit of Cardiac Rehabilitation	**Y**	**Y**
National Cardiac Arrest Audit (NCAA)	**Y**	**Y**
National Inflammatory Bowel Disease Programme	**Y**	**N**
National Emergency Laparotomy Audit (NELA)	**Y**	**Y**
Elective Surgery (National PROMs Programme)	**Y**	**Y**
National Paediatric Diabetes Audit (NPDA)	**Y**	**Y**
National Pregnancy in Diabetes (NPID) Audit	**Y**	**Y**
National Adult Diabetes Inpatient Audit (NADIA)	**Y**	**Y**
NADIA Harms Audit	**Y**	**Y**
National Diabetes Foot Care Audit (NDFA)	**Y**	**Y**
National Diabetes Adult Audit	**Y**	**Y**
National Diabetes Transition Audit	**Y**	**Y**

Stroke National Audit (SSNAP)	**Y**	**Y**
Learning Disability Mortality Review Programme (LEDER)	**Y**	**Y**
National Smoking Cessation Audit	**Y**	**Y**
National COPD Audit Programme - Pulmonary Rehabilitation	**Y**	**Y**
National COPD Audit Programme – COPD in Secondary Care	**Y**	**Y**
National COPD Audit Programme – Adult Asthma	**Y**	**Y**
National COPD Audit Programme – Paediatric Asthma	**Y**	**Y**
National Audit of Seizure management in Hospitals (NASH)	**Y**	**Y**
Non-Invasive Ventilation – Adults	**Y**	**Y**
Society for Acute Medicine's Benchmarking Audit (SAMBA)	**Y**	**Y**
Serious Hazards of Transfusion (SHOT)	**Y**	**Y**
Assessing cognitive impairment in Older People - Emergency Departments	**Y**	**Y**
Care of Children in Emergency Departments	**Y**	**Y**
Mental Health care in Emergency Departments	**Y**	**Y**
National Ophthalmology Audit	**Y**	**Y**
British Society of Urological Surgeons (BAUS) – Cystectomy Audit	**Y**	**Y**
BAUS – Nephrectomy Audit	**Y**	**Y**
BAUS – Radical Prostatectomy Audit	**Y**	**Y**
BAUS – PCNL Audit	**Y**	**Y**
BAUS – Stress Urinary Incontinence Audit	**Y**	**Y**
Reducing the Impact of serious infections – Antibiotic Resistance and Sepsis	**Y**	**Y**

Appendix 3 – Participation in Mandatory Clinical Audits

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, *and for which data collection was completed during 2019/20*, 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.

Title	Number of Cases submitted	% submitted of those required
UK Parkinson's Audit	Neurology – 21 OT – 11 Physiotherapy – 10 SaLT – 10	100% (all required data submitted)
National Adult Diabetes Audit	Trust – 8796 cases submitted	100% (all required data submitted)
National Adult Diabetes Inpatient Audit	CONQ - 54 EDGH - 54	100% (all required data submitted)
National Paediatric Diabetes Audit	Trust – 155 cases submitted	100% (all required data submitted)
National Pregnancy in Diabetes Audit	CONQ - 13 EDGH - 11	100% (all required data submitted)
National Community Acquired Pneumonia (Adult)	CONQ - 40 EDGH - 118	CONQ – 30% EDGH – 65%
National Non-Invasive Ventilation - Adults	CONQ - 10 EDGH - 12	CONQ – 100% EDGH – 25%
National Smoking Cessation Audit	CONQ - 99 EDGH - 166	100% (all required data submitted)
Society for Acute Medicine's Benchmarking Audit (SAMBA) – June 2019 Round 1	CONQ – 52 EDGH – did not participate	CONQ – 100%
Society for Acute Medicine's Benchmarking Audit (SAMBA) – January 2020 Round 2	CONQ – 41 EDGH – did not participate	CONQ – 100%
Assessing cognitive impairment in older people (RCEM)	CONQ - 69 EDGH - 45	CONQ – 63% EDGH – 41%
Mental Health (RCEM)	CONQ - 77 EDGH - 134	CONQ – 70% EDGH – 100%
Care of Children (RCEM)	CONQ - 95 EDGH - 54	CONQ – 86% EDGH – 49%
Acute Bowel Obstruction (NCEPOD)	12 x Clinical Questionnaires 4 x Case notes 2 x Organisational Questionnaires	100% Clinical Questionnaires 100% Case notes 100% Organisational Questionnaires
Out of Hospital Cardiac Arrest (NCEPOD)	14 x Clinical Questionnaires 18 x Case notes 2 x Organisational Questionnaires	82% Clinical Questionnaires 100% Case notes 100% Organisational Questionnaires
Dysphagia (NCEPOD)	6 x Clinical Questionnaires 8 x Case notes 2 x Organisational Questionnaires	75% Clinical Questionnaires 100% Case notes 100% Organisational Questionnaires

Appendix 4 – Other Non-Mandated National Clinical Audits

The Trust participated in seven non-mandated national audits in 2019/20 as follows:

National Clinical Audit	Specialty
(NASH 3) National Audit of Seizure Management in Hospitals	Accident & Emergency
National Potential Donor Audit (PDA)	Critical Care
ABCD nationwide Libre Audit	Diabetes / Endocrinology
Transforming Motor Neurone Disease Care	Physiotherapy
BHIVA national clinical audit 2019: management pathways for new HIV diagnoses	Sexual Health
BASHH national audit 2019: times to appointment, test results and treatment	Sexual Health
National Chlamydia Screening Programme Audit 2019	Sexual Health

Appendix 5 – Equality Impact Assessment

1.	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?	No	All priorities are underpinned by a commitment to improve the quality of services and outcomes for patients and carers of all protected characteristics.
2.	Has the Quality Account taken into consideration any privacy and dignity or same sex accommodation requirements that may be relevant?	Yes	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.
3.	Is there any evidence that some groups are affected differently?	No	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.
4.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	No discrimination identified
5.	Is the impact of the Quality Account likely to be negative and if so, can the impact be avoided?	No	No negative impact identified

Appendix 6 – Glossary

A

Acute Kidney Injury
Acute Kidney Injury (AKI) is sudden damage to the kidneys that causes them to not work properly. It can range from minor loss of kidney function to complete kidney failure.

Ambulatory Emergency Care
Ambulatory Emergency Care (AEC) is the provision of same-day emergency care for patients who would otherwise be considered for emergency admission.

Anaerobic bloodstream infections
An anaerobic bloodstream infection is caused by anaerobes, which are bacteria that cannot grow in the presence of oxygen.

C

Care Pathway
This is an anticipated care plan that a patient will follow, in an anticipated time frame, and is agreed by a multi-disciplinary team (a team made up of individuals responsible for different aspects of a patient's care).

Care Quality Commission (CQC)
The Care Quality Commission (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: www.cqc.org.uk

Chronic Obstructive Pulmonary Disease (COPD)
Chronic Obstructive Pulmonary Disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. It includes emphysema (damage to the air sacs in the lungs) and chronic bronchitis (long-term inflammation of the airways).

CHKS
CHKS is a provider of healthcare intelligence and quality improvement services. This includes hospital benchmarking and performance information to support decision making and improvement.

Clinical Audit
Clinical Audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clostridium difficile or C. difficile / C.diff
Clostridium difficile (also known as 'C. difficile' or 'C. diff') is a gram positive bacteria causing 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.

Commissioning for Quality and Innovation (CQUIN)
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: www.dh.gov.uk/en/

Culture
Learned attitudes, beliefs and values that define a group or groups of people.

D

Data Quality
Ensuring that the data used by the organisation is accurate, timely and informative.

Data Security and Protection Toolkit (DSPT)
The Data Security and Protections Toolkit (DSPT) is an online performance tool developed by NHS Digital to support organisations to measure their performance against the National Data Guardian's data security standards.

Datix/DatixWeb
On 1st January 2013 ESHT introduced electronic incident reporting software known as DatixWeb. Incidents are reported directly onto the system by any employee of the organisation, about incidents or near misses 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.

Department of Health (DOH)
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.

Deteriorating patient
A patient whose observations indicate that their condition is getting worse

Discharge
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.

Division
A group of clinical specialities managed within a management structure. Each has a clinical lead, nursing lead and general manager.

Duty of Candour (DoC)
Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory duty of candour be introduced for health and care providers. This is further to the contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. In interpreting the regulation on the duty of candour we use the definitions of openness, transparency and candour used by Robert Francis in his report:

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it

E

End of Life Care (EOLC)
End of Life Care (EOLC) is healthcare for patients in the final hours or days of their lives, or for those with a terminal illness or terminal condition that has become advanced, progressive and incurable.

Excellence in Care Programme
The Excellence in Care Programme will provide a framework and ongoing review for quality care and leadership at departmental level. It is identified as a priority in the Patient Safety and Quality Strategy and will empower wards/departments to deliver high quality care through effective leadership and improvement culture.

F

Friends and Family Test (FFT)
The NHS Friends and Family Test (FFT) were created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give their views after receiving care or treatment.

G

General Medical Council (GMC)
The General Medical Council (GMC) is an organisation which maintains the official record of medical practitioners. The GMC also regulates doctors, set standards, investigate complaints.

Guardians of Safe Working Hours (GOSWH)
GOSWHs champion safe working hours for junior doctors. The roles are independent from the Trust management structure and are supported by the British Medical Association (BMA) to:

- Act as champions for safe working hours for junior doctors and students
- Support exception reporting, monitoring and resolving rota gaps

- Oversee compliance with the safeguards set out under the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

H

Health Research Authority (HRA)
The Health Research Authority (HRA) is an executive non-departmental public body of the Department of Health. The HRA exists to provide a unified national system for the governance of health research. Its core purpose is to protect and promote the interests of patients and the public in health and social care research by:

- ensuring research is ethically reviewed and approved
- promoting transparency in research
- overseeing a range of committees and services
- providing independent recommendations on the processing of identifiable patient information where it is not always practical to obtain consent, for research and non-research projects

Healthwatch
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.

Hospital Episode Statistics
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.

Hospital Standardised Mortality Ratio (HSMR)
Hospital Standardised Mortality Ratio (HSMR) is an indicator of whether death rates are higher or lower than would be expected.

I

Integrated Performance Review (IPR)
Meeting attended by members of Trust board, senior leads from the division, Finance, HR, Knowledge Management

K

Key Performance Indicators (KPIs)
Key Performance Indicators, also known as KPIs, help an organisation define and measure progress towards organisational goals. Once an organisation has analysed its mission, identified all its stakeholders, and defined its goals, it needs a way to measure progress towards 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.)

M

Methicillin Resistant Staphylococcus Aureus (MRSA)
MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections.

Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK
The Confidential Enquiry into Maternal Deaths is a national programme investigating maternal deaths in the UK and Ireland. Since June 2012, the CEMD has been carried out by the MBRRACE-UK collaboration, commissioned by the Healthcare Quality Improvement Partnership.

Multidisciplinary
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.

N

National Audit of Dementia
The National Audit of Dementia is commissioned on behalf of NHS England and the Welsh Government. They measure the performance of general hospitals against standards relating to delivery of care which are known to impact people with dementia while in hospital. The standards are from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals charter and reports from the Alzheimer's Society, Age Concern and Royal Colleges.

National Clinical Audit Patient Outcomes Programme (NCAPOP)
Set of national clinical audits, registries and confidential enquiries which measure healthcare practice on specific conditions against accepted standards. These projects give healthcare providers' benchmarked reports on their performance, with the aim of improving the care provided.

National Confidential Enquiry into Patient Outcome and Death – NCEPOD 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 ESHT participate in national enquiries and review the published reports to make sure any recommendations are put in place.

National Institute for Health and Clinical excellence (NICE) 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: www.nice.org.uk

NHS Digital
Formerly the Health and Social Care Information Centre (HSCIC), NHS Digital is the national provider of information, data, IT infrastructure and systems to the health and social care system.

NHS England (NHSE) and NHS Improvement (NHSI)
From 1st April 2019 NHS England and NHS Improvement begun working together as a single organisation, designed to better support the NHS to deliver improved care for patients and support delivery of the NHS Long

Term Plan.

P

Palliative care
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.

Patient Reported Outcome Measures (PROMs)
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 from patients on the reported outcomes of their surgical intervention and compare themselves to other Trusts nationally.

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

Privacy and dignity
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.

Providers
Providers are the organisations that provide NHS services, e.g. NHS trusts and their private or voluntary sector equivalents.

Public Health England (PHE)
Public Health England (PHE) is an executive agency of the Department of Health and Social Care. PHE provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific expertise and support.

R

Research
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.

Research Ethics Committee (REC)
There are more than 80 NHS Research Ethics Committees across the UK. They exist to safeguard the rights, safety, dignity and well-being of research participants.

RECs review research proposals and give an opinion about whether the research is ethical. They also look at issues such as the participant involvement in the research. The committees are entirely independent of research sponsors (the organisations responsible for the management and conduct of the research), funders and the researchers themselves. This enables them to put participants at the centre of their review.

Risk Adjusted Mortality Indicator (RAMI)
The Risk Adjusted Mortality Indicator (RAMI) is a mortality rate that is adjusted for predicted risk of death. It is usually used to observe and/or compare the performance of certain institution(s) or person(s), e.g. hospitals or surgeons.

Root Cause Analysis (RCA)
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.

Royal College of Emergency Medicine (RCEM)
The College is established to advance education and research in Emergency Medicine. The College is responsible for setting standards of training and administering examinations in Emergency Medicine for the award of Fellowship and Membership of the College as well as recommending trainees for CCT in Emergency Medicine. The College works to ensure high quality care by setting and monitoring standards of care and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

S

Safety Huddles
Short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical, the opportunity to understand what is going on with each patient and anticipate future risks to improve patient safety and care.

Secondary Uses Service (SUS)
The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support NHS in the delivery of healthcare services.

Sepsis
The body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure and death.

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 in hospital, other health service premises or other premises where healthcare is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern.

Sign up to Safety
Sign up to Safety is a campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result.
By signing up to the campaign, organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient safety, helping to ensure patients get harm free care every time, everywhere.
Chief Executives of NHS England, The Care Quality Commission, the NHS Trust Development Authority, Monitor, NHS Improving Quality and the NHS Litigation Authority have all signed up to align their work with this campaign.

Speak Up Guardian
A person who supports staff to raise concerns.

Strategy
A high level plan of action designed to achieve long term or overall aims.

Summary Hospital-level Mortality Indicator (SHMI)
SHMI is a hospital-level indictor which measures whether mortality associated with hospitalisation is 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 SMHI value, Trusts are banded between 1 and 3 to indicate whether their SMI is low (3), average (2) or high (1) compare 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.

Surgical Site Infection Surveillance Service (SSISS)
The Surgical Site Infection Surveillance Service (SSISS) helps hospitals across England record and follow-up incidents of infection after surgery, and use these results to benchmark, review and change practice as necessary.

Sussex MSK Partnership East (SMSKPE)
Sussex MSK Partnership East are a local partnership bringing together primary care, specialist musculoskeletal (muscles, joints and bones) care, community, mental health and well-being experts to deliver the whole musculoskeletal service in East Sussex.

Sustainability and Transformation Partnership (STP)
This is an arrangement where NHS health organisations and local authority organisations, clinical commissioning groups and local councils who commission and provide health and care work together. The purpose is to produce a long-term plan outlining how local health and care services will evolve, improve and continue over the next five years.

T

Trauma Audit and Research Network (TARN)
The Trauma Audit and Research Network provides major trauma centre audits and information to help doctors, nurses and service managers to drive improvement.

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.

U

UK Obstetric Surveillance System (UKOSS)
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.

V

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.

VitalPAC VitalPAC is a mobile clinical system that monitors and analyses patients’ vital signs to identify deteriorating conditions and provide risk scores to trigger the need for further necessary care. It removes the need for paper charts and manages scheduled observations based on clinical need.

Winter Flu Self-Assessment

Meeting information:			
Date of Meeting:	01.12.20	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Steve Aumayer

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☒

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state: Public Health England			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Not necessary – outlined within the paper	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

1.1 Seasonal Influenza Campaign

Every year health care providers are asked to support their patient facing staff in receiving a flu vaccine. ESHT has demonstrated a year on year improvement in the number of staff who have been offered and have received a vaccine.

This year has looked very different due to the global pandemic of COVID19 (SARS2-CoV) and in May NHS E/I circulated a letter to health care providers stating that it was essential to have a robust Flu plan for the forth coming season.

Flu is a very common, highly infectious illness most prevalent over the winter months. It can develop into more serious illnesses, such as bronchitis and pneumonia. In the UK, the estimated number of excess deaths thought to be due to seasonal Flu varies each year, but has been as high as 10,000.

Healthcare workers, as members of the general population, are susceptible to Flu. When coupled with the potential for a third of flu cases being transmitted by asymptomatic individuals it means patients are at particular risk.

Flu is unpredictable. Vaccines are adjusted each year to match them as closely as possible to the latest strains and the vaccine provides the best protection available against the virus.

Front line health care workers are actively encouraged to have the Flu vaccination. It can take up to three weeks post vaccination to develop immunity therefore the vaccine is made available to staff at the earliest opportunity within the season.

1.2 ESHT Target for uptake by Frontline Health Care Workers

2017/18 – 70%
2018/19 – 75%
2019/20 – 80%
2020/21 – 90% (as opposed to previous years, this target is not connected to a CQUIN)

1.3 Evaluation and key points of learning from 2019/20 Flu campaign:

Target to vaccinate 80% of front line staff – (4132 staff)
At the end of our flu campaign (March 2020) ESHT had vaccinated 87% of patient facing staff. This percentage represents our most successful flu campaign to date.

Occupational Health feel are the main contributors to this year's success were:

- The dedicated TWS Flu team. The team were responsible for recruitment, training and support for peer vaccinators – started in August and continued throughout the campaign
- The divisional support in recruiting peer vaccinators, including time for training and vaccinating. Sharing information at IPRs led to a divisional improvement in uptake
- The early planning of the Flu campaign
- The "Flu Enquiry" dedicated email improved responses to queries and flu vaccination requests
- Regular data supported the OH flu team in targeting staff groups where support in increasing uptake was required – i.e. Doctors, qualified Nurses, Midwives and Health Visitors
- Support from senior clinical staff in promotion of the Flu campaign with posters throughout the trust which were well received
- Social media presence (in particular Twitter) regarding Flu to better reach staff. This was well received with multiple interactions/retweets
- Availability of flu facts to dispel any myths, ensuring that staff have access to research supporting the efficacy of the vaccine and the accumulative benefit to immunity of having the vaccine every year
- Regular recognition of all staff involved in delivery of the campaign and on its completion in March/April 2020

Frontline staff % uptake since 2016

Staff Group	% uptake in 2016/17	% uptake in 2017/18	% uptake in 2018/19	% uptake in 2019/20	% uptake as of 09.11.20
All Doctors	**39%**	**62%**	**63%**	**81%**	**73%**
Qualified Nurses, midwives and health visitors	**36%**	**60%**	**64%**	**73%**	**97%**
All other professionally qualified clinical staff, which comprises of:- (Qualified scientific, therapeutic and technical staff, Qualified allied health professionals, other qualified ST&T and qualified ambulance staff)	**70%**	**95%**	**90%**	**99%**	**92%**
Support to clinical staff, which comprises of: - Support to doctors and nurses, Support to ST&T staff, Support to ambulance staff.	**81%**	**81%**	**90%**	**99%**	**41%**
Total	**53%**	**72%**	**76%**	**87%**	**73%**

1.4 Plan for 2020/21

No CQUIN target set. Internal target of 90% of patient facing staff to receive the flu vaccine.

- Peer led campaign – to avoid an increase in foot fall to clinical areas, and reduce risk of poor social distancing
- Prompt campaign offering vaccines to staff to prepare the Trust for winter pressures
- A rapid Two phased approach for staff aged 18-64
  - Phase 1 - patient facing staff (w/c 28/09/2020)
  - Phase 2 – all staff (w/c 19/10/2020)

- Dedicated TWS Flu team responsible for recruitment, training and support for peer vaccinators – started in August and continuing throughout the campaign
- Dedicated clinics in OH for non-patient facing staff
- Bespoke clinics held by OH staff to target hard to reach staff i.e. housekeepers etc.
- Divisions supporting peer vaccinators, Assistant Directors of Nursing and Heads of Nursing to nominate a minimum of two peer vaccinators per area
- Request that all Infection Control Link nurses sign up as peer vaccinators – unfortunately uptake from this group has been poor
- Establish a Flu Enquiry dedicated email box to better field and respond to flu requests
- Bespoke clinics arranged following risk assessment for non-patient facing areas
- Continued agreement to keep a static denominator throughout the campaign (will be audited again at the end to determine if this would have impacted on the final uptake figure)
- Targeting of groups where the greatest increase in uptake is required – i.e. Doctors, qualified Nurses, Midwives and Health Visitors
- Continued collection of anonymised data from those who decline the vaccine
- Continued expansion in use of social media – in particular Twitter
- Make research available to staff supporting the efficacy of the vaccine and the accumulative benefit to immunity of having the vaccine every year
- Continued improvements in reporting to facilitate the identification of areas of low uptake and to target efforts
- Ongoing recognition of all staff who are supporting or have been involved in delivery of the campaign
- **Flu campaign has to be completed in by end of November 2020 due to anticipated impact of COVID vaccine roll out (see risks)**

1.5 Risks to success of the campaign

- Increased workload demands because of COVID19 on top of existing winter pressures may reduce front line staff ability to take on or fully deliver the peer vaccinator role
- Social distancing and COVID safety
- Written instruction only includes RGN as peer vaccinators, which limits the number or peer vaccinators
- National restrictions on increasing orders of flu vaccines could result in a vaccine shortage locally
- Rapid roll out of the campaign may not give enough time to capture all staff
- Recent notification from NHS E/I that flu campaign has to be completed by end of November as there must be a clear 7 day break from receiving the flu vaccine before the COVID vaccine can be given
- Trivalent vaccine not ordered for staff as 400 vaccines ordered by IPC for patient use, historically this stock has been shared (in previous less than 25 staff who are 65+ have had their vaccine via OH)
- Due to unclear national direction on how to access further stock IPC unable to share the 400 vaccines. Staff aged 65+ advised to access their vaccines via their GP

3. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

- Flu Team – weekly since September 2020
- Infection Prevention and Control – Helen Tingley & Lisa Redmond – ongoing
- HSSG – ongoing
- OH&W governance group - monthly
- OD & Engagement – Lorraine Mason – on agenda from October 2020

4. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

- Board acknowledgement that the ambition of 90% of patient facing staff being vaccinated may not now be achievable given the need to complete the flu campaign by the end of November
- The board will receive a review of the flu campaign 2020/21 in the New Year

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2020

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	**Yes – process established for anonymous decliners**
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	**Yes- supported by Heather Fowler in Pharmacy**
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	**Yes attached**
A4	Agree on a board champion for flu campaign	**Yes – Chief People Officer**
A5	All board members receive flu vaccination and publicise this	**All board members have been offered the vaccine.**
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	**Yes – linked with JSC**
A7	Flu team to meet regularly from September 2019	**Yes – weekly**
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	**Yes –available on the extranet or leaflets available for staff**
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	**No. Drop in clinics and roaming vaccinators have not been supported this year to ensure social distancing and the reduction of avoidable footfall to areas**
B3	Board and senior managers having their vaccinations to be publicised	**All board members have been offered the vaccine.**

B4	Flu vaccination programme and access to vaccination on induction programmes	**No- flu vaccination for those in clinical areas available from peer vaccinators, those in non-patient facing areas are able to book an appointment.in OH.**
B5	Programme to be publicised on screensavers, posters and social media	**Yes – Communications team leading**
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	**Yes - weekly updates provided to the board and service leads- the electronic documentation supports this process. Divisions given data in preparation for their IPRs.**
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	**Yes – continuing to recruit in all areas. Improved training and support for 2019/20**
C2	Schedule for easy access drop in clinics agreed	**No – previous learning has shown that drop is clinics are not always best approach, however in 2020 also aboded to ensure social distancing can be maintained in the OH dept.**
C3	Schedule for 24 hour mobile vaccinations to be agreed	**No – though vaccine will be made available out of hours to night staff via peer vaccinators.**
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	**Yes – Communications team leading**
D2	Success to be celebrated weekly	**Yes – weekly update in Comms**

Learning from Deaths 1st April 2017 to 30th June 2020

Meeting information:			
Date of Meeting:	1st December 2020	Agenda Item:	11.1
Meeting:	Trust Board	Reporting Officer:	David Walker

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSI/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? No	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The attached report on "Learning from Deaths" follows the requirements set out by the Care Quality Commission. The mortality database was designed to reflect this process and has also been updated to incorporate the Medical Examiner review process which commenced at the Trust on September 1st.

The Medical Examiner process is working well so far, ensuring compliance with the legal and procedural requirements associated with current and proposed reformed processes of certification, investigation by coroners and registration of deaths.

Cases referred by the Medical Examiners for further scrutiny are highlighted to divisions and discussed at specialty Mortality and Morbidity meetings.

The current "Learning from Deaths" report details the April 2017 – June 2020 deaths recorded and reviewed on the mortality database. The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability on a quarterly basis, to ensure accuracy in reporting.

Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme however, feedback to individual Trusts from these external reviews is extremely slow. Internal reviews therefore continue, in order to mitigate any risk.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

N/A

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board are requested to note the report. "Learning from Deaths" reports are required on a quarterly basis.

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard June 2020-21

Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

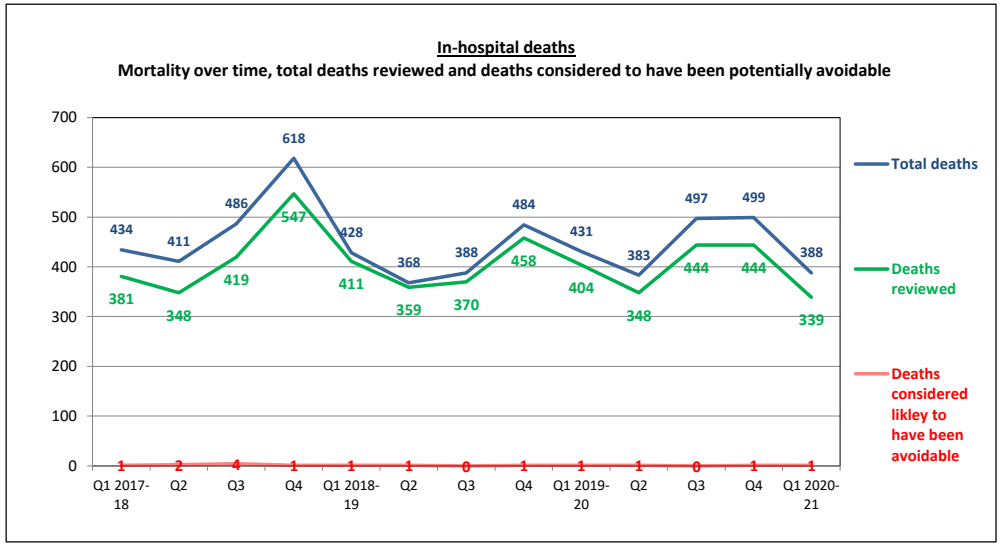
Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 09/11/2020)

Total number of in-hospital deaths, deaths reviewed and deaths deemed avoidable (does not include patients with identified learning disabilities)

Time Series:	Start date	2017-18	Q1

End date	2020-21	Q1

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
120	107	92	99	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
388	499	339	444	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
388	1810	339	1640	1	3



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	25.0%	This Quarter (QTD)	2	50.0%	This Quarter (QTD)	1	25.0%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	25.0%	This Year (YTD)	2	50.0%	This Year (YTD)	1	25.0%	This Year (YTD)	0	0.0%

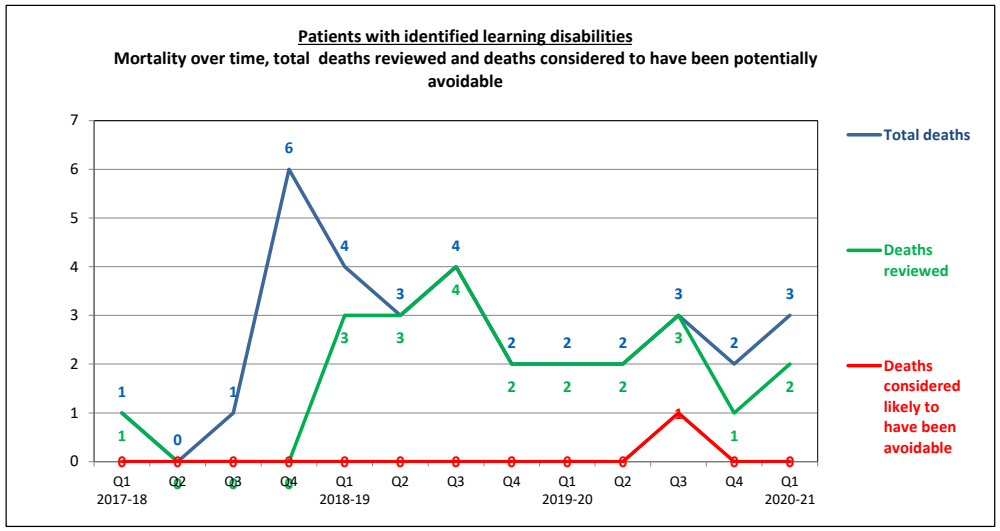
Data above is as at 09/11/2020 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were no care concerns expressed to the Trust Bereavement team relating to Quarter 1 2020/21 deaths.
Complaints - Of the complaints closed during Quarter 1 2020/21 which were relating to 'bereavement', none have overall care ratings of 'poor care' on the mortality database.
Serious incidents - There was one severity 5 incident reported in Quarter 1 2020/21. This case was discussed at the Mortality Review Audit Group where an avoidability rating of 3 - probably avoidable (more than 50:50) was agreed.
As at 09/11/2020 there are 543 April 2017 - June 2020 deaths still outstanding for review on the Mortality database.

Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 09/11/2020)

Total number of deaths, deaths reviewed and deaths deemed avoidable for patients with identified learning disabilities

Time Series:	Start date	2017-18	Q1	End date	2020-21	Q1

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	2	2	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	9	2	8	0	1



The LeDeR (learning disability mortality review) programme is now in place and the learning disability deaths are being reviewed against the new criteria externally. Feedback from these external reviews will be received by the Trust in due course. Prior to the national requirement to review learning disability deaths using the national LeDeR methodology, the deaths were reviewed by the learning disability nurse and Head of nursing for safeguarding who entered their review findings on the mortality database.
As feedback from the wider external LeDeR has not yet been received, the internal reviews are being continued in order to mitigate against any risk.

Infection Prevention & Control – Annual Report 2019/2020

Meeting information:			
Date of Meeting:	1st December 2020	Agenda Item:	11.2
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

Purpose of paper: (Please tick)			
Assurance	☐	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2019/20. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, achievements and challenges are presented.

The prevention of avoidable infections is fundamental to safe patient care. Prevention and control of healthcare associated infections (HCAIs) remains a priority for ESHT and we have a programme of activities to implement national initiatives and reduce infection rates. ESHT employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection but it is the responsibility of all staff in the organisation to comply with Trust policies and implement these. The Trust reports performance and activities related to IPC regularly throughout the year to the local clinical commissioning groups (CCGs).

Key points during 2019/20 were:

- A new infectious disease caused by SAR-CoV-2 a new form of coronavirus, has emerged and spread worldwide resulting in a global pandemic. The first cases identified at ESHT occurred in March 2020. The infection dominated the work of the IPCT in the later quarter of 2019/20 as the full support of the IPCT was required with the emergency response.
- The number of MRSA bacteraemia cases reported was 3 avoidable infections. Peripheral cannulas were associated with MRSA and MSSA bacteraemias.
- *Clostridium difficile* infections (CDI) limit was achieved. The trust reported 51 cases from 51 patients, against a limit of 68. There was one lapse in care likely to have contributed to the development of CDI related to antimicrobial prescribing.

- The mandatory orthopaedic surgical site infections surveillance scheme data indicates that the incidence of infection with orthopaedic hip and knee surgery has returned within national limits for the year 2018/19 (most current report). Participation in the national improvement project to reduce surgical site infection in primary hip and knee surgery continued.
- The incidence of E. coli bacteraemia reduced by 27%.
- There were a small number of outbreaks of seasonal influenza and norovirus that were well managed.

The full IPC annual report for 2019/20 is available in the appendix to the Board papers.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

- Monthly reports are presented to Trust Infection Prevention & Control Group and the Patient Safety and Quality Group.
- Annual report was reviewed by TIPCG - November 2020.
- Quality & Safety Committee – 19 Nov 2020

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

For approval.

Complaints Annual Report 2019/20 data

Meeting information:	
Date of Meeting: 1st December 2020	Agenda Item: 11.3
Meeting: Trust Board	Reporting Officer: Vikki Carruth

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The Complaints and PALS Annual Report 2019/20 details the activity of the Complaints Team and Patient Advice and Liaison Service (PALS) at East Sussex Healthcare NHS Trust for the year 2019/20. All data provided has been extracted from Datix, the risk management database the Trust uses for recording complaints and contacts with PALS, and is presented alongside data for the previous three years for comparative purposes and trend analysis.

- The Trust received 583 new complaints across all services in 2019/20; this represents an increase of just 25 complaints compared to 2018/19 (n=558).
- The Trust acknowledged 100% of new complaints within three working days.
- The Trust's process for reporting compliance with published complaint response timescales was reviewed in December 2019, following observations made by the Care Quality Commission (CQC) during their inspection the previous month when they reviewed a sample selection of complaint files. Please see section 3.4, which starts on page 10, for more information on this.
- There were 58 complaints reopened in 2019/20; this represents a reopen rate of 9.6% of all complaints closed in the year period, and demonstrates a further sustained reduction in numbers compared to 2018/19 (n=80/13.4% of all complaints closed).
- There were 14 complaints overdue at the end of 2019/20. This was in part due to the review of the process for recording response times, coupled with clinical and operational pressures during the emergence of the COVID-19 pandemic in March 2020.

- There was a reduction in the number of PALS contacts for 2019/20 (n=6,611) compared to 2018/19 (n=6,805); this was the third consecutive year with a drop in contacts since 2016/17.

- Finally, the Trust received 18 contacts and 13 case outcomes from the Parliamentary and Health Service Ombudsman (PHSO) in 2019/20 (please note some of the outcomes relate to cases the PHSO had opened in previous years). Of the outcomes provided, the PHSO decided not to investigate seven cases they had considered, three cases were investigated but not upheld in favour of the complainant and three cases investigated were partially upheld in favour of the complainant.

The objectives for the Complaints Team in 2020/21 are:

- To ensure a satisfactory rate of compliance with the published complaint response timescales based on the principles agreed in December 2019; and

- To review the way the Complaints Team works with clinical divisions to more proactively identify, log, monitor, deliver and evidence learning arising from complaints, and to regularly publish these examples of learning.

The full Complaints and PALS annual report for 2019/20 is available in the appendix to the Board papers.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality and Safety Committee 22nd October 2020.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

To receive the report.

Annual Safeguarding Report - 2019/2020

Meeting information:			
Date of Meeting:	1st December 2020	Agenda Item:	11.4
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state: ……N/A……			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

It has been another busy year for safeguarding with the additional impact of the Cov19 Global Pandemic taking effect late in Q4.

It was anticipated that a lockdown would significantly impact on vulnerable people and families and this has sadly proven to be the case. The team have seen significant increases in the numbers and complexities of cases for both adults and children. Similarly for patients requiring mental health support specialist services are now seeing a huge increase in demand.

Information is being shared via the usual safeguarding groups and committees and next year's annual report will provide more detail and breakdown.

This report provides information regarding the key issues that have arisen from national and local safeguarding guidance and incidents. Achievements and challenges are also discussed with more detailed information regarding the various elements of safeguarding.

The key areas to note for 2019/2020 include;

- A move to adopt a "Think family" approach to ensure better transition and alignment between children's and adult's services with significant changes to training and practice.
- A redesign of Mental Capacity Act and Deprivation of Liberty training and support to staff, moving to e-solutions, following a review of training and staff knowledge.
- Strengthened arrangements and continued close working with Mental Health colleagues to ensure where patients are sectioned and admitted to ESHT that governance is strong. There are still challenges at times with access and capacity to specialist MH Services for adults and children, which is a national challenge. There is a significant impact on the EDs.

- Update on the HIDVA post.
- Ensuring awareness and training are current including county lines, cuckooing, human trafficking, modern slavery and abuse involving coercion and control.
- Update on services for Looked After Children.
- An increase in the delivery of Safeguarding Supervision in Adult and Child Specialist areas, specifically the community which has seen an increase in patients who self-neglect and more complex caseloads.

The full Safeguarding annual report for 2019/20 is available in the appendix to the Board papers.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

ESHT Professional Advisory Group
ESHT Safeguarding Operational Committee
ESHT Safeguarding Strategic Group
Multiagency SAB Board
Multiagency LSCB Board
Quality & Safety Committee – 19 Nov 20

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

Continued support for the safeguarding agenda.

Trust Board Meetings in Public 2021

Due to Covid, we are currently planning to hold all of our meetings virtually in 2021 using MS Teams. Members of the public can attend these meetings, but we ask them to do so with cameras and microphones off. They will have the opportunity to ask questions at the end of each meeting.

Should circumstances change then we will consider whether meetings can be changed from MS Teams to in person.

9th February		0930 - 1230
13th April		0930 - 1230
8th June		0930 - 1230
13th July	**AGM**	1400 – 1700
10th August		0930 - 1230
12th October		0930 - 1230
14th December		0930 - 1230

Use of Trust Seal

Meeting information:			
Date of Meeting:	1st December 2020	Agenda Item:	16
Meeting:	Trust Board	Reporting Officer:	Chair

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The purpose of this paper is to provide an overview of the use of the Trust Seal since the last Board meeting.

Sealing 58 – Salisbury Trading Ltd, 1st October 2020
Laundry Lease at EDGH for a 3 year term.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Not applicable.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to note the use of the Trust Seal since the last Board meeting.

East Sussex Healthcare NHS
NHS Trust

Infection Prevention & Control

Annual Report
2019 - 2020

"Our patients will not be harmed by a preventable infection"

NHS
ESHT
Infection Prevention and Control

CONTENTS

Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2019/20. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements and challenges are presented.

The prevention of avoidable infections is fundamental to safe patient care. Prevention and control of healthcare associated infections (HCAIs) remains a priority for ESHT and we have a programme of activities to implement national initiatives and reduce infection rates. ESHT employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection but it is the responsibility of all staff in the organisation to comply with Trust policies and implement these. The Trust reports performance and activities related to IPC regularly throughout the year to the local clinical commissioning groups (CCGs).

Key points during 2019/20 are:-

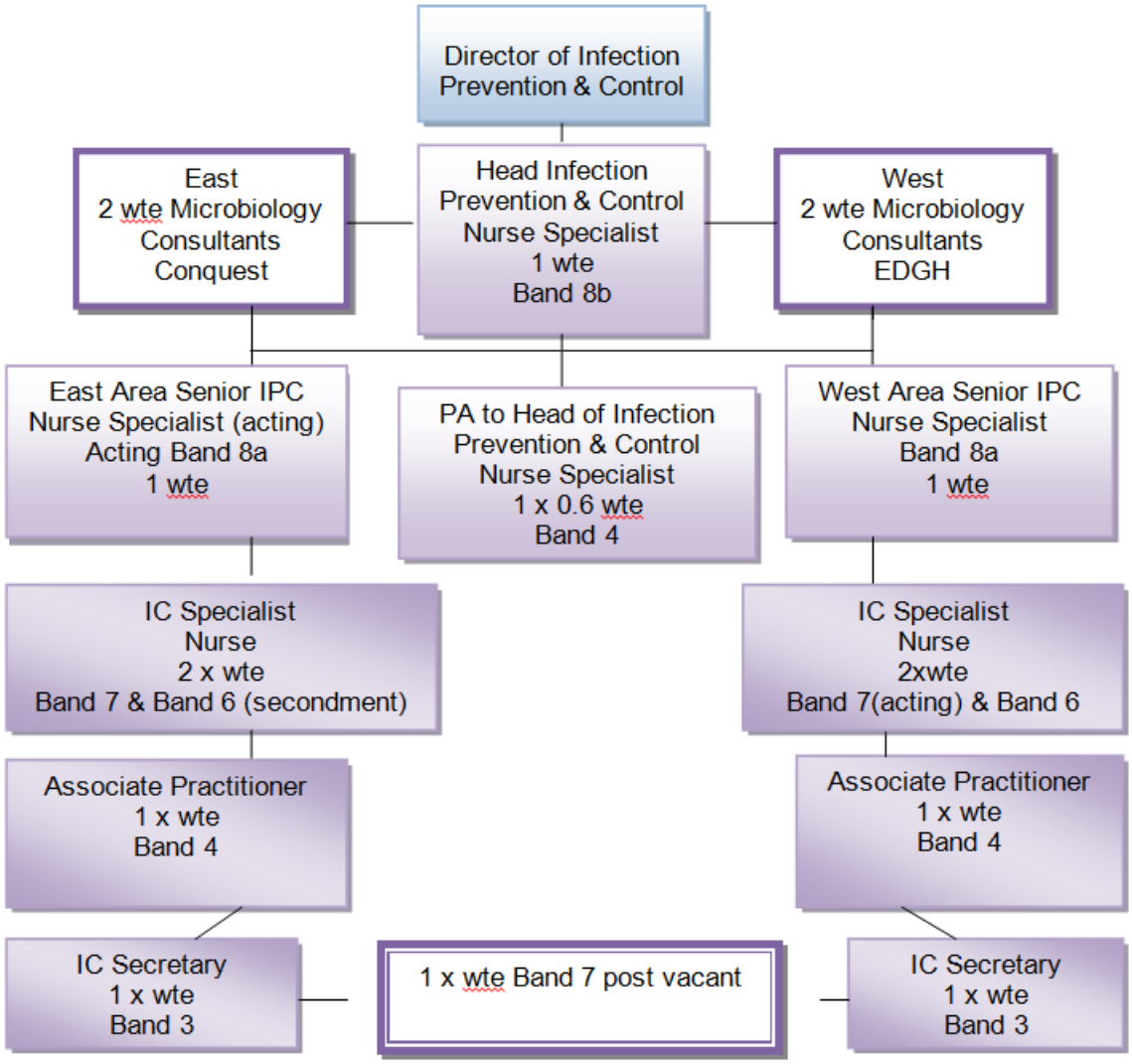
- A new infectious disease caused by SARsCoV-2 a new form of coronavirus has emerged and spread worldwide resulting in a global pandemic. The first cases identified at ESHT occurred in March 2020. The infection dominated the work of the IPCT in the later quarter of 2019/20 as the full support of the IPCT was required with the emergency response.
- A serious incident was reported in response to an outbreak of COVID-19 involving staff and patients at the Bexhill Irvine Unit in March 2020.
- The number of MRSA bacteraemia cases reported was 3 avoidable infections.
- Peripheral cannulas were associated with MRSA and MSSA bacteraemias.
- *Clostridium difficile* infections (CDI) limit was achieved. The trust reported 51 cases from 51 patients, against a limit of 68. There was one lapse in care likely to have contributed to the development of CDI related to antimicrobial prescribing.
- The mandatory orthopaedic surgical site infections surveillance scheme data indicates that the incidence of infection with orthopaedic hip and knee surgery has returned within national limits for the year 2018/19 (most current report). Participation in the national improvement project to reduce surgical site infection in primary hip and knee surgery continued.
- The CQUIN for reduction of antimicrobial consumption was achieved and the incidence of E. coli bacteraemia reduced by 27%.
- There were a small number of outbreaks of seasonal influenza and norovirus that were well managed.

Lisa Redmond, Head of Infection Prevention and Control

1. Structure

The Chief Nurse is the Executive Lead and Director of Infection Prevention and Control (DIPC), within the Trust and sits on the Trust Board.

Infection Prevention & Control Team Structure

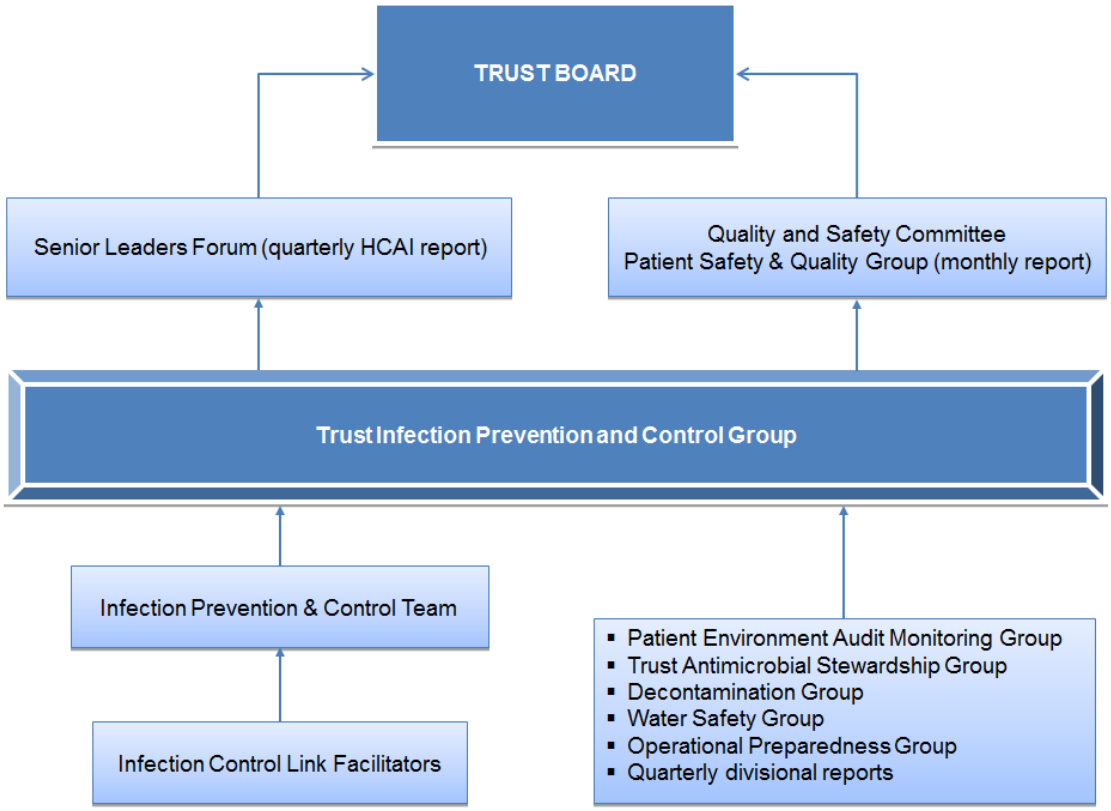


The IPCT comprises of specialist Infection Prevention and Control nurses and administrative staff. Two area teams (East and West) based in each of the acute hospital sites provide Infection Prevention and Control support to all ESHT services in their local area (acute, community, inpatient and domiciliary).

In addition to the IPCT, the Trust also funds 4 x wte Consultant Microbiologist posts (2 on each acute site) based within the Diagnostics Anaesthetics and Surgery Division who work closely with the IPCT, one of whom undertakes the role of Infection Prevention and Control Doctor.

An Orthopaedic Surgical Site Infection Surveillance Nurse is appointed within the Diagnostics Anaesthetics and Surgery Division and an Antimicrobial Prescribing Lead post is appointed within the Out of Hospital Division.

1.1 Infection Prevention & Control internal reporting arrangements



The Trust Infection Prevention and Control Group (TIPCG) is chaired by the DIPC/ Chief Nurse Director of Nursing. The Group meets monthly and has wide representation from throughout the Trust including from Clinical Units, Occupational Health, Pharmacy, Commercial Division and also external membership from the local department of Public Health England (PHE). The TIPCG reports monthly to Patient Safety and Quality Group regarding performance and operational issues and also compliance against Outcome 8 Regulation 12 "Cleanliness and Infection Control" Health & Social Care Act 2008. (See reporting structure in 1.1)

Each of the Clinical Units report directly to the TIPCG on compliance with regulatory standards for IP&C. Clinical Matrons and Clinical Managers have the responsibility for the prevention and control of infection in their local area in line with national and local policies and guidelines. Each clinical department has appointed an Infection Control Link Facilitator (ICLF) who with educational support and guidance from the IPCT is responsible for cascading and monitoring compliance with Infection Prevention and Control practices at local level.

1.2 Infection Prevention & Control external reporting arrangements

Externally, the DIPC or Head of IPC report directly on performance to the CCG Head of Quality and Nursing and the Clinical Quality Review Group (CQRG) held by the local clinical commissioning groups (CCGs);

- Hastings & Rother CCG
- Eastbourne Hailsham and Seaford CCG

1.3 Infection Control Link Facilitators

There are approximately 80 Link Facilitators across the Trust. Each new ICLF is provided with an induction programme provided by the IPCT. With the educational support and guidance from the IPCT, they are responsible for cascading and monitoring compliance with infection prevention and control practices at clinical level. The IPCT hold monthly ICLF meetings on each acute site.

The ICLFs are provided with education and training from the specialist IPCT and other relevant specialists. In addition the Trust also encourages and supports ICLFs to undertake further training to support them in their role. The ICLFs complete monthly hand hygiene audits, other Trustwide audits, cascade training and revised or new policies and initiatives under the guidance of the IPCT.

1.4 Joint working across the local health economy

The Trust IPCT continues to work with the Clinical Commissioning Group (CCG) and Public Health England (PHE) colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission.

The IPC specialist nurses are members of the Infection Prevention Specialists Regional Network Meeting who share and discuss local initiatives, innovations and work towards common goals across Sussex.

The IPCT in collaboration with PHE, East Sussex County Council and the Network Group have worked collaboratively on the emerging threat of the new disease SARS CoV2 and its associated infection COVID-19. Prior to the emergence of this disease in January 2020 we had focused efforts on the reduction of catheter associated urinary tract infections in response to the new reduction targets set by NHS improvement for reducing Gram negative bacteraemias by 50% across the whole health economy by 2021. The challenge with the global pandemic of COVID-19 has required the IPC programme of work to change priorities in order to resource the safe provision of care to patients with this new disease and ensure that staff are equipped to deliver care using the necessary infection control precautions to prevent transmission to themselves and others.

Surveillance of community acquired Clostridium difficile infections and Gram-negative bacteraemias is undertaken by the ESHT IPC team on behalf of the local CCGs under a service level agreement.

2. Compliance with Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008

The Trust is required to undertake self-assessment against Care Quality Commission (CQC) standards and regulations, develop action plans for improvement if required and provide evidence of compliance, including against Outcome 8 which specifically relates to cleanliness and infection control.
Associate Practitioners within IPC support compliance monitoring against standards for cleanliness and infection control and provide real time feedback to clinical teams on their performance highlighting areas of good practice or the need for improvement.

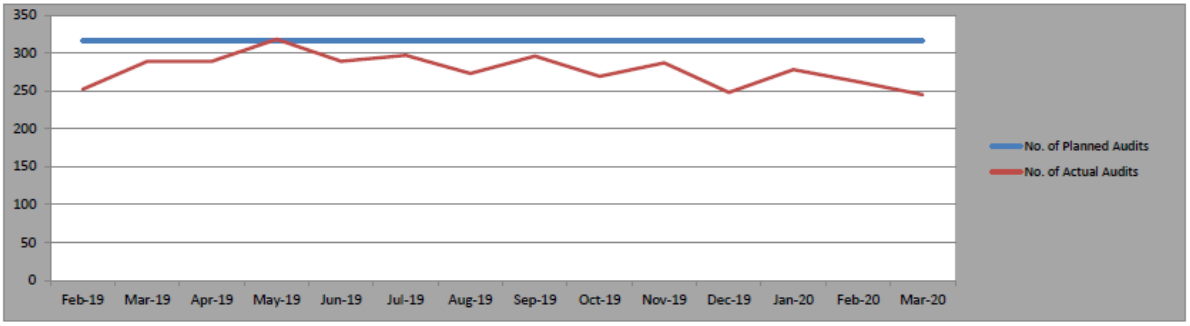
The TIPCG receives reports from Divisions as evidence of local compliance and assurance which is then reported to the Trust Patient Safety and Quality Group.

The CQC re-inspection in 2018 which assessed the trust overall as Good and outstanding for caring; reported that "*Infection prevention and control was now a real strength*".

The National Specification of Cleanliness (NSC) audits continue to be monitored through the TIPCG and the Divisional Integrated Performance Reviews. (See table below for planned versus actual numbers of audits).

Number of NSC Audits Planned vs Number Completed

Month	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. of Planned Audits	316	316	316	316	316	316	316	316	316	316	316	316	316	316
No. of Actual Audits	252	289	289	318	289	297	273	296	269	287	248	278	262	245



The Trust NSC target score for Clinical equipment and Housekeeping was assessed as >92%, overall this was achieved although there were some low scoring areas. Where an area has consistently low scores they are asked to attend the Patient Environmental Audit Meeting (PEAM) to provide assurance of the actions being taken to address the low compliance.

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
House Keeping	98.18	97.98	97.57	96.80	97.44	98.14	97.85	97.76	98.23	98.14	98.20	98.03
Clinical Staffing	95.98	94.03	92.83	90.88	89.33	96.27	94.15	95.38	94.39	95.84	95.10	93.35
Estates	92.95	92.27	93.09	92.48	92.31	91.94	92.39	90.20	91.50	91.79	92.29	93.15

The introduction of the Clinical Orderly role to support cleaning of clinical equipment has significantly improved compliance scores. Vacancies for the role can cause lower compliance. Lower estates scores relate to aging infrastructure which requires investment, works are prioritised by risk; the average annual score for estates (92%) is compliant with NSC. It is anticipated that forthcoming "building for our future" project work being led by our Estates ad Facilities directorate, will significantly improve the standards of the estate.

3. Mandatory Surveillance

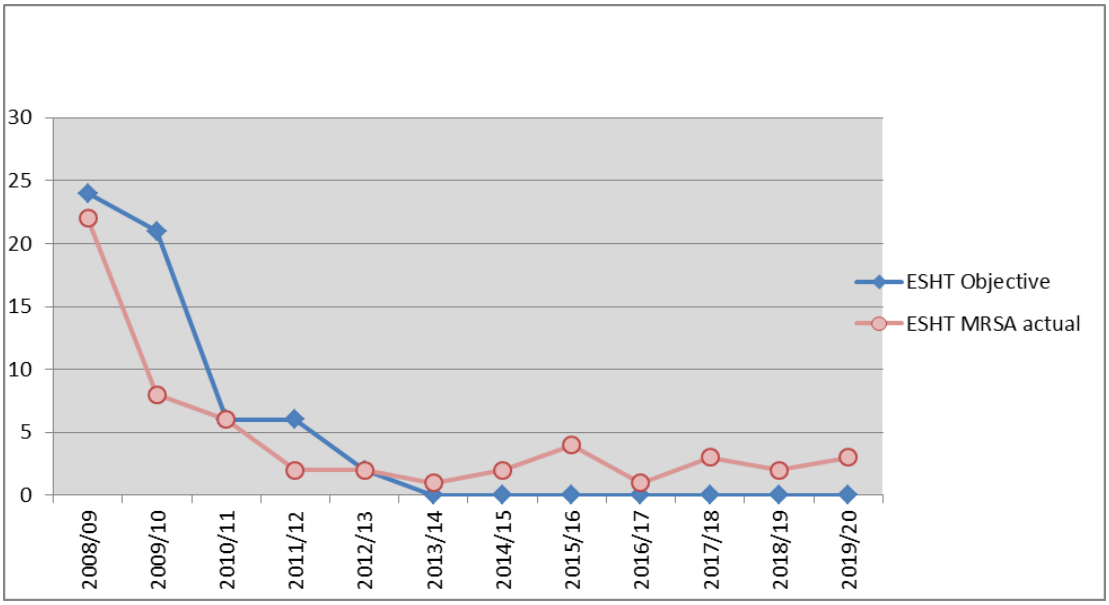
The Department of Health (DH) requires NHS Trusts to take part in a national mandatory and voluntary surveillance programme. This involves providing information about a number of specific infections including bloodstream infections due to Methicillin resistant S*taphylococcus aureus* (MRSA bacteraemia) and diarrhoea due to *Clostridium difficile* infection (CDI).

Each Trust is set an annual objective for numbers of MRSA bacteraemias and CDI. Not all cases of CDI or bacteraemias are avoidable or due to lapses and therefore the focus is on the concept of preventing avoidable harm. The number of MRSA bacteraemias has reduced significantly therefore the tolerance is now zero avoidable infections. All MRSA bacteraemia and CDI diagnosed and apportioned to the Trust are investigated by a post infection review (PIR) conducted by a multi-disciplinary team to ensure any potential lessons learnt are acted upon and shared across the organisation. Cases of CDI are reported as being a lapse in care likely to have resulted in CDI, a lapse in care unlikely to have resulted in CDI or no lapse in care.

Since 2011, bloodstream infections due to methicillin sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* have been added to the national mandatory surveillance. In 2017/18 a new Quality Premium was introduced to reduce the number of *E. coli* bacteraemias and mandatory reporting of *Pseudomonas aeruginosa* and *Klebsiella species* bacteraemias was also introduced. If surveillance identifies that the bacteraemia may have been related to our care then a PIR is conducted to identify if lessons can be learned.

3.1 MRSA bacteraemia

We continue to have a zero tolerance approach to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported 3 cases of Healthcare associated MRSA bacteraemia in 2019/20 compared to two cases in 2018/19.



- One case assessed as avoidable in April, likely due to due to peripheral cannula. Assessed as avoidable due to poor documentation of assessment of the PVC. Patient recovered.

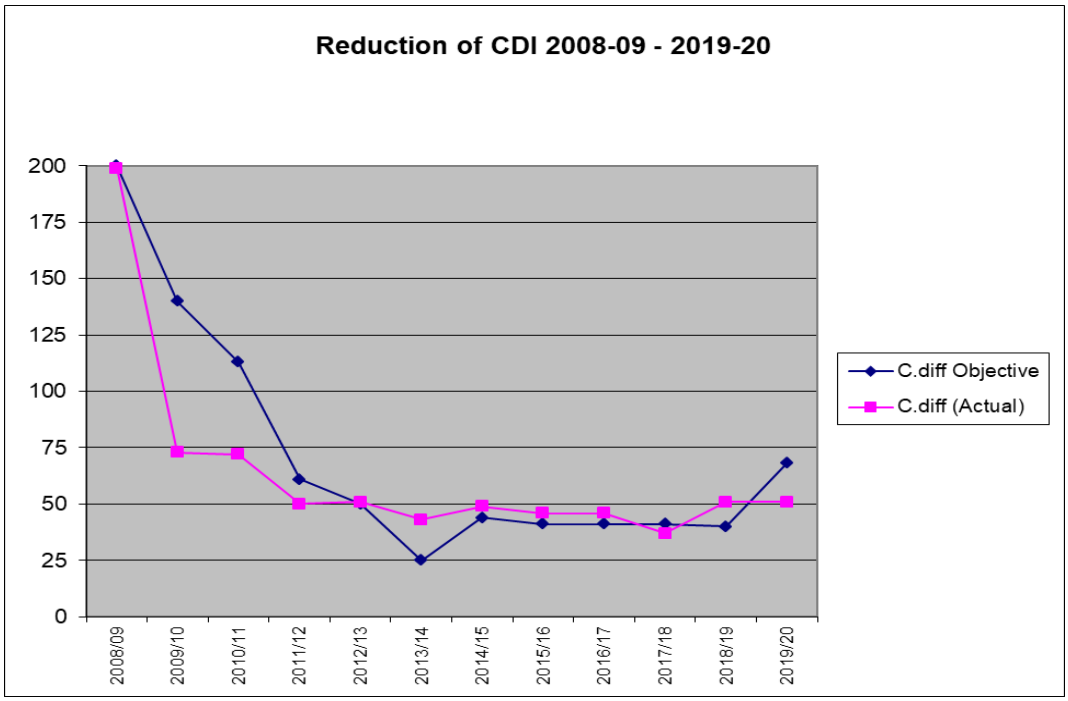
- One case in August, assessed as avoidable due to: inadequate screening for MRSA, poor documentation of cannula assessment. Source possibly cannula or sacral ulcer. Low compliance in hand hygiene audit and NSC audit score also noted. Patient discharged to continuing care.

- One case in September, assessed as probable contaminant (avoidable) because only one culture bottle was positive; but the patient was treated as they have a

prosthetic heart valve and trans-oesophageal echo could not be performed to exclude vegetation on the valve.

3.2 *Clostridium difficile* infection (CDI)

The annual limit set for 2019/20 was 68 cases for ESHT to take account of prior healthcare exposure within 28 days. In total 51 cases were attributed to ESHT for 2019/20. 10 cases were community onset healthcare associated because the CDI diagnosis was made within 28 days of a patient's treatment in hospital rather than related to a current admission. The number of *C.difficile* infections reported annually within ESHT is shown in the chart below.



Prior to 2011/12 the number of cases reported are related to acute inpatients only. From 2012/13 onwards the number of cases also includes cases reported from the additional community inpatient beds following integration.

Each case of CDI diagnosed beyond 48 hours of admission undergoes a multi-professional post infection review (PIR) investigation. Findings of these PIRs are considered to assess if each case constitutes a lapse of care likely to have resulted in CDI, a lapse of care unlikely to have resulted in CDI or no lapse of care.

>72hrs CDI	2019/2020
No Lapse in Care	**19**
Lapse in Care likely to have contributed to outcome	**1**
Lapse in Care unlikely to have contributed to outcome	**31**
TOTAL cases (year to date)	**51**

A multi-professional post infection review was undertaken for each case and the vast majority of cases were considered not preventable or had lapses in care identified which did not contribute to the development of CDI.

Lapses in Care

The year ended with 1 lapse in care with a patient being cared for during November. The infection occurred in an 80 year old patient who had been diagnosed with a stroke and required antibiotic treatment during their 5 month stay for pneumonia and catheter associated urinary tract infection. A lapse was considered as some of the antibiotics prescribed were not as per ESHT guidance or per discussion with the consultant microbiologist. It was also noted that the environmental cleanliness scores were low at the time. The patient was in the last days of life when the diagnosis was made and CDI was not on the death certificate.

Outbreaks and Periods of Increased Incidence (PIIs)

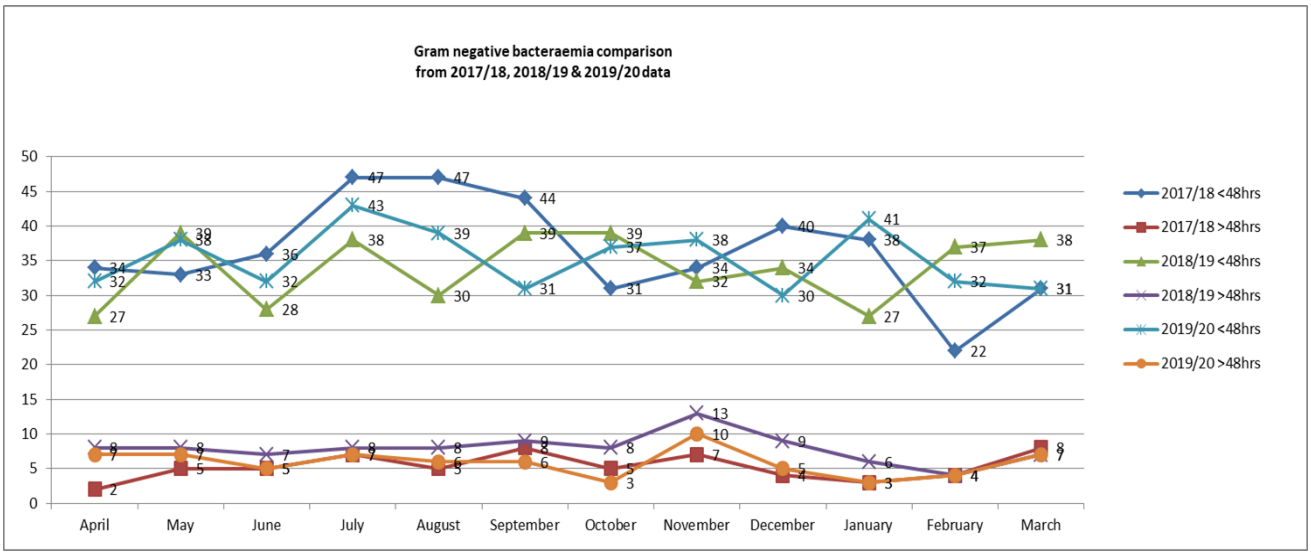
In line with national guidelines, if there are two or more cases of CDI identified on the same ward within 28 days of each other these are investigated as a PII. Further tests are performed at a specialist reference laboratory to compare the *C. difficile* bacteria and to see if they are the same type (known as ribotyping). Any found to be the same ribotype are considered to be outbreaks. All CDIs related to ESHT as sent routinely for ribotyping to help detect outbreaks.

There were three incidences when two cases were considered to be possibly related on three different wards. The Ribotyping later confirmed that incidence on ward 1 and 2 were not related to each other and therefore not an outbreak. The cases on ward 3 could not be excluded as an outbreak because the organism was not isolated from one of the samples sent to the reference laboratory therefore we could not compare Ribotyping results. The ward was actively engaged to minimise the risk of ongoing transmission and no further acquisition occurred.

3.3 *E.coli* Bacteraemias

The reporting of *E.coli* bacteraemia is mandatory for all provider Trusts. The Government announced that it plans to reduce healthcare associated Gram-negative bloodstream infections in England by 50% by 2021. *E.coli* bacteraemia generally represent 55% of all Gram negative infections therefore the initial focus is expected to be for Trusts to demonstrate a 10% reduction in both pre and post 48 hour cases with baseline data collected from January 2016 to December 2016. During this period ESHT reported 67 cases of E. coli bacteraemia. Last year this reduced to 64 cases. This year we have reported 46 cases, representing a reduction of 26% on the incidence reported in 2018/19.

The IPC team is also currently undertaking the *E.coli* bacteraemia primary care data collection on behalf of the CCG under a service level agreement. An upward trend in the numbers of community attributed cases (<48 hours) has now settled.



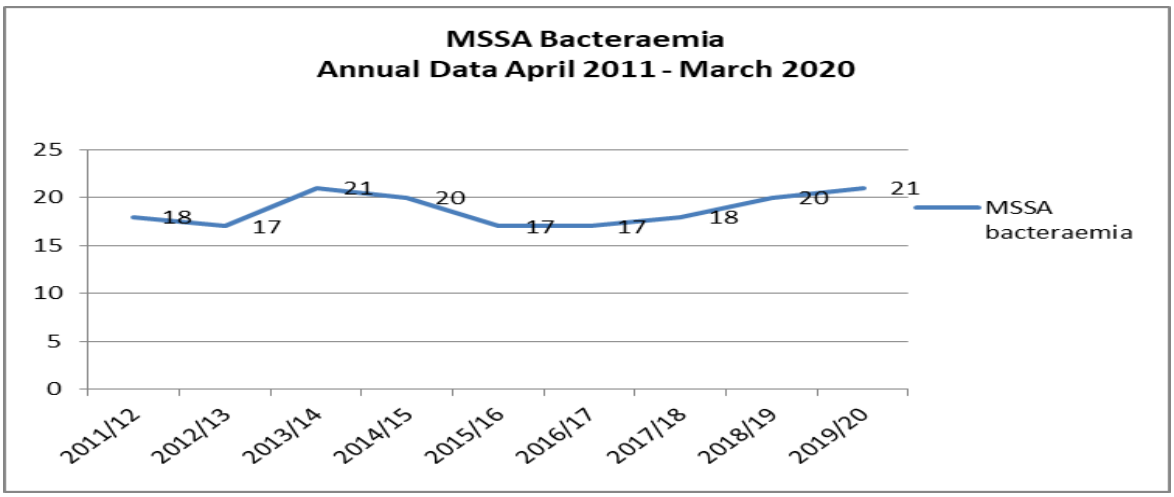
The graph indicates an increase in November similar to previous years' data. The quarterly incidence was similar to other periods. E. coli remains the most common cause of GNBs.

Organism	Total	UTI source	CAUTI source	Biliary	Other	Unknown
E. coli	46	17	6	8	11	10
Klebsiella sp.	17	8	4	1	7	1
Pseudomonas	7	3	1	1	3	0
Total (%)	70	28	11	10	21	11

37% of GNBs are related to UTI which is the same as last year however there was a reduction in the incidence of catheter associated urinary tract infection (CAUTI), from 46% to 30%.

The IPC team reviews cases of *E.coli* bacteraemia which are thought to be related to hospital acquired catheter associated urinary tract infections (CAUTI). We aim to undertake Post Infection Reviews (PIRs) but this is difficult to achieve due to workload and competing demands.

3.4 Mandatory reporting of Methicillin sensitive Staphylococcus aureus



The number of MSSA bacteraemia at ESHT remains stable. Three cases were assessed during post infection review, as potentially avoidable during the year. All cases were considered a result of peripheral cannulation. All patients recovered. The assistance of the vascular access team is sought at the time of investigation to ensure staff are aware of the correct management of intravascular lines and vessel health preservation.

3.5 Mandatory Surgical Site Infection Surveillance Scheme

Since 2004 all NHS Trusts undertaking orthopaedic surgery are required to complete the mandatory surveillance study program devised by the Surgical Site Infection Surveillance Service (SSISS) Public Health England (PHE) for a minimum of three consecutive months per year. ESHT have maintained this recommended gold standard since January 2010 and practiced a continuous study to establish any patterns or trends over time. A standardised set of demographic and operation-related details are submitted for every patient undergoing Hip and Knee Prosthetic Replacement Surgery including re-surfacing and revision (excluding 1st stage revision where spacer implant is used) as well as the surgical procedure, inpatient stay, post discharge reports and complete relevant data of any case readmitted with a SSI during the first post-operative year.

Please note: PHE SSISS studies are undertaken prospectively and submitted quarterly but results are published 12 months retrospectively as infection rates are influenced by performance and readmissions within the audit population over each 12 month surveillance period. Finalised results are therefore only available up until the end of March 2019 although data from April 2019 onwards is within the surveillance system and continues to be analysed and officially reported by PHE at the end of the following year. ESHT submitted data for the four quarters of the year (April 18 – March 2019).

Core data 1st April 2018 – 31st March 2019

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts (data April 2014 -March 2019)
Total hip replacement	395	2	0.5%	0.5% (95% CI 0.5-0.6%)
Total knee replacement	497	2	0.4%*	0.5% (95% CI 0.5-0.5%)

Surgical site infection rates for prosthetic hip and knee surgery were similar to the national average which stands at 0.5%.

There was an increase in post-operative wound infections in Trauma & Orthopaedic patients in 2017. The Infection Prevention and Control Team have undertaken an investigation at the time to establish if the higher rates represent an outbreak of infection. An action plan was initiated to address some practice issues identified during the investigation, which may have been contributing to the overall increased rate.

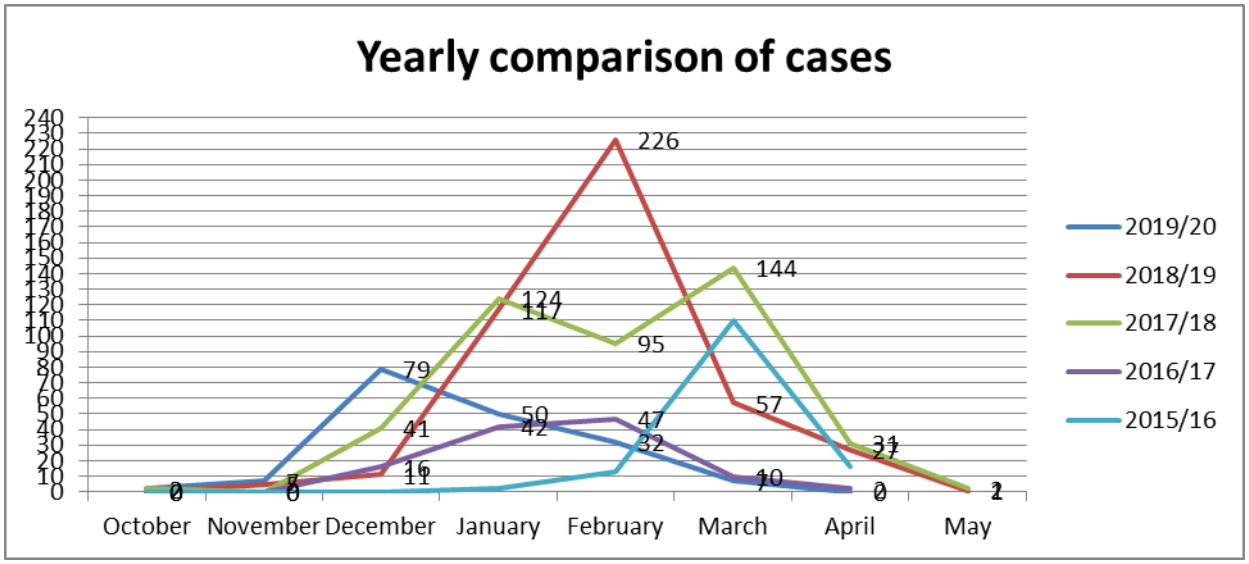
In addition, the process for agreeing cases that meet the definition for reporting to PHE has been strengthened. A multi-professional group chaired by the Chief Nurse (DIPC) has been convened to assess cases prior to submission to PHE. Ongoing Surveillance of surgical site infection of spinal surgery will be undertaken on as part of the national voluntary scheme under Public Health England (PHE).

The higher background rate of surgical site infection in hip and knee surgery is being monitored by the orthopaedic surgical site infection surveillance nurse through the national mandatory surveillance of orthopaedic surgical site infection scheme. The number of cases being reported to PHE for 2018/19 appears to have returned to our usual level during 2019. Discussions are underway regarding the need for additional resource in the SSISS "team" as it currently consists of one specialist nurse looking at one speciality. Resources would enable inclusion of other surgical specialities/services.

ESHT has taken part in a national study "Quality Improvement in Surgical Teams (QIST)" which intends to halve the rate of orthopaedic surgical site infection through the use of nasal and skin decolonisation of patients to prevent carriage of MSSA causing infection. Patients having planned primary hip and knee replacement surgery were invited to take part in the study which was led by the orthopaedic team with collaboration from pharmacy, research, information management and IPC. The team has received national recognition for the benefits of the improvement project and the orthopaedic department are reviewing how the learning from this can be used to benefit patients in other surgical categories.

3.6 Influenza

All acute trusts are required to report on a weekly basis during the Influenza season the number of cases of Influenza requiring admission to intensive care to determine the burden on critical care units nationally.



This year seasonal influenza occurred between December and February. 178 cases were diagnosed of which 162 were Influenza A and 16 cases of Influenza B. Once again additional resources were provided to enable testing for influenza to be undertaken at both Conquest and EDGH so that results were available quickly. This new process worked well. The IPCT responded to each case of Influenza to assess the risk, contact trace and provide advice to patients and staff. Patients were managed in line with national guidance and the Surrey and Sussex guidance for managing influenza patients in times of operational escalation. The majority of confirmed Influenza patients presented to the Trust with flu like symptoms on admission indicating that they had acquired the infection in the community (incubation period 1-4 days).

Detection of hospital acquired cases can be complicated by the fact that the swab taken to confirm influenza is a PCR test that can remain positive for several weeks after a patient has the infection therefore diagnosis of current influenza needs to be based largely on symptoms. 17 were assessed as likely healthcare associated. There was an outbreak of Influenza on Newington ward during December which involved 8 patients. The outbreak was well managed.

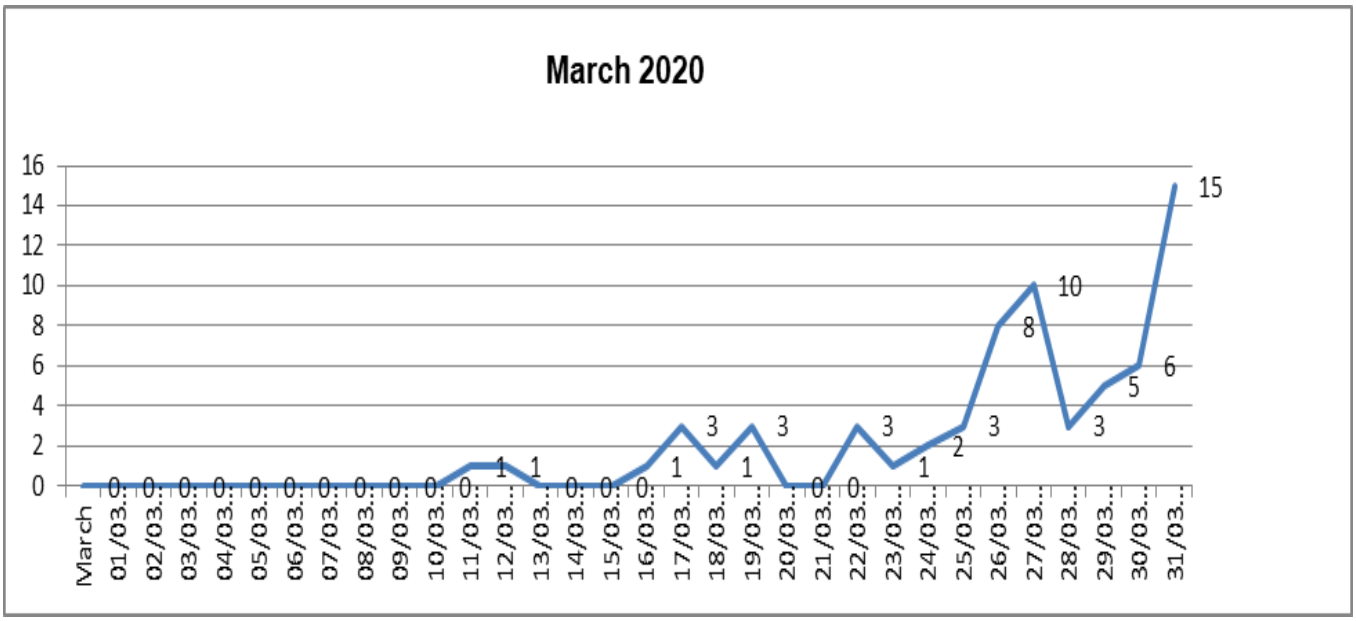
Over 87% of ESHT frontline clinical staff were vaccinated against seasonal influenza. This has been achieved as a result of the campaign managed by Occupational Health and Wellbeing and successful utilisation of a peer vaccination scheme.

4. Emerging Threats and Operational Preparedness

The Emergency Preparedness, Resilience & Response (EPRR) group was established in response to the threat of emerging infectious diseases such as VHF (Viral Haemorrhagic fever) including the Ebola virus, Pandemic Influenza and CPE. The EPRR manager reports to the TICPG on matters that impact on infection prevention and control. The trusts response to the Global Pandemic of a new infection, SARs CoV-2 Coronavirus infection (COVID-19) has been co-ordinated by the EPRR team.

4.1 SARS CoV-2, COVID-19

The coronavirus disease 2019 (COVID-19) outbreak is a global public health problem. After its occurrence in the Republic of China in December 2019, the disease spread worldwide and the virus is highly contagious. This respiratory infection is considered to be mainly spread by droplet and contact transmission but there is also aersol transmission. Close contact in crowded places is an important contributing factor to SARS-CoV-2 transmission. Scientific understanding of the disease is still developing and guidance has changed and developed in response to new knowledge.



Response to the increasing prevalence of COVID-19 has required considerable planning and transformation or reconfiguration of services in order to protect those people considered most vulnerable to catastrophic effects of the disease and to ensure that sufficient respiratory support services are available to those who need it. This has been co-ordinated using the EPRR framework. The IPC service has been key in supporting the ESHT COVID-19 plan, to ensure the safety of all staff caring for or

supporting the provision of services to patients with this new infectious disease and undertake surveillance and contact tracing to prevent and control transmission of the infection. Fit testing of staff to provide the correct filtering respiratory facemasks (FP3 masks) was an essential role for IPC in the early preparation for COVID-19. A specific fit testing team has since been established to provide a consistent trained workforce to undertake this assessment and release the IPCT.

4.2 Carbapenemase Producing Enterobacteriaceae

Carbapenemase producing *Enterobacteriaceae* (CPE) are bacteria that are resistant to Penicillin, Cephalosporin and Carbapenemase antibiotics and often have resistance to multiple other antibiotics. This means that there may be only one or two antibiotics that can be used to treat them. They are a potentially major problem because these bacteria cause common infections such as urinary tract and intra-abdominal infections. ESHT has seen very few cases of infection with these bacteria to date. However appropriate IPC measures are in place to manage the risk should a case arise. All admissions are assessed for risk of CPE and if the patient has been treated in another healthcare facility within the UK or aboard in the previous 12 months they are screened for CPE. If a patient tests positive, a recorded alert is added to the patient's electronic record as an early warning to clinicians to guide treatment and source isolation. There have been no outbreaks of CPE at ESHT in 2019/20.

5 Incidents related to infection

5.1 Serious Incidents (SIs) and risks managed by the Infection Prevention & Control Team

ESHT reports outbreaks of infection as possible serious incidents to the Weekly Patient Safety Summit (WPSS) who agree if an SI report or Amber (for internal learning) SI is required. These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome. In addition to this the team undertake risk assessments in response to organisms that could pose a risk to patients and/or staff in order to ensure they were safely managed. The PIR/RCA investigations and subsequent recommendations and completion of actions are monitored by the TIPCG.

Two outbreaks of MRSA infection were fully investigated.

Month	Location	Organism	Incident
July	SCBU	MRSA	2 cases of MRSA investigated as the same. No further acquisition no harm therefore not escalated as SI
September	Maternity unit	MRSA	3 patients in maternity had caesarean sections & were found to have MRSA in their abdominal wounds. IPC working with the clinical team to strengthen adherence to NICE guidance on prevention of surgical site infections.

Critical Incident due to suspected Viral Haemorrhagic Fever.

In November, a critical incident was reported in relation to a patient admitted with a history of fever and clinically very unwell who had returned from Uganda and was being assessed as at risk of Viral Haemorrhagic Fever (VHF). Infection control precautions

were taken until VHF was excluded from diagnosis. The patient had extensive tests and it was considered that his symptoms may have been as a result of yellow fever infection as the area he visited was reporting cases at the time and his blood tests suggest exposure to this infection (he confirmed that he had not received vaccination in the past). An internal debrief occurred and a multi-agency debrief was undertaken. The incident highlighted improvements required in multi-agency communication and that the provisional pathway which had been identified at the Conquest site worked well. The lack of a similar facility on the EDGH site was been acknowledged on the trust risk register and is monitored via the Trust Infection Control Group.

Serious Incident related to outbreak of COVID-19
A comprehensive serious incident investigation has been undertaken in relation to an outbreak of COVID-19 which occurred at Bexhill Irvine Unit in March/April 2020. This SI is almost complete and will be shared via the trust's usual governance processes shortly.

5.2 Norovirus

During the winter months Norovirus is often circulating in the community and the risk of outbreaks in the in-patient setting related to Norovirus increases.

The following wards were closed due to outbreaks of confirmed Norovirus

Month	Area	No. of people affected	Lost bed days
April 2019	EDGH	3	1 day
December 2019	EDGH	11	14 days
December 2019	EDGH	3	1 day
January 2020	EDGH	28	13 days
January 2020	EDGH	6	3

The outbreaks were well managed by IPC and the Clinical Site team, in line with national guidance.

6. Infection Prevention Activities and Innovation

6.1 Hand Hygiene Promotion

The Trust IPCT continues to co-ordinate an annual programme to promote effective hand hygiene throughout the Trust including;

- Monitoring of compliance by clinical staff with monthly audits.
- Monthly hand hygiene promotional posters
- Training of ICLFs to undertake practical hand hygiene training of clinical staff.
- Providing training of all staff on induction (joining the organisation) and at regular mandatory updates.
- Ad-hoc training when indicated for focused improvement.
- Series of focussed hand hygiene promotion events for staff and patients including participation in the International World Hand Hygiene Day during May 2019.

6.2.1 Hand Hygiene Compliance

Monthly hand hygiene audits are undertaken by Infection Control Link Facilitators (ICLFs) measuring compliance by healthcare staff in direct contact with patients. Observations are made in each clinical area and feedback is given at the time of audit by the Infection Control Link Facilitator, staff responses are noted as part of the audit. Results are monitored to detect trends and act where frequent non-compliance occurs.

The ICLFs should complete and submit 10 observations every month. If an area doesn't return an audit for one month the matron is contacted, if for two consecutive months the Head of Nursing for that area is contacted and if there is no audit for three consecutive months it is escalated to the Chief Nurse (DIPC).

A "Fit to Care" hand hygiene compliance check list has been introduced for clinical teams who are working in environments such as clinica and community settings and cannot be easily audited, to provide assurance that staff have undergone the correct IPC training and have the right equipment to be compliant with IPC policies.

In April 2018 the Trust's recording system (Meridian) for hand hygiene compliance was discontinued. To facilitate the transition from Meridian to Allocate's My Assure system the ICLFs were asked to submit paper copies of their hand hygiene audits.

The chart below provides details of the overall Trust compliance. Since the introduction of Allocate for the submission of hand hygiene audits it has been much more difficult to obtain data and analyse on a trustwide level. We are able to obtain information on each ward's compliance but the system does not collate this into a format to provide a view of overall compliance, instead IPCT has to calculate the compliance data for each hospital. Members of the IPC team have worked with staff in the Allocate team to try to address this but a satisfactory solution has not been achieved yet.

Totals	April 2019		May 2019		June 2019		July 2019		Aug 2019		Sept 2019		Oct 2019		Nov 2019		Dec 2019		Jan 2020		Feb 2020		March 2020	
	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
EDGH Total	99	218	95	219	98	229	77	326	87	299	81	299	99	228	100	236	99	213	99	135	99	170	83	227
Conquest Total	100	238	97	250	100	215	80	299	88	266	78	326	92	244	100	210	99	206	99	159	100	211	85	114
Community Total	97	20	92	32	97	38	58	53	62	45	63	91	100	30	100	31	100	21	100	10	100	35	84	50
Trust Overall Compliance	99	476	95	501	98	482	72	678	79	610	74	716	97	502	100	477	97	440	98	304	99	416	84	381

The overall compliance is very good. Data for March shows a significant reduction, there was notably fewer audits undertaken in Quarter four as a result of redeployment of staff and reallocation of services in response to the COVID-19 pandemic. In order to

validate this data and provide assurance regarding its accuracy, the associate practitioners in the IPC team audit compliance with hand hygiene and bare below the elbows. Their audits evidence that overall there is good compliance among trust staff.

6.2 Infection Prevention & Control Compliance Monitoring Programme

AUDIT	Quarter 1				Quarter 2				Quarter 3				Quarter 4			
	EB	CQ	Total Compliance		EB	CQ	Total Compliance		EB	CQ	Total Compliance		EB	CQ	Total Compliance	
			#	%			#	%			#	%			#	%
MRSA compliance monitoring																
Total audits	106	197	**303**		120	217	**337**		109	185	**294**		93	38	**131**	
Complied	96	181	**277**	**91%**	102	200	**302**	**88%**	100	174	**274**	**93%**	86	37	**123**	**94%**
Hand Hygiene Audit																
Total audits	159	139	**298**		160	190	**350**		129	156	**285**		29	2	**31**	
Complied	149	130	**279**	**94%**	148	168	**316**	**90%**	108	133	**241**	**84%**	23	2	**25**	**89%**
Audit of universal precautions																
Total audits	149	81	**230**		145	101	**246**		106	77	**183**		35	0	**35**	
Complied	142	77	**219**	**95%**	132	88	**220**	**89%**	90	61	**151**	**82%**	26	0	**26**	**74%**
Bare Below Elbow Audit																
Total audits	313	300	**613**		295	66	**361**		303	79	**382**		51	0	**51**	
Complied	309	298	**607**	**99%**	292	63	**355**	**97%**	296	77	**373**	**97%**	49	0	**49**	**96%**
Commode Audit																
Total audits	78	61	**139**		82	79	**161**		72	63	**135**		57	0	**57**	
Complied	63	60	**123**	**81%**	73	75	**148**	**91%**	62	61	**123**	**91%**	43	0	**43**	**75%**
Sharps audit																
Total audits	147	246	**393**		155	263	**418**		116	237	**353**		15	19	**34**	
Complied	112	211	**323**	**82%**	125	211	**336**	**80%**	86	185	**271**	**76%**	7	19	**26**	**73%**

The common themes of non-compliance for MRSA audit are staff not documenting the application of the antimicrobial body wash and hair wash. Hand hygiene and bare below the elbow audits identified that staff failed to perform hand hygiene before and/or after patient contact as per Trust Policy and some are wearing wrist watches in clinical areas. Personal Protective Equipment (PPE) audits showed some staff not using appropriate PPE and failure to perform hand hygiene before donning and after doffing. (Since March significant support and improvements have been introduced and noted re: PPE and regular formal auditing has been introduced via the HoN's quality rounds) For the Commode audit, the common theme of non-compliance was bodily fluids found on commodes. The common themes of non-compliance for the Sharps Audit are container lids were left open rather than availing of the temporary closure mechanism. During Quarter 4 the asscoaite practitioners were assisting with Mask Fit testing of staff for FFP3 respiratory protection and training staff on donning and doffing of PPE therefore very few compliance audits were undertaken particularly at Conquest as staffing within the team was also reduced due to staff sickness during wave 1 of Covid.

6.3 Audit activity

The IPCT co-ordinates a number of planned and unplanned audits throughout each year to monitor compliance with core infection prevention and control standards and any areas of risk or concern which may arise as a result of incidents. A reduced number of audits were completed during this year. The One Together audit of compliance with best practice across the surgical pathway was commenced with women's health with a focus on good practice in caesarean section and hysterectomy surgery. This work will continue into 2020/21 as the process has slowed due to availability of IPCT who are supporting the COVID-19 pandemic.

The following audits were completed:

- Monthly staff hand hygiene audits
- Quarterly Peer hand hygiene audits
- National Specification of Cleanliness audits reported and monitored monthly at TIPCG – compliant.

6.3 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required.

- Mandatory training and induction for all staff and volunteers
- Annual updates for clinical staff, patient facing staff, food handlers and other high risk groups
- 3-yearly mandatory training for non-clinical, non-patient facing staff.
- Training is provided monthly to ICLFs on the control and management of key infections for cascade to clinical teams.
- Focused training has been delivered directly to ward staff on control and management of CPE, CDI, MRSA and decontamination of beds and equipment.
- Train the trainer sessions in Hand Hygiene and Fit Testing of FFP3 masks (cascaded by ICLFs)

Compliance with attendance at mandatory induction and update sessions remains above 85% and is monitored by the Trust along with other mandatory components of the Trust mandatory training programme.

Since Quarter 4 the main focus of the IPCT has been to train all staff on the safe appropriate use of personal protective equipment for use during the COVID-19 pandemic to provide safe care for patients. This has involved considerable resource using online and practical demonstrations and development of training material and printed visual instruction and guidance.

The IPCT held training days on both acute sites in February with ICLF staff from all areas invited to attend. The focus was on preparedness for the COVID-19 pandemic particularly wave 1 surge with presentations and practical application of PPE so that this information could be disseminated to clinical teams. This work has continued throughout the pandemic and will likely continue for the foreseeable future as Covid is becoming part of our new normal.

6.4 Professional Development

All specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings.

As well as utilising the in-house Learning & Development training programme team members have been supported in attending other essential specialist training and conferences required to maintain their professional practice to enable them to provide education and training to others in the organisation including:-

- Infection Prevention Society, London South Branch development days
- Annual Infection Prevention and Control Conference
- Mentoring skills development workshop
- Foundation degree in Health and Social Care
- Public Health Practitioners Register Course
- Functional skills assessment

Our associate practitioners have both now completed the foundation degree in Health and Social Care.

7. Housekeeping Services

The housekeeping services for ESHT continue to be provided by the in-house team within Estates and Facilities. Housekeeping resources are matched to each area in line with the National Specification for Cleanliness (NSC) guidelines and the associated risk ratings – Very high Risk, High Risk, Significant and low risk.

Regular audits in line with the National Specification for Cleanliness of all areas are undertaken by our independent NSC audit team to ensure that the Cleaning services are achieving the required standards and for 2019 – 20 we have consistently achieved an improved score of 97.92% compliance against a target score of 92.58% for our Housekeeping scores across the Trust.

The National Specification for Cleanliness standards are currently under review, we have had the opportunity to provide feedback to PHE to help support their development and understand any impact on our cleaning services moving forward. To date these have not been released.

7.1 Deep clean programme

An important part of housekeeping services is to support the reduction of infections and meeting CQC regulation 12 “Cleanliness and infection Control”. We have a 24hr Rapid Response team on each acute site which supports the clinical operational demand and provides a service ‘out of hours’. The housekeeping team works in close partnership with IPCT and has worked on alternative ways of ensuring cleanliness standards are maintained. Weekly NSC review meetings are held to discuss standards in partnership with IPCT, and actions are drawn up to address low standards if needed in any areas until a structured deep clean plan can be established. During the Winter months to support the added pressures we employ a cleaning team on each acute site to work alongside the rapid response team to ensure standards are continuously met.

7.2 Activity

Housekeeping continued to receive demands from all areas for cleaning support from the Rapid Response Team including single rooms, bed space cleans, and others this averages at about 200+ calls per month per acute site. To meet this demand, calls for cleans are prioritised and communication and support is structured from the IPCT and clinical site leads and clear plans are in place at all levels to ensure patient disruption is minimised

7.3 Service development

The Housekeeping department continues to use HPV Hydrogen Peroxide Vaporisation units to support the reduction of infections by destroying organisms, this process is undertaken by the rapid response team who are on site 24hrs and can be deployed to any site if called upon and this will be sustained in the modernisation plan.

To support IPCT working practices and water safety, we have revised our sink cleaning procedures. Standard operating procedures have been revised and training rolled out to all Housekeeping personnel.

We have also worked to strengthen our recording mechanisms for tap flushing to support water safety and have devised specific check sheets for each area to complete each day. These are checked weekly by the Housekeeping Supervisors and signed off monthly by the Housekeeping Managemt teams.

8. Antimicrobial Stewardship Activities and Innovation

The Trust has an established Antimicrobial Stewardship Group (ASG) has a core membership of a consultant microbiologist, medical consultant, Clinical Pharmacy Manager, Lead Antimicrobial pharmacist and a CCG representative. The purpose of the ASG is to support the prudent use of antimicrobials to reduce the development and spread of antimicrobial resistance. The is acheived by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Developing a strategic plan with the aim to continuously improve the use of antimicrobial with ESHT and the local community
- Ensuring safe and cost effective use of antimicrobials taking local, national and international bacterial resistance rates into account.
- Monitoring antimicrobial usage (reviewing daily divided doses, antimicrobial expenditure data and compliance to guidelines using a point prevalence audit) and addressing any issues that may arise.
- Undertaking audits on antimicrobial prescribing practice and providing feedback to TIPCG, ASG and MOG
- Providing advice to other specialist groups/committees on use of antimicrobials
- Providing education to staff on all matters relating to prescribing and administration of antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship
- The lead antimicrobial pharmacist providing feedback from lesson learnt, following a Post Infection Reviews to the pharmacy team.

8.1 Antimicrobial Prescribing Policy and Guidelines

The adult and paediatric guidelines are reviewed, and updated if required, by the ASG on regular basis. The guidance is peer-reviewed, evidence based and specialist Consultants and/or Allied Health professional (AHP) are consulted for advice. The antimicrobial guidelines are available on a smartphone app and desktop.

8.2 Multi-disciplinary Ward Rounds

The aim is to reduce the inappropriate prescribing of antibiotics, reduce the risk of treatment failure, the development of antimicrobial resistance and provide support to the prescribing team and ensure specialist input into the highest risk/most critical patients in the hospitals.

Following the outbreak of Covid-19, the ward based face to face ward rounds were temporary placed on hold and moved on-line.

The Consultant Microbiologists (CMM) and antimicrobial pharmacists continue to participate in daily Intensive Care Multi-disciplinary team ward rounds at both sites, weekly *Clostridium difficile* infection and immunocompromised haematology-oncology ward rounds at EDGH have remained in place (on-line/by phone). This enabled the ward rounds to continue and the number of wards rounds increased - along with a broader participation of health profressionals. The new AMS ward rounds include orthopaedics, diabetic foot infection management, gastroenterology and endocrinology.
In addition, the AMS wards rounds are targeted and started on a ward/area if there is a concern, for example a ward with an unexpected high use of broad spectrum antibiotic. CDI outlier.

The medical and surgical teams have provided positive feedback to the consultant microbiologists and AMS team members - there is good engagement from the clinicians and ward AHPs.

The AMS ward round has made a number of interventions that include;

1. stopping treatment
2. escalating/ de-escalating the antibiotic
3. switching administration route from an intravenous to oral treatment
4. continuing current treatment and providing advice on duration/review date.
5. Providing advice to the medical or surgical team on the prescribing of antibiotics for a CDI antigen or toxin positive patient.

8.3 Training

The Trust antimicrobial e-learning module prescribing has been updated and is available on the internet. All Trust doctors are required to pass this module – as part of induction or at least every three years. In addition, the Consultant Microbiologists and pharmacy provide face to face teaching about antibiotic prescribing for FY1 and FY2 doctors.

For pharmacy, there is an antibiotic training pack to help support the development of rotational pharmacists in antimicrobial use and prescribing. This training pack is based on the Royal Pharmaceutical Society antimicrobial training guidance.

8.4 Antibiotic Incident reports

The lead antimicrobial pharmacist is also involved in reviewing of incidents reported on Datix involving antimicrobials. An antimicrobial and ward pharmacist, where possible, attends Post Infection Reviews.

8.5 Audit of antimicrobial usage

Improving antimicrobial stewardship at East Sussex Healthcare NHS Trust (ESHT) forms part of the quality improvement strategy for patient safety, help to reduce inappropriate prescribing and optimise antibiotic use. The Trust total antimicrobial consumption rate is monitored using pharmacy and admission data, the use of Public Health England (PHE) fingertip and Define.

Table 1 is a comparisoin of the Antimicirobial Consumption rate and the year and year growth of antimicrobial use at ESHT versus England (average using data provided by PHE fingertips.

	2018/19 (DDD/1000 hospital admission)	**2019/20** (DDD/1000 hospital admission)	**Increase/decrease (y/y)**
ESHT	4038	4069	0.8%
England (average)	4480	4655	+3.9%
ESHT vs. England average	-9.9%	-12.6%	

Table 1

The rate of total antimicrobial use at ESHT has increased in the last year by 0.8% (2018/19 vs. 2019/20 – Data from PHE fingertips) . The increase and antimicrobial consumption rate for ESHT are lower when compared to average England and non-teaching hospital consumption.

To monitor and provide assurance, pharmacists undertake a monthly antimicrobial stewardship audit reviewing antimicrobial prescribing, by ward and consultant, to help identify any area(s) of concern and highlight where improvements can be made. As a result of the Covid-19 pandemic the monthly antimicrobial audits were placed on hold. The prescribing and appropriate use of antimicrobials were reviewed by the clinicial pharmacists. Any inappropriate prescribing is challenged and concerns are raised to lead antimicrobial pharmacist. If needed, the concern will be escalated to the Antimcirobial Stewardship and Infection Prevention and Control Groups.

The electronic prescribing and medication administration system (ePMA) is planned to be rolled-out, in a phased manner, in December 2020. The ePMA should address the need to undertake a monthly audit as the review and antimicrobial use will be able to be undertaken on live prescribing data. This will enable pharmacy and microbiology to monitor antimicrobial prescribing more effectively, target AMS ward rounds and reduce the inappropratie use of antibiotics.

8.6 Antibiotic CQUIN 2019/20

Due to Covid-19 pandemic, the CQUIN 2019/20 measures were withdrawn and ESHT was advised that the CQION AMS payment will be paid in full.

9. Water Safety Incidents

9.1 *Legionella* species:

Legionella pneumophila serogroup 1 is the most virulent strain causing the majority of infections. The remaining non-pneumophila species (found in water and soil) are considered non-pathogenic until shown to cause disease, mainly associated with severely immunosuppressed patients.

Legionella pneumophila was isolated from water samples at Bexhill hospital, Urology Investigation Suite and Nuclear Medicine this year. Remedial measures were taken and the repeat result show further reduction in the level isolated. Legionella non-pneumophila legionella has been isolated in water samples in several clinical areas at the Conquest hospital. IPC inform the clinical matron and check that there is recorded evidence of flushing and cleaning of outlets. Estates and Facilities team are supporting regular flushing of water outlets. The risk was managed and monitored by the water safety group.

There has been no known hospital acquired cases of *Legionella* to date. Legionella sp. has not been identified at EDGH this year.

9.2 *Pseudomonas aeruginosa*

Pseudomonas sp. has been detected in routine water sampling in the Special Care Baby Unit at Conquest Hospital in 2018 was resolved by Quarter 2 of 2019. The Bexhill renal unit also required support with managing Pseudomonas sp. The risk was mitigated by increasing tap flushing and use of bacterial filters. The renal dialysis service is run by Brighton and Sussex University Hospitals Trust who were informed of the problem. There has now been three consecutive tests clear of pseudomonas. There were no associated clinical infections.

10. Clean care award

The quarterly clean care award recognises departments who have worked to maintain or improve standards in infection prevention and control.To win the award departments need to demonstrate the following:

- No preventable/avoidable infections
- 10 hand hygiene observations submitted each month
- Compliance with average monthly National Specifications for Cleanliness (NSC) audit scores
- Consistent attendance at the monthly Infection Control Link Facilitators meetings.

And/or

- Significant clinical engagement to improve standards of IPC.

Winners of the Clean Care award 2019/20

The Occupational Therapy team with Dr Adrian Bull, Chief Executive

Quarter 1	Critical Care, Conquest and Pevensey ward, EDGH
Quarter 2	Physio, Conquest and Podiatry, EDGH
Quarter 3	MacDonald ward, Conquest and Occupational Therapy, EDGH
Quarter 4	Baird ward, Conquest and Pathology Team, EDGH

The MacDonald Ward team with Dr Adrian Bull, Chief Executive

11. Annual Programme of Work / Priorities for 2020/21

The global COVID-19 pandemic will continue to be a significant priority for the IPC service and the DIPC.
Key areas of work include;

Supporting safe provision of care and safe working practices for staff.

Training and guidance on use of PPE, patient pathways and contact tracing of those exposed to infections.

Advising clinical and support services as required.

Compliance with regulation 12, outcome 8 and review of the new COVID-19 board assurance framework (BAF).

Supporting antimicrobial stewardship to prevent avoidable C. difficile infections.

Improving rates of surgical site infection – building on the good work of the QIST research programme, for primary total Hip and Knee replacement surgery in order to reduce surgical site infection rate.

Agree training to support ANTT competence and audit compliance with care and management of peripheral venous cannula.

Produce visitor and Patient information in relation to COVID-19 and other prevalent infections.

The above will be incorporated into the Infection Prevention and Control's Annual Programme of Work and monitored through the TICPG.

We endorse the Infection Prevention Society's vision that:
"No person is harmed by a preventable infection"

East Sussex Healthcare NHS Trust

Annual Report

Complaints
&
Patient Advice and Liaison Service (PALS)
2019/20

Executive Sponsor:	Vikki Carruth, Director of Nursing
Report Author:	Darren Langridge-Kemp, Complaints, PALS and Patient Experience Manager
Date:	September 2020 (v4 Final)

Contents

1. Executive Summary for 2019/20

This report details the activity of the Complaints Team and Patient Advice and Liaison Service (PALS) at East Sussex Healthcare NHS Trust for the year 2019/20. All data provided has been extracted from Datix, the risk management database the Trust uses for recording complaints and contacts with PALS, and is presented alongside data for the previous three years for comparative purposes and trend analysis.

- The Trust received 583 new complaints across all services in 2019/20; this represents an increase of just 25 complaints compared to 2018/19 (n=558).

- The Trust acknowledged 100% of new complaints within three working days.

- The Trust's process for reporting compliance with published complaint response timescales was reviewed in December 2019, following observations made by the Care Quality Commission (CQC) during their inspection the previous month when they reviewed a sample selection of complaint files. Please see section 3.4, which starts on page 10, for more information on this.

- There were 58 complaints reopened in 2019/20; this represents a reopen rate of 9.6% of all complaints closed in the year period, and demonstrates a further sustained reduction in numbers compared to 2018/19 (n=80/13.4% of all complaints closed).

- There were 14 complaints overdue at the end of 2019/20. This was in part due to the review of the process for recording response times, coupled with clinical and operational pressures during the emergence of the COVID-19 pandemic in March 2020.

- There was a reduction in the number of PALS contacts for 2019/20 (n=6,611) compared to 2018/19 (n=6,805); this was the third consecutive year with a drop in contacts since 2016/17.

- Finally, the Trust received 18 contacts and 13 case outcomes from the Parliamentary and Health Service Ombudsman (PHSO) in 2019/20 (please note some of the outcomes relate to cases the PHSO had opened in previous years). Of the outcomes provided, the PHSO decided not to investigate seven cases they had considered, three cases were investigated but not upheld in favour of the complainant and three cases investigated were partially upheld in favour of the complainant.

The objectives for the Complaints Team in 2020/21 are:

1. To ensure a satisfactory rate of compliance with the published complaint response timescales based on the principles agreed in December 2019; and

2. To review the way the Complaints Team works with clinical divisions to more proactively identify, log, monitor, deliver and evidence learning arising from complaints, and to regularly publish these examples of learning.

2. Summary of Activity 2019/20

New Complaints Received - All		583
Complaint Rate Per 1,000 Bed Days - All		2.2
New Complaints Received – By Division	DAS	170
	Medicine	189
	OOH	35
	Urgent Care	98
	WC&SH	63
Complaint Rate Per 1,000 Bed Days – By Division	DAS	2.7
	Medicine	1.2
	OOH	2.2
	WC&SH	3.2
Top 3 Primary Complaint Subjects	Standard of Care	238
	Patient Pathway	102
	Communication	90
Top Sub Complaint Subject For Each Top Primary Complaint Subject	**Standard of Care**	**238**
	Lack of Confidence in Delivery of Care	66
	Patient Pathway	**102**
	Delays in Access to Service/Treatment - Outpatient	33
	Communication	**90**
	Lack of Communication/Information	19
Top 3 Complaint Specialties – All Complaints	Emergency Department	97
	General Surgery	44
	Trauma and Orthopaedics	30
Top 3 Complaint Locations – All Complaints	Out Patients Department – EDGH	90
	Out Patients Department – CQ	77
	Emergency Department - CQ	52
Complaints Closed		605
Complaints Reopened		58
Complaint Reopened Rate		9.6%
PHSO Contacts Received	Case Enquiries	14
	Advice of Intent to Investigate	4
PHSO Outcomes Received	Complaint Did Not Require Investigation	7
	Complaint Was Not Upheld in Favour of Complainant	3
	Complaint Was Partially Upheld in Favour of Complainant	3
	Complaint Was Fully Upheld in Favour of Complainant	0
PALS Contacts Recorded	Advice/Assistance/Information	3,784
	Concerns/Issues	2,801
	Suggestion/Comment	26
	Total	6,611
Compliments	Including Friends and Family Test Feedback	38,586
	Excluding Friends and Family Test Feedback	1,703

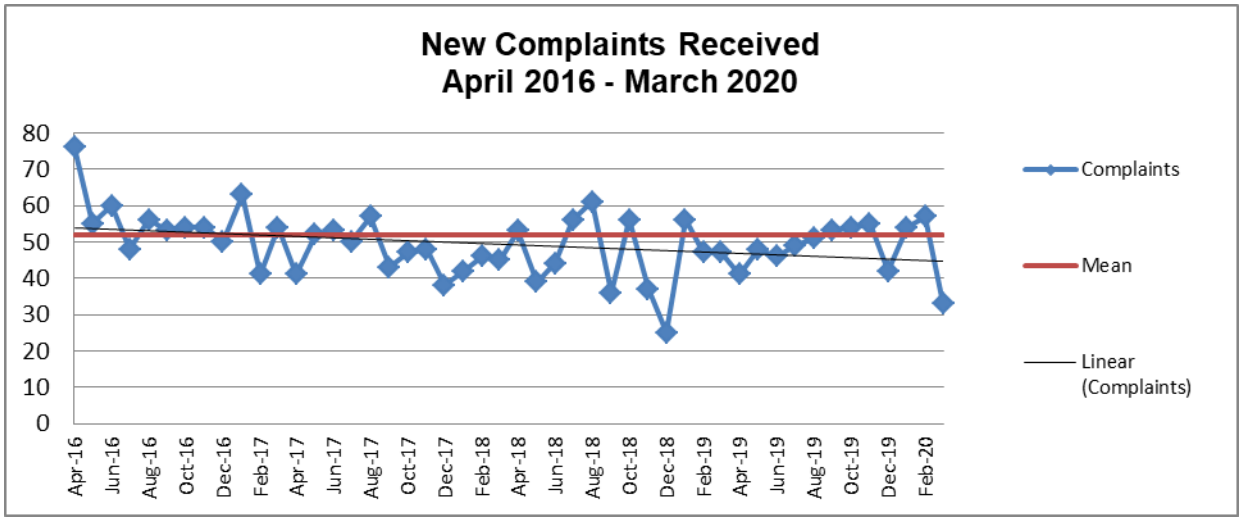
3. Complaints

The Trust considers complaints to be an important source of patient feedback, providing opportunities for services to reflect on and improve the care and treatment provided to our local population. All complaints received are investigated in accordance with the Trust's "Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (The 4C's Model)", which itself is underpinned by the principles of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the NHS Constitution.

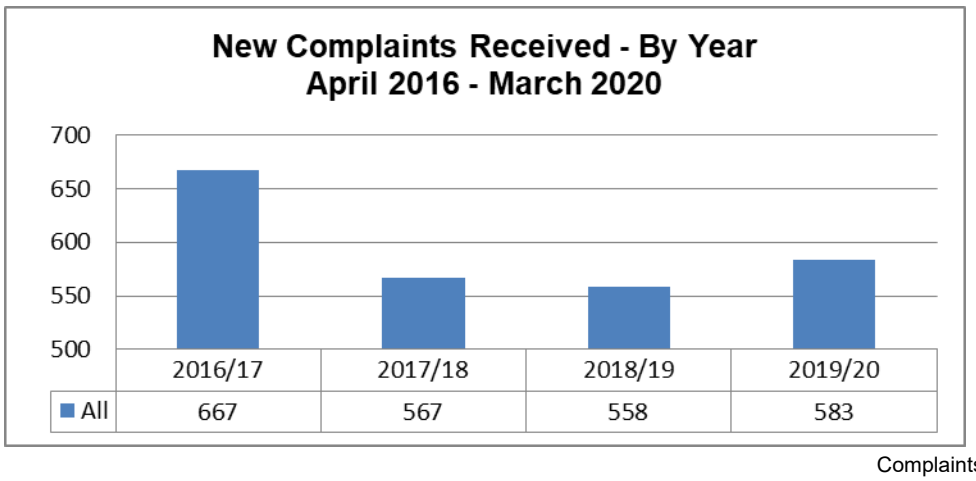
The Trust makes every effort to resolve complaints locally as far as it is possible to through comprehensive investigations, high quality responses and, where appropriate, Local Resolution Meetings (LRM's). The Trust also promotes and appropriately signposts complainants to local advocacy services to ensure they can access and/or seek independent support with their complaint; our local advocacy service is provided by an organisation called The Advocacy People (previous known as seAp - Support Empower Advocate Promote) with whom the Trust has a strong working relationship.

3.1 Complaints Received and Complaint Rates

The following chart represents new complaints received between 1 April 2016 and 31 March 2020, measured against the average mean.

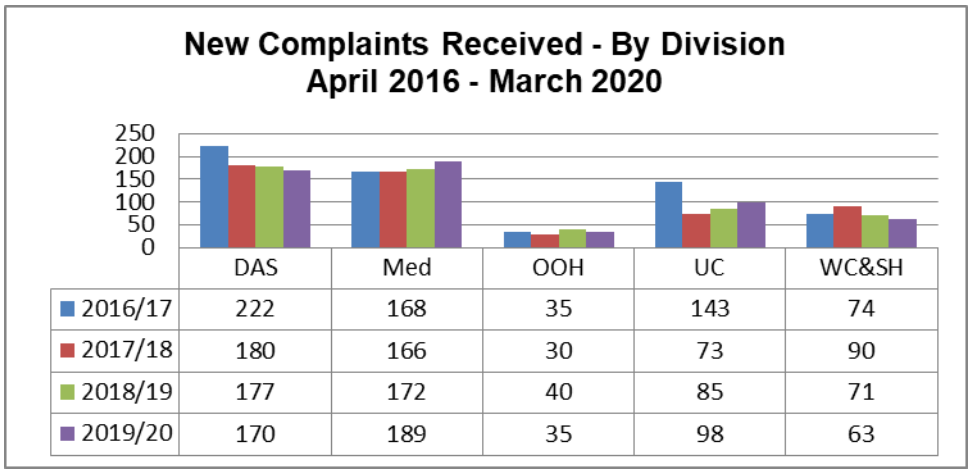


The number of new complaints received in 2019/20 (n=583) is the highest level since 2016/17 (n=667), but sits just below the four-year average of 594. The following chart presents new complaints received year-on-year since 2016/17.



Once a new complaint has been assessed and triaged to determine the issues that need to be investigated and responded to, it is assigned to a clinical division. This is usually the clinical division most closely linked to the events that are the source of the complaint, or where the most serious matters have arisen if several clinical divisions are involved. Any complaints about non-clinical matters, such as car parking or toilet facilities, are assigned to the appropriate non-clinical division.

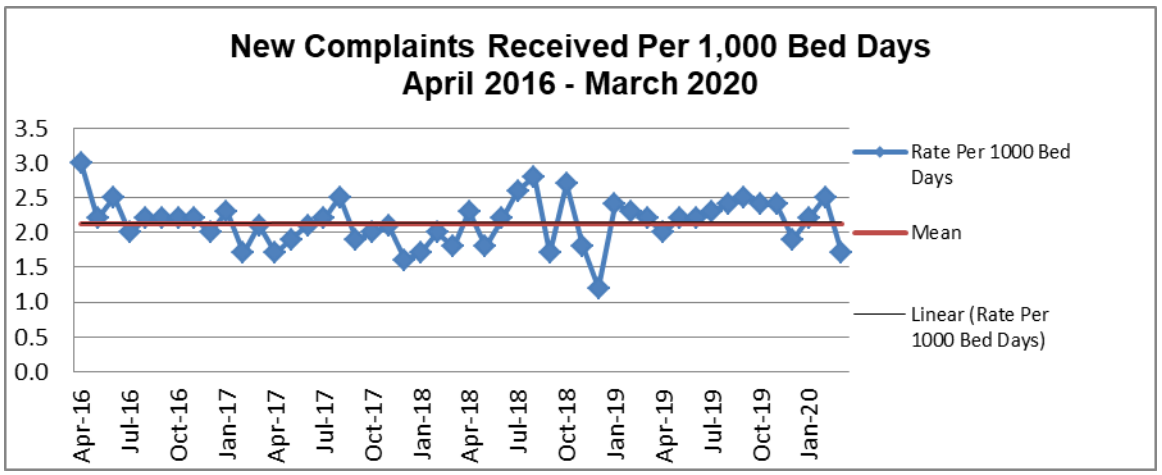
In terms of distribution of new complaints, the following chart represents complaint assignment to each clinical division for the last four years.



	DAS	Med	OOH	UC	WC&SH
2016/17	222	168	35	143	74
2017/18	180	166	30	73	90
2018/19	177	172	40	85	71
2019/20	170	189	35	98	63

These figures demonstrate that complaints by assignment to clinical divisions have been stable year-on-year, with only minor variations noted. The exception to this was the high number of complaints received in respect of Urgent Care (Emergency Departments) in 2016/17; however, no specific reason could be identified for the high number that year.

The complaints rate per 1,000 bed days for all new complaints assigned to clinical divisions in 2019/20 was 2.2. The following chart represents the complaints rate for the period 1 April 2016 to 31 March 2020.



This shows that the complaints rate has, in the main, been in line or within an acceptable tolerance of the mean, with notable exceptions being traditional holiday periods such as the summer and Christmas holidays and more recently, the emergence of the COVID-19 pandemic.

3.2 Primary and Secondary Complaint Subjects

As part of the assessment and triage process, new complaints are also assigned a primary subject to facilitate identification and analysis of themes and trends. The following table sets out the top three primary complaint subjects for the last four years, compared to the overall number of new complaints received in that year.

2016/17		2017/18		2018/19		2019/20	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
All Complaints	**667**	**All Complaints**	**567**	**All Complaints**	**558**	**All Complaints**	**583**
Standard of Care	221	Standard of Care	194	Standard of Care	226	Standard of Care	238
Communication	143	Communication	137	Communication	83	Patient Pathway	102
Patient Pathway	127	Patient Pathway	94	Patient Pathway	82	Communication	90

Whilst there was a change in ranking for 2019/20, the top three primary complaint subjects have remained the same for the last four years and combined, accounted for in excess of 70% of all new complaints received each year.

Each primary complaint subject can then be categorised by secondary complaint subjects to facilitate more detailed coding of complaint issues. The following tables provide a breakdown of the top five secondary complaint subjects under each of the top three primary complaint subjects, based on the ranking for 2019/20 as the most recent dataset. As before, these figures are provided in comparison with the overall number of new complaints received in that year.

Standard of Care

"Standard of Care" has, since 2016/17, remained the top primary complaint subject with the largest number of new complaints assigned to it. The top five secondary complaint subjects falling under this are set out in the table below.

	2016/17	**2017/18**	**2018/19**	**2019/20**
All Complaints	**667**	**567**	**558**	**583**
Standard of Care	**221**	**194**	**226**	**238**
Lack of Confidence in Delivery of Care	39	18	84	66
Missed Diagnosis	14	29	29	43
Poor Bedside Manner				19
Problems/Complications Following Surgery/Procedure		15	25	18
Delay in Nursing Intervention				15
Overall Care	125	67		
Pain Control	20		12	
Incorrect Diagnosis		20	12	
Medication Error	11			
Lack of Diagnosis			8	
Delay in Medical Review			8	

Of Note In 2019/20:	
Incorrect Diagnosis	12
Lack of Diagnosis	11
Total of All Diagnosis Issue Complaints	66

In 2019/20, there was a large (48.2%) increase in the number of complaints about missed diagnoses. Of the 43 complaints received, 17 related to the Emergency Departments (CQ =12, EDGH =5). However, the remaining 26 complaints related to 20 different locations which may provide some assurance that complaints about missed diagnoses were not significantly occurring in any other one area outside of the Emergency Departments.

As footnoted in the previous table, there were a further 23 complaints about diagnoses (lack of or incorrect diagnosis). However, there were no discernible concerns or themes arising from this as they complaints spanned 15 different locations. This brought the total number of complaints about diagnoses in 2019/20 to a total of 66 (27.7% of new complaints being received in 2019/20).

Finally, “Poor Bedside Manner” and “Delay in Nursing Intervention” appeared in the top five secondary complaint subjects for the first time since 2016/17 (n=19 and n=15 respectively). However, complaints about “Poor Bedside Manner” were attributed to 13 different locations, whilst those for “Delay in Nursing Intervention” were attributed to 11 different locations, suggesting there are no particular trends in this respect.

Patient Pathway

“Patient Pathway” has consistently featured in the top three primary complaint subjects since 2016/17, and was assigned to the second highest number of new complaints in 2019/20. The top five secondary complaint subjects falling under this are set out in the table below.

	2016/17	**2017/18**	**2018/19**	**2019/20**
All Complaints	**667**	**567**	**558**	**583**
Patient Pathway	**127**	**94**	**82**	**102**
Delays in Access to Service/Treatment - Outpatient	70	47	28	33
Appointment Issues	39	13	13	18
Delays in Access to Service/Treatment - Inpatient		12	22	17
Lack of Follow Up/Monitoring		7	13	12
Referral Delays	9		4	9
Admission Issues	6	6	2	
Transfer Between Wards/Hospitals	3			

There were no significant changes in the number of complaints assigned to the secondary complaint subjects in 2019/20 when compared to the previous year.

Communication

“Communication” has also consistently featured in the top three primary complaint subjects since 2016/17, and was assigned the third highest number of new complaints in 2019/20. The top five secondary complaint subjects falling under this are set out in the following table.

	2016/17	2017/18	2018/19	2019/20
All Complaints	**667**	**567**	**558**	**583**
Communication	**143**	**137**	**83**	**90**
Lack of Communication/Information	46	36	24	19
Verbal Information for Relatives	8	9		10
Inappropriate Communications			7	10
Written Information for Patients	21	18	7	9
Verbal Information for Patients	18	18		9
Confidentiality Issues	11	9	7	7
Listening and Respecting Patient Choice	11	15	11	6
Delayed Communications/Information			6	
Breaking Bad News			5	
Conflicting Information			5	

Whilst “Lack of Communication/Information” remained the top secondary complaint subject under “Communication” in 2019/20, it is reassuring to see the actual number of complaints recorded against it have dropped year-on-year; a drop of 58.7% from 2016/17.

3.3 Complaints by Specialty and Location

As part of the assessment and triage process, new complaints are assigned to the specialty and location to which the complaint relates. The following tables set out the top 15 complaint specialty’s, followed by the top complaint locations.

Top 15 Complaint Specialty's	2016/17	2017/18	2018/19	2019/20
All Complaints	**667**	**567**	**558**	**583**
Emergency Department	126	71	84	97
General Surgery	45	39	35	44
Trauma and Orthopaedics	36	38	35	30
General Medicine	51	47	45	26
Gastroenterology	26	19	25	25
Urology	43	21	25	24
Cardiology	19	20	15	20
Paediatrics	25	28	28	19
Radiology	23	16	16	19
Neurology			11	19
Obstetrics	13	22	15	18
Gynaecology	24	32	21	16
Respiratory Medicine		8	8	16
Oncology				16
Frailty	10	12		15
Geraitrics and Services for the Elderly		14	18	14
Acute Medicine				14
Ear, Nose and Throat	13	19	10	12
Appointments	20	9		11
Maxillo Facial		7	7	9
Ophthalmology - EDGH	13		8	
Ophthalmology - CQ	12	8	10	
Stroke Team	11	8		
Endocrinology and Diabetes		11	11	
Endoscopy			8	

Of the top 15 complaint specialty's for 2019/20, 12 of these have featured every year in the top complaint speciality analysis for the last four years. Additionally for 2019/20 Neurology, Respiratory Medicine, Oncology and Acute Medicine all had larger numbers of new complaints compared to previous years.

Top Complaint Locations	2016/17	2017/18	2018/19	2019/20
All Complaints	**667**	**567**	**558**	**583**
Out Patients Department - EDGH	78	86	71	90
Out Patients Department - CQ	53	46	38	77
Emergency Department - CQ	54	34	31	52
Emergency Department - EDGH	74	33	53	43
Patients Home	28	27	37	27
Acute Assessment Unit			10	17
Richard Ticehurst Surgical Assessment Unit	12	14	12	12
Multiple Locations		10	11	10
Baird Ward				10
Radiology Department - CQ				10
Hailsham 4 Ward	23	10	12	
Acute Medical Unit - EDGH	20	17	11	
Administration	18	10		
De Cham Ward	13			
Kipling Ward	10			
Out Patients Department - Bexhill	10			
Egerton Ward		11		
Frank Shaw Ward		10		
Mirrlees Ward		10		
Cuckmere Ward			10	
Ophthalmology Out Patient Department - CQ			10	
No. Other Locations With Less Than 10 Complaints Each	114	95	94	86

As with the top complaint speciality's, the first five top complaint locations for 2019/20 are areas that have appeared every year since 2016/17. Of note, there has been an increase in the number of new complaints for both Out Patients Departments, which may be linked to the trend identified in PALS activity regarding concerns with appointments being cancelled and/or rescheduled at little or no notice. The weight of complaints for both Emergency Departments has also alternated in terms of numbers received and which site the complaint relates to for the last two years.

3.4 Closed Complaints, Response Rates and Outcomes

In 2019/20, the Trust closed a total of 605 complaints. This was an anticipated increase on 2018/19 (n=599), given the correlating increase in the number of new complaints received.

In terms of compliance with the Trust's published timescales for responding to complaints (30 working days for non-complex cases and 45 working days for complex cases), it was noted by the CQC during their inspection in November 2019 that the date being used to record when a complaint was closed was at odds with the Trust's formal complaints process.

This was subsequently identified as being a result of an historical understanding dating back in excess of 10 years whereby a complaint was closed on the day the Complaints

Team had finalised the formal response for signature, and not the day it was signed and despatched to the complainant. As part of an ensuing investigation, an analysis of 200 randomly selected cases closed during 2019/20 revealed that on average, complaints were being signed and sent five working days later than they had been closed by the Complaints Team.

Whilst this is disappointing, it should be noted that the Trust's response rates to complaints were significantly in time compared to the response metric of six months as set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. In December, it was confirmed that complaints would not be closed until they had been signed and despatched to complainants, and compliance with complaint response timescales is now measured using this metric.

The following table sets out the compliance rates for closed complaints in 2019/20 against each complaint response timescale, using both the historical and the revised metrics which came into effect part-way through the reporting year.

Metric	30 Working Days (No.)	30 Working Days (%)	45 Working Days (No.)	45 Working Days (%)	All Closed Complaints (No.)	All Closed Complaints (%)
New/ Current	142	27.1%	20	24.7%	162	26.8%
Historic	433	82.6%	63	77.8%	496	82.0%

Unfortunately, the use of the historical metric has also meant that internal reports on complaint activity and response rates have not, up until the end of November 2019, used the complaint despatched date as the compliance measure. The Trust is only required to externally report complaint handling activity to NHS Digital (via the Strategic Data Collection Service) for KO41a returns using just the total number of complaints closed and not whether these were closed in time (as complaint response timescales are agreed locally and differ from organisation to organisation), and so there has been no requirement for external remedies or reputational harm.

Regulation 17, Section (b), of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, states that the Trust is required to record an outcome for each complaint. The codes we use are a variant of the outcome codes used by the PHSO. The following tables set out complaints closed by outcome annually since 1 April 2016, firstly as a whole number, and then as a percentage of the number closed. For example, 169 complaints closed in 2019/20 were fully upheld in favour of the complainant, which represents 27.9% of all cases closed.

Complaint Outcomes	2016/17	2017/18	2018/19	2019/20
No. Complaints Closed	747	612	599	605
Investigation Complete; No Actions/Learning Identified (Not Upheld)	177	145	127	134
Investigation Complete; Apologies Required But No Actions/Learning Identified (Partly Upheld)	294	250	239	302
Investigation Complete; Apologies Required And Actions/Learning Identified (Upheld)	164	160	160	169

Complaint Outcomes - As A %	2016/17	2017/18	2018/19	2019/20
No. Complaints Closed	747	612	599	605
Investigation Complete; No Actions/Learning Identified (Not Upheld)	23.7%	23.7%	21.2%	22.1%
Investigation Complete; Apologies Required But No Actions/Learning Identified (Partly Upheld)	39.4%	40.8%	39.9%	49.9%
Investigation Complete; Apologies Required And Actions/Learning Identified (Upheld)	22.0%	26.1%	26.7%	27.9%

3.5 Learning from Complaints

As part of complaint handling, the Trust is committed to the implementation of learning arising from complaint investigations to prevent, as far as it is possible, any recurrence of the source of complaints being raised. There have been small areas of progress made in 2019/20 in terms of clinical divisions identifying and taking ownership of learning from complaints or complaint themes and trends.

In 2020/21, the Governance Team will progress further methods of engaging and supporting clinical divisions to take more robust action on the learning complaints can provide. The following are examples of learning identified and embedded following complaint investigations during 2019/20.

13729

This complaint concerned poor information provided in clinic letters for patients having CT colonography scans and that changing facilities for patients with mobility issues was poor, with no chairs in the changing area. The letter for CT colonography appointments was reviewed by the Clinical Manager for CT Scanning, and formal guidelines have been written for staff to ensure that all patients are told how to prepare for this procedure. The appointment letter template was also reviewed and amended, advising patients what clothing to wear and what items would need to be removed before a scan.

13988

The complainant raised a concern that a Junior Doctor in the Emergency Department did not follow guidance regarding the assessment of potential immobilised spinal trauma patients. Whilst the Trust does not have a local policy for managing these patients, it was recognised the NICE guidelines for patients presenting with spinal injuries was not followed. To prevent this from happening again, it was agreed that the management of these patients would be added to future training sessions for all doctors in the Emergency Department.

14047

This complaint concerned a mother's labour on 22 July 2018 where she suffered a uterine rupture, which was also subject to a Serious Incident investigation. Whilst rupturing of the uterus is considered to be a very rare incident, the Obstetric and Maternity Team's yearly teaching update for identifying and dealing with obstetric emergencies now includes a section of uterine rupture.

14160

The patient was having a cannula inserted for CT colonoscopy and given a pillow on which to rest her arm. This had blood on it, and the patient was concerned about infection control and the possibility of contracting HIV or Hepatitis. Full explanations were given with assurances that Trust's Infection Control Policy was adhered to. The curtained cannulation area was not occupied by anyone else in between the patient's use of it. The conclusion from the investigation undertaken was that the blood was almost certainly from the patient. The pillow case is always changed between patients as a matter of infection control. Since this incident, the CT Scanning Team have changed their practice and removed all pillow cases from the cannulation area and instead, use a disposable sheet on the pillow which is removed after every use and the pillow itself is cleaned.

14222

The complainant attended the Orthotic Department on 7 February 2020 as he was concerned he had not been contacted about his shoes. He learnt they had been ready for

collection since the end of October 2019, and only one attempt had been made to contact him by telephone to alert him of this. As a result of this, the clinical division have implemented a process whereby if we are unable to contact a patient by telephone, a letter will be sent to them to advise their item is ready for collection.

Additionally, in February 2020 the Trust received a copy of the Healthwatch report entitled "Shifting the Mindset". Healthwatch completed a review of national data from Trusts and their report contains a number of recommendations that the Trust is examining including:

- publish regular complaints reports and ensure they contain details on learning and improvement; and
- improve public confidence in the complaints system by communicating learning from complaints in more accessible ways such as leaflets and "You Said, We Did" boards.

3.6 Reopened Complaints

Whilst the Trust endeavours to resolve all complaints as far as it is possible to upon first receipt, there are occasions when complainants are not happy with the response they have been provided with, or the response generates queries and questions that need clarification or further investigation. In some cases, we can offer to reinvestigate their original complaint and go back to staff with the queries and questions raised, whilst in other cases we may find a Local Resolution Meeting (LRM) would be helpful in achieving a satisfactory outcome. When we agree to undertake further work on a complaint, the original complaint record is reopened as this generates a new set of investigation targets and deadlines for completion of a further response, and can be tracked as part of regular complaint reporting.

The rate of reopened complaints has steadily decreased since 2016/17; this may be the result of several factors including improved standards of complaint triage to better identify the issues that need investigating and responding to, improved quality of complaint investigations, and further work undertaken to ensure complaint issues are fully answered as well as making sure that any new issues arising from investigations are also answered in full. The following table sets out the reopened complaints rate for the last four years by whole number and reopen rate.

Complaint Reopen Rate	2016/17	2017/18	2018/19	2019/20
No. Complaints Closed	747	612	599	605
No. Complaints Reopened	132	92	80	58
% Complaints Closed Then Reopened	17.7%	15.0%	13.4%	9.6%

3.7 Post-Complaint Survey

In September 2016, the Trust launched a post-complaint survey to seek feedback from complainants about their experience of raising a complaint. The creation of a feedback survey formed part of the recommendations arising from a piece of collaborative work between the Complaints Team and Healthwatch East Sussex in January 2016. In the first year, the response rate to the post-complaint survey was 39.6% however, it dropped the following year and in 2018/19 the response rate had further dropped to 27.9% with many responses simply levelling criticism at the Trust as a whole and nothing more. This was reported at the Patient Experience and Engagement Steering Group (PEESG) in August

2019, where Healthwatch East Sussex has representation, and a collective decision was reached to bring the current post-complaint survey to an end.

In July 2019, Healthwatch East Sussex agreed to work collaboratively with the Complaints Team again in the role of "critical friend". As part of this, new ideas for collating feedback on the experience of complainants raising a complaint will be on the agenda. This will be followed up with Healthwatch East Sussex.

4. Parliamentary and Health Service Ombudsman (PHSO)

If a complainant is unhappy with the Trust's response(s) to their complaint and all local avenues of resolution have been exhausted, they have the right to take their complaint to the PHSO. The PHSO are an independent body who make final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations The Trust fully complies with all requests for information made by the PHSO, and appropriately acts upon decisions and direction given in any case.

In 2019/2020, the Trust received 18 contacts from the PHSO (down from 20 in 2018/19) and were provided with 13 case outcomes (down from 19 in 2018/19), although it should be noted that some of the outcomes related to cases opened by the PHSO in previous years. Of the 18 contacts, 14 were formal enquiries about cases the PHSO were considering for an investigation, and four contacts were to provide advice of intent to proceed with an investigation. In terms of the 13 case outcomes, there were seven cases the PHSO decided not investigate, three cases that were investigated but the PHSO decided not to uphold in the favour of the complainant, and three cases that were investigated and partially upheld by the PHSO in the favour of the complainant.

The following provides a summary of the three cases partially upheld in the favour of the complainant, together with details of the PHSO's findings and direction for resolution.

Case 1 (2017/2018)

The initial complaint was around the care of a patient who had advanced vaginal cancer, whereby the family had concerns with the surgery and complications thereafter.

The PHSO did not see any evidence of a delay in diagnosis of cancer and found that there was nothing to suggest the patient was showing active signs of an infection when discharged. Whilst a urine test suggested a urinary tract infection (UTI) may have been present, the correct antibiotic treatment was provided. However, the PHSO found that there was a service failure as there was a delay in the provision of antibiotic treatment for severe sepsis (given 3 hours 15 minutes after patient met criteria) on readmission to hospital the following day, which they considered denied the patient of the best possible chance of recovery. Sadly the patient died 10 days later.

The PHSO recommended that i) the Trust write to the complainant to apologise for the service failure and for its impact, ii) make a payment of £500.00 to the complainant in recognition of being left without the opportunity to know the full extent of the impact of the service failure and, iii) produce an action plan to ensure the relevant sepsis guidance was followed appropriately in the future.

Case 2 (2017)

The complainant raised a concern about the decision to withdraw community nursing visits to her late stepson, which she felt impacted upon his wellbeing. She felt that should an

Acute Care Nurse Practitioner (ACNP) be on leave, then a home visit should take place in order to determine as to whether it is appropriate to end service provision.

The PHSO found failings in the follow up arrangements by the ACNP and a lack of communication to ensure the patient and complainant were aware that no further appointments would be arranged for three months due to staff sickness. The PHSO felt there was a missed opportunity to notice deterioration in the patient's health.

The PHSO recommended that the Trust i) write to the complainant to apologise and acknowledge the impact of the failings, ii) make a payment of £200.00 to the complainant in recognition of the distress caused and, iii) consider the process for the handover of patients when a practitioner takes emergency leave, focusing specifically on the communication between the community team and the patient.

Case 3 (2017)
A number of concerns were raised by a complainant regarding the care and treatment his late wife received and a missed opportunity to diagnose her condition, as she was readmitted within 24 hours and died the following day as a result of a perforated bowel. Other issues were around presence of bruising, pain relief, personal care and nutritional needs not being met.

The PHSO decided to partially uphold the case, as they identified one failing in the care provided. They considered that although the patient did have dementia, this was not a legitimate reason to withhold information from her in terms of her C-diff results and it was discriminatory to assume that a person with dementia could not understand. However, in view of the additional information the Trust provided at the Provisional Views stage and because of the apology given to the complainant via the PHSO, they concluded that it was not necessary to make any recommendations.

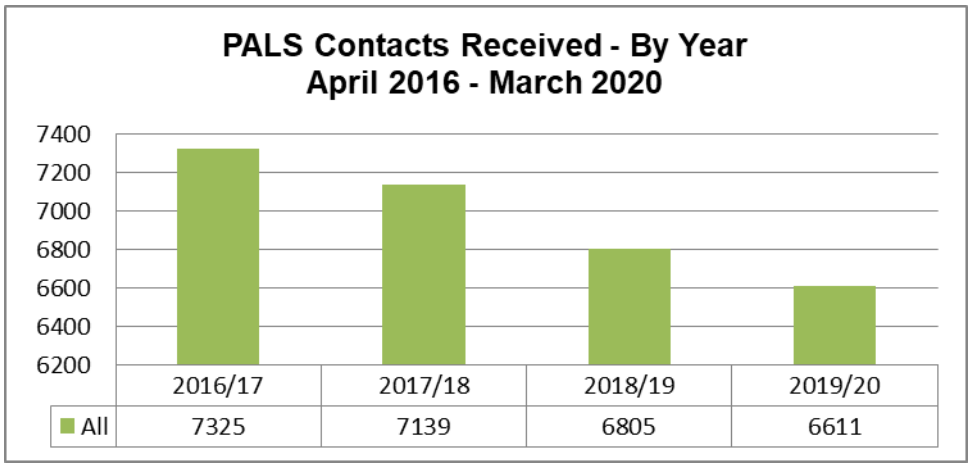
The PHSO did not uphold the following elements of the complaint: i) Bruising – they could not conclude that the Trust was to blame for the bruising the patient suffered or that we failed to provide the complainant with an adequate explanation, ii) Pain relief – they found no evidence to suggest the patient was given inadequate pain relief during her hospital admission, iii) Personal care – they found no evidence to suggest that the patient was not properly assisted with her personal care, iv) Nutrition – they found that the patient was appropriately assessed using the Malnutrition Universal Screening Tool (MUST) in line with national guidance, so the risk of malnutrition was identified and reasonable steps were taken to address the cause of the patient sometimes declining food, v) Diagnosis (abdominal issues) – they did not agree that an opportunity to diagnose the patient's condition earlier and provide potentially life-saving treatment was missed.

The PHSO also commented that they found the Trust's written responses to the complainant to be clear, comprehensive and reasonable.

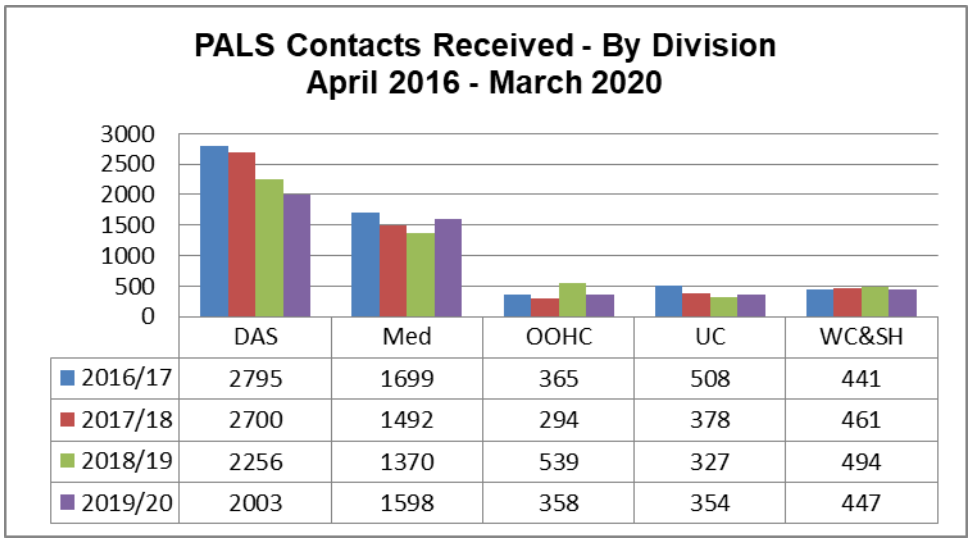
5. Patient Advice and Liaison Service (PALS)

PALS provide a vital role for the Trust by helping patients, their relatives and members of the public with assistance, advice and information, and any concerns or issues that can be handled quickly and locally without the need for a formal complaint. There is a PALS office at both of the acute hospital sites and the teams can be accessed by telephone, email or in person by walking into one of the offices (no appointment is required).

In 2019/20, PALS recorded 6,611 contacts which is a drop of 194 contacts on 2018/19 (n=6,805). Furthermore, this is the third consecutive year where there has been a drop in contact rates which has dropped by 9.7% since 2016/17. The following chart presents PALS contacts received year-on-year since April 2016.



As with new complaints, PALS contacts are also assigned to a clinical division. Any contacts about non-clinical matters, such as car parking or toilet facilities, are assigned to the appropriate non-clinical division. In terms of distribution of PALS contacts, the following chart represents assignment to each clinical division since April 2016.



	DAS	Med	OOHC	UC	WC&SH
2016/17	2795	1699	365	508	441
2017/18	2700	1492	294	378	461
2018/19	2256	1370	539	327	494
2019/20	2003	1598	358	354	447

In contrast to complaints activity where just 0.5% (n=28) of new complaints received related to non-clinical matters, 28.0% (n=1,851) of PALS contacts were for issues not related to a clinical area. Furthermore, contacts for non-clinical matters have increased year-on-year since 2016/17 and from 2017/18, has received the second highest number of contacts after DAS (in 2019/20, DAS accounted for 30.3% of all contacts and Medicine accounted for 24.2%). This may in part be a result of the consistently high number of contacts from patients unable to contact a department, together with an increasing number of contacts regarding issues with appointments; collectively these areas on their own accounted for 56.0% of contacts in 2019/20.

In terms of the type and method of contact with PALS, the following tables set out data for the last four years.

PALS Contacts - By Contact Type				
	2016/17	2017/18	2018/19	2019/20
All Contacts	**7325**	**7139**	**6805**	**6611**
Advice/Assistance/Information	3796	3825	4013	3784
Concerns/Issues	3520	3268	2774	2801
Suggestion/Comment	9	22	18	26

PALS Contacts - Top 3 Contact Methods				
	2016/17	2017/18	2018/19	2019/20
All Contacts	**7325**	**7139**	**6805**	**6611**
Email	1616	1196	1110	1555
In Person	1244	1443	1553	1691
Telephone	4152	4229	3862	3056

Whilst the proportion of contacts by type for 2019/20 remains largely unchanged compared to 2018/19, contacts by method have seen a 10.5% drop in telephone contacts and contacts by email have increased by 7.2% on last year.

All concerns and issues raised with PALS are assigned a primary contact subject. For the last four years the top five primary contact subjects have been the same and after a minor switch in ranking in 2017/18, have also been in the same ranking. The following table sets out the top five primary contact subjects since April 2016.

2016/17		2017/18		2018/19		2019/20	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
All Contacts	**7325**	**All Contacts**	**7139**	**All Contacts**	**6805**	**All Contacts**	**6611**
Communication	1275	Communication	1121	Communication	752	Communication	744
Patient Pathway	830	Patient Pathway	690	Patient Pathway	625	Patient Pathway	590
Standard of Care	330	Provision of Services	326	Provision of Services	482	Provision of Services	427
Provision of Services	206	Standard of Care	310	Standard of Care	313	Standard of Care	284
Attitude of Staff	203	Attitude of Staff	213	Attitude of Staff	190	Attitude of Staff	189

“Communication” remains the top primary contact subject and with little change on figures reported in 2018/19, whilst the remaining four top primary contact subjects reflect a reduction in numbers that correlates with the overall reduction in PALS contacts for 2019/20.

All PALS contacts assigned a primary contact subject are also assigned a secondary contact subject; this brings an additional layer of information to the data. The following table sets out the top 10 secondary contact subjects for the last four years.

	2016/17	2017/18	2018/19	2019/20
All Contacts	**7325**	**7139**	**6805**	**6611**
Unable to Contact Department	913	720	373	368
Appointment Issues	448	359	270	328
Unhappy With Attitude	195	203	172	178
Lack of Notification of Cancellation			100	168
Lack of Confidence in Delivery of Care	127	134	132	122
Lack of Information/Communication	112	118	88	110
Multiple Cancellations		79	97	106
Clinical Service/Treatment Not Available/Delays	203	235	188	95
Delay in Reporting/Communicating Test Rsults				90
Written Information for Patients			69	73
Admission Issues	138			
Overall Care	106	90		
Delayed Communication/Information	84	80		
Lack of/Delay in Referral	66	84		
Delays in Access to Service/Treatment - Outpatient			77	

Of Note In 2019/20 Regarding Appointment Issues:

Appointment Issues	328
Lack of Notification of Cancellation	168
Multiple Cancellations	106
Short Notification of Cancellation	33
Cancellation of Clinic	26
Cancellation of Surgery	8
	669

The top secondary contact subject for the last three years has been “Unable to Contact Department”, and is once again top in 2019/20 with little change in numbers compared to the previous year despite the overall drop in the number of PALS contacts. However, the ongoing rollout of the Trust’s new telephony system may mitigate some of these contacts during 2020/21, subject to the longer term impact of COVID-19. The other primary observation for this data in 2019/20 was the 21.5% increase in contacts about “Appointment Issues”. Furthermore, the sub-table above highlights the number of contacts with PALS on a wider range of secondary contact subjects relating to appointments; these six secondary contact subjects alone account for 10.1% of all PALS contacts in 2019/20.

Given the role of PALS and the number of acute and community settings the Trust operates from, it is understandable that contacts with PALS can be attributed to a large number of different specialty’s, and in excess of 200 different locations. The following tables set out the top 15 specialty’s and the top locations for PALS contacts since 2016/17.

Top 15 Specialty's for PALS Contacts	2016/17	2017/18	2018/19	2019/20
All Contacts	**7325**	**7139**	**6805**	**6611**
Clinical Administraion		499	687	551
Emergency Department	373	342	326	342
Urology	313	252	271	334
Other	315	317	253	321
Gastroenterology	228	283	185	281
Trauma and Orthopaedics	497	379	323	277
General Surgery	340	257	278	269
Ear, Nose and Throat	236	255	222	247
General Medicine	254	303	252	245
Cardiology	236	214	198	234
Gynaecology	171	171	209	200
Ophthalmology Eastbourne	338	468	300	199
Neurology			165	199
Radiology	238	247	206	166
Paediatrics	162	171	165	152
Corporate Governance (Incuding FOI)				132
Outpatients	549			
Medical Records	216			
Podiatry	143			
Maxillo Facial		168		
Financial Services		152		
Bladder and Bowel Service			225	

Of note in 2019/20 Urology, Gastroenterology, and Cardiology all had increases in PALS contacts compared to the previous year and as with new complaints, there has also been an increase in PALS contacts for Neurology in 2019/20. These increases may be led by service demand, clinical or operational pressures, and staff shortages particularly where there may be a national shortage of staff in particular specialty's.

The spike in contacts for the Bladder and Bowel Service in 2018/19 was, as anticipated, a one-off event due to the contractual changes in the provision of continence products.

And lastly, Corporate Governance appears in the top 15 specialty's for 2019/20 however, the figure of 132 (which primarily relates to contacts requesting information and advice on how to make Subject Access Requests for things like copies of medical records) is comparable to previous years (for example, 2018/19 n=140), but just may not have made the top 15 in that year.

Top Locations for PALS Locations	2016/17	2017/18	2018/19	2019/20
All Contacts	**7325**	**7139**	**6805**	**6611**
Out Patients Department - EDGH	1329	1248	1212	1288
Administration	1751	1291	1161	1178
Out Patients Department - CQ	815	660	565	542
Patients Home	121	214	466	245
Emergency Department - EDGH	188	179	157	189
Booked Admissions Department	236	233	205	181
Emergency Department - CQ	128	130	136	140
Radiology Department - CQ	149	112	97	85
Cashiers	78	140	100	81
Switchboard - CQ				69
Orthopaedics Out Patients Department - CQ	73	110		68
Cardiology Department - CQ			55	67
Health Records Library - EDGH	71			48
Ear, Nose and Throat Out Patients Department - CQ				47
Radiology Department - EDGH	118	100	61	
Community or Public Areas	77			
Fracture Clinic	70	124	82	
Richard Ticehurst Surgical Assessment Unit	65		53	
Audiology Department		130	61	
Endoscopy Unit - EDGH		72		
Orthopaedics Out Patients Department - EDGH		71	105	
MRI Scanning		68		
Acute Assessment Unit			81	
Physiotherapy - CQ			61	
No. Of Other Locations Contacts Recorded Against	207	217	219	210

The top three locations for PALS contacts over the last four years remains unchanged, with just a minor shift in ranking; this reflects the volume of contact with PALS about appointments, particularly where appointments have been cancelled with little or no notice and patients have not received a letter about this, or repeated cancellations of appointments, again, with no letters being received to advise of this.

As a result of the aforementioned reference to contacts in 2018/19 relating to the Bladder and Bowel Service, contacts recorded to the location of “Patients Home” saw a similar reduction in 2019/20 to correlate with this.

There was an anticipated spike in contacts in 2019/20 relating to “Switchboard - CQ” as a result of technical issues arising from the rollout of the Trust’s new telephony system, and there was an increase in the number of contacts relating to the location of “Health Records Library – EDGH” on 2018/19 due to the number of patients seeking advice and support in making Subject Access Requests for matters such as requesting copies of medical records.

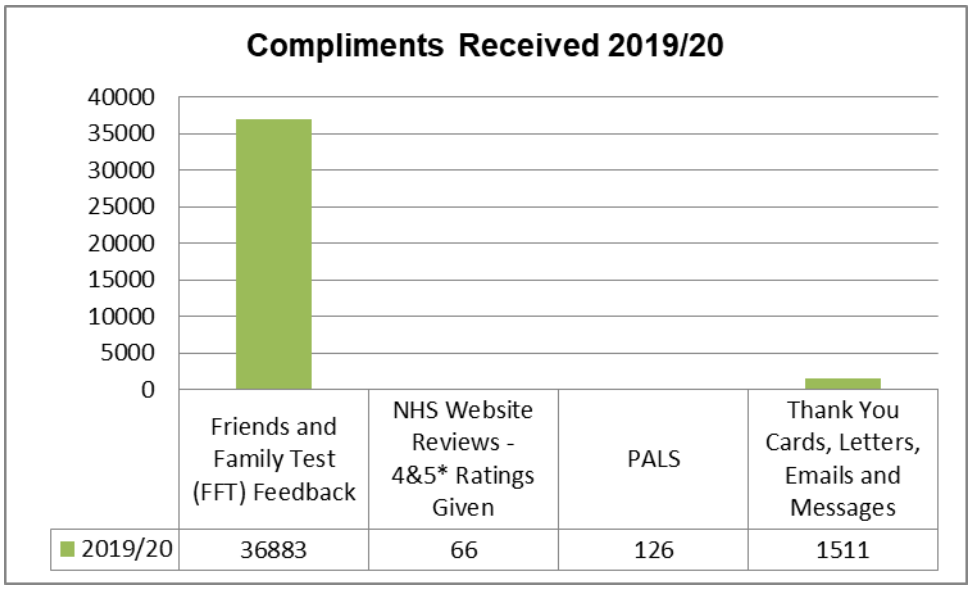
Finally, “Cashiers” regularly appears as a location for PALS contacts; however, this is not due to concerns or issues. This is because PALS handle patient travel reimbursements when the Cashiers Department is closed, or when patients are too unwell to make their way to the Cashiers Department given its location in relation to the main hospital; this further demonstrates how PALS supports staff and patients.

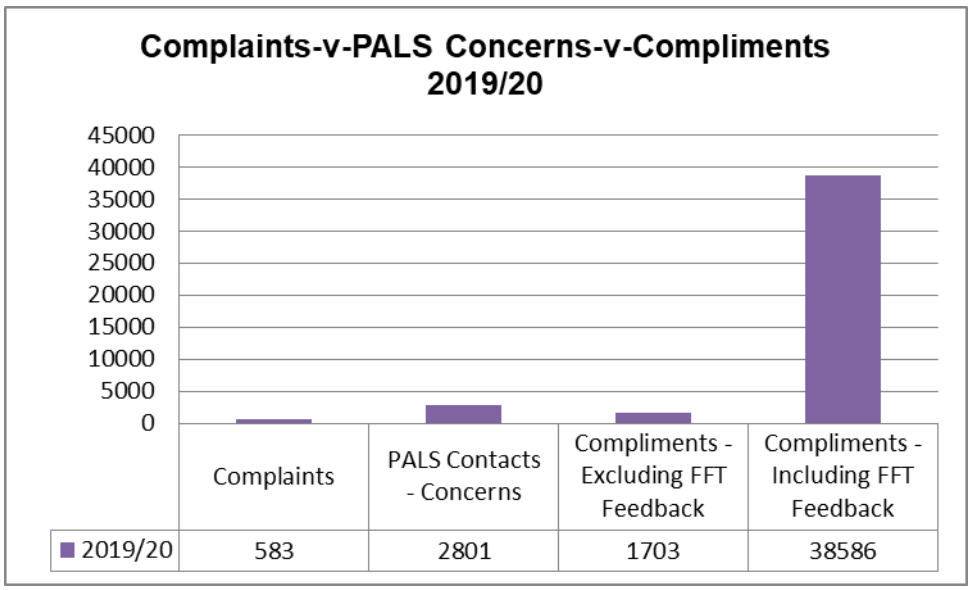
6. Compliments

It is always disappointing when patients and/or their relatives have cause to raise a concern or a complaint about the standard of care and treatment provided, our facilities or where our values of kindness, compassion, dignity and respect have not been upheld, and it is reassuring to know the Trust has robust processes to investigate and respond to these.

However, it is also important to recognise that much care and treatment takes place without issue, and the Trust receives many compliments and plaudits from patients. This underlines the fact that whilst sadly things don't always go to plan or as we would want or hope for, a great deal of our activity does meet the needs and satisfaction of our patients and their relatives.

In order to reflect on all types of feedback the Trust received from patient's and their relatives in 2019/20, the following tables set out the number and type of compliments and plaudits received, and then how this compares with the number of formal complaints and concerns raised with PALS.





The fact that patients and/or relatives have taken the time to contact the Trust with complimentary feedback and comment is hugely appreciated by our staff.

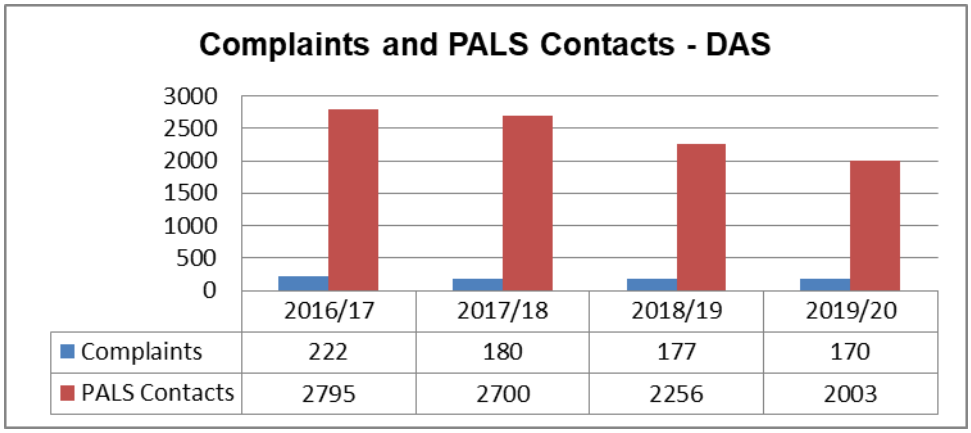
7. Complaints and PALS Activity by Clinical Division

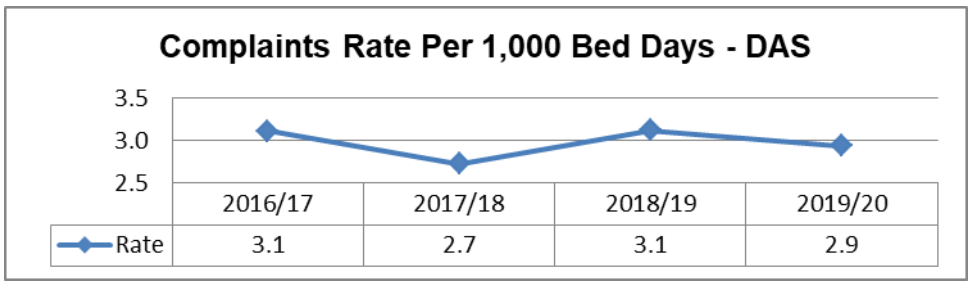
In order to review complaints and PALS activity for each clinical division over the last four years, the following section sets out headline data in key areas for analysis of trends and themes.

7.1 Diagnostics, Anaesthetics and Surgery (DAS)

DAS is a large clinical division and incorporates a comprehensive range of specialty's in both inpatient and outpatient modalities; it therefore consistently incurs a higher number of complaints and PALS contacts.

Over the last four years, DAS has seen a consistent reduction in the number of complaints and PALS contacts attributed to its services as evidenced in the following tables.





Top 3 Primary Complaint Subjects							
2016/17		**2017/18**		**2018/19**		**2019/20**	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
All Complaints	**222**	**All Complaints**	**180**	**All Complaints**	**177**	**All Complaints**	**170**
Standard of Care	116	Standard of Care	97	Standard of Care	74	Standard of Care	71
Communication	103	Communication	93	Patient Pathway	27	Patient Pathway	33
Patient Pathway	82	Patient Pathway	82	Attitude	22	Communication	19
				Communication	22		

In 2019/20, the top three secondary complaint subjects under the top primary complaint subject of "Standard of Care" were:

- Lack of Confidence in Delivery of Care (n=21)
- Problems/Complications Following Surgery/Procedure (n=15)

- Missed Diagnosis (n=12)

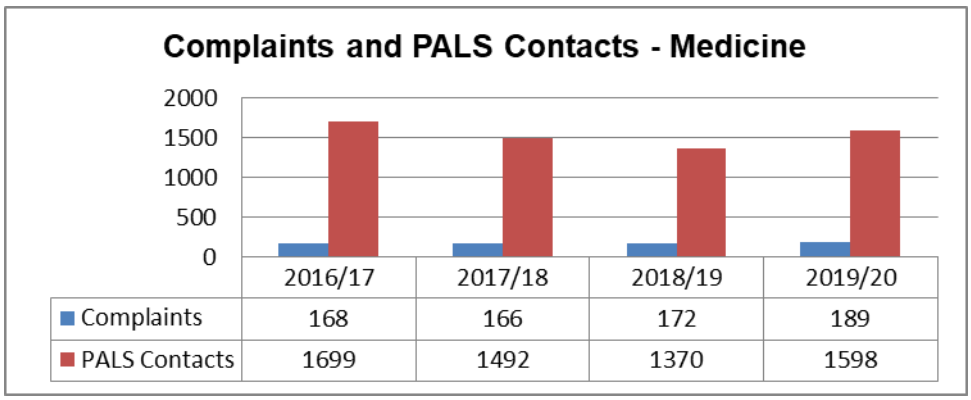
Top 3 Complaint Specialty's				
	2016/17	2017/18	2018/19	2019/20
All Complaints	**222**	**180**	**177**	**170**
General Surgery	45	39	35	44
Trauma and Orthopaedics	36	38	35	30
Urology	43	21	25	24
Radiology			16	

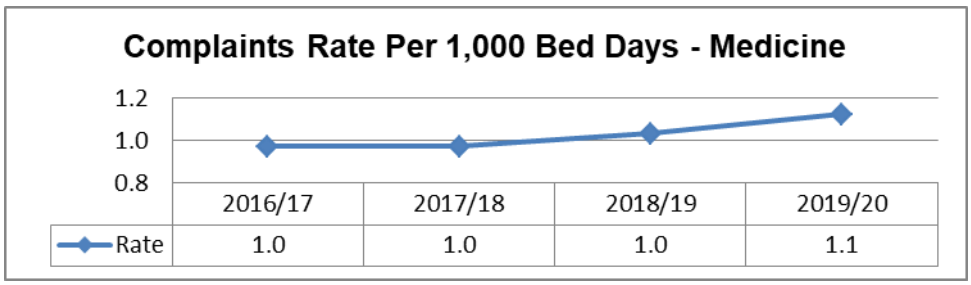
Top 5 Complaint Locations				
	2016/17	2017/18	2018/19	2019/20
All Complaints	**222**	**180**	**177**	**170**
Out Patients Department - EDGH	38	32	24	34
Out Patients Department - CQ	27	27	13	32
Richard Ticehurst Surgical Assessment Unit	9	14	12	12
Radiology - CQ				10
Gardner Ward				7
Hailsham 4	20	8	11	
De Cham Ward	12			
Egerton Ward		11		
Ophthalmology Outpatients - CQ			10	

7.2 Medicine

Medicine is also a large clinical division and incorporates a comprehensive range of specialty's in both inpatient and outpatient modalities; therefore like DAS, it consistently incurs a higher number of complaints and PALS contacts.

In 2019/20, Medicine experienced small increases in the number of complaints and PALS contacts it received compared to the previous three years, where complaints activity had remained relatively steady and PALS contacts had been consistently reducing, as noted in the following tables.





Top 3 Primary Complaint Subjects							
2016/17		**2017/18**		**2018/19**		**2019/20**	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
All Complaints	**168**	**All Complaints**	**166**	**All Complaints**	**172**	**All Complaints**	**189**
Communication	92	Standard of Care	100	Standard of Care	66	Standard of Care	88
Standard of Care	90	Communication	99	Communication	33	Communication	33
Patient Pathway	62	Patient Pathway	49	Patient Pathway	25	Patient Pathway	30

In 2019/20, the top three secondary complaint subjects under the top primary complaint subject of “Standard of Care” were:

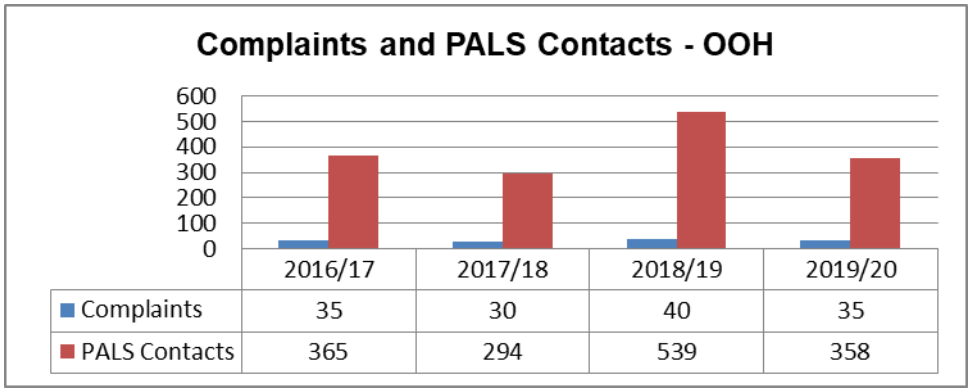
- Lack of Confidence in Delivery of Care (n=22)
- Delays in Nursing Interventions (n=9)
- Missed Diagnosis (n=7)
- Overall Care (n=7)

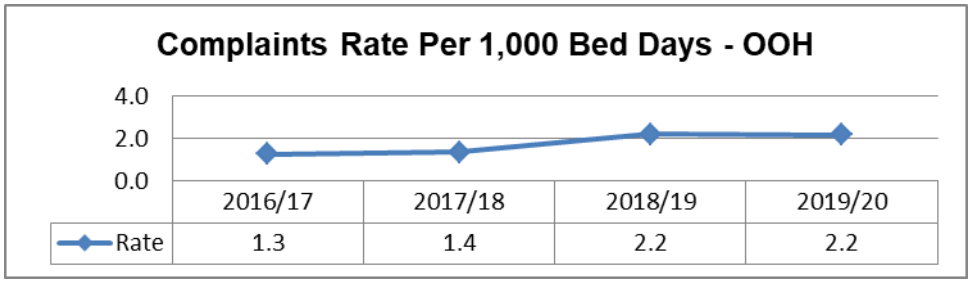
Top 3 Complaint Specialty's				
	2016/17	**2017/18**	**2018/19**	**2019/20**
All Complaints	**168**	**166**	**172**	**189**
General Medicine	43	46	45	26
Gastroenterology	25	20	25	25
Cardiology	19	20		20
Geraitrics and Services for the Elderly		14	18	

Top 5 Complaint Locations				
	2016/17	**2017/18**	**2018/19**	**2019/20**
All Complaints	**168**	**166**	**172**	**189**
Out Patients Department - EDGH	18	31	32	41
Out Patients Department - CQ	15	11	14	24
Acute Assessment Unit			10	17
Baird Ward				10
Cuckmere Ward		8	9	9
Jevington Ward			7	9
Administration	15			
Acute Medical Unit - EDGH	11	17	10	
Berwick Ward	8	7		
Wellington Ward	8			
Tressell Ward		8		
Seaford 4 Ward		7		
Newington Ward			7	

7.3 Out of Hospital (OOH)

The number of complaints and PALS contacts attributed to the services under OOH has remained relatively low compared to other clinical divisions, with minimal changes over the last four years. The only exception to this has been the spike in PALS contacts in 2018/19 due to the contractual changes to continence products in both adult and children's services as evidenced in the following tables.





Top 3 Primary Complaint Subjects							
2016/17		**2017/18**		**2018/19**		**2019/20**	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
All Complaints	**35**	**All Complaints**	**30**	**All Complaints**	**40**	**All Complaints**	**35**
Patient Pathway	20	Communication	17	Standard of Care	12	Patient Pathway	11
Communication	16	Standard of Care	14	Patient Pathway	9	Standard of Care	8
Standard of Care	9	Patient Pathway	9	Provision of Services	6	Provision of Services	6

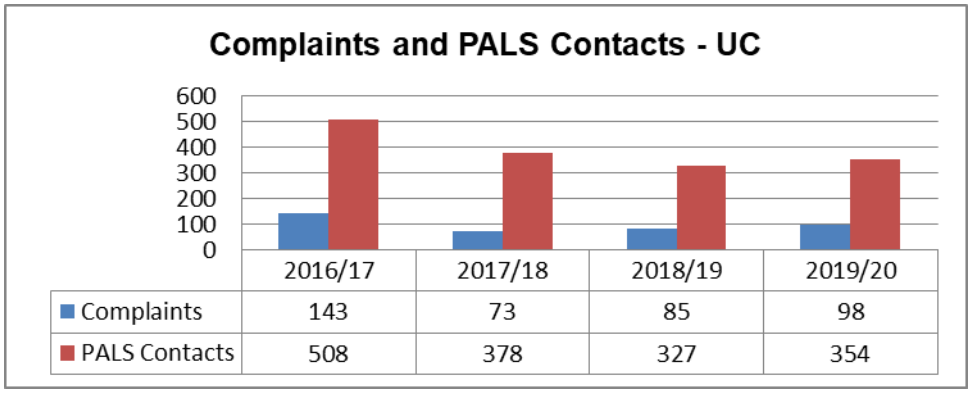
In 2019/20, the top secondary complaint subject under the top primary complaint subject of "Patient Pathway" was "Delays in Access to Service/Treatment – Out Patient" (n=6).

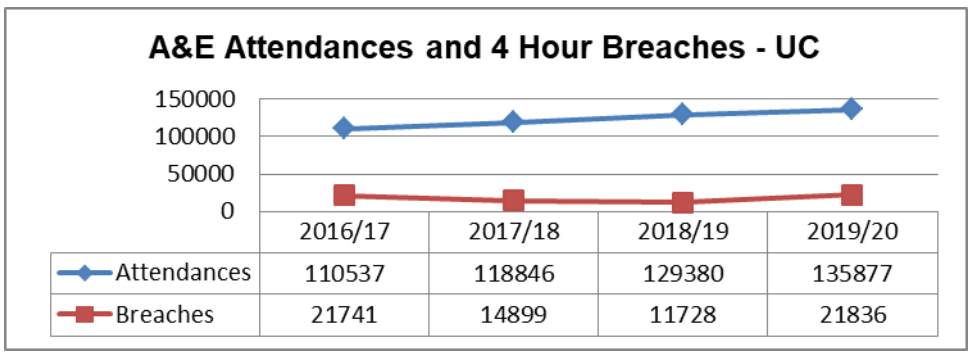
Top 3 Complaint Specialty's				
	2016/17	2017/18	2018/19	2019/20
All Complaints	**35**	**30**	**40**	**35**
MSK (Hastings and Rother)				6
Physiotherapy - Out Patients			4	5
Physiotherapy	5	7	3	3
District Nursing - Eastbourne	4	3		3
District Nursing - Hastings and St Leonards		3		3
Orthotics			3	3
Podiatry	6		6	
Intermediate Care		4		
Occupational Therapy		3		

Top 5 Complaint Locations				
	2016/17	2017/18	2018/19	2019/20
All Complaints	**35**	**30**	**40**	**35**
Patients Home	16	13	15	13
Out Patients Department - CQ	4		3	3
Orthotics				3
Physiotherapy - CQ				3
Physiotherapy - EDGH				3
Out Patients Department - EDGH	3	3	4	
Irvine Unit - Bexhill		6		

7.4 Urgent Care

The number of complaints and PALS contacts about UC has, for the last three years, remained relatively steady following the higher than usual figures reported in 2016/17. The following tables set out the activity in UC.





NB: there is no complaints rate for UC as they do not have inpatient bed activity.

Top 3 Primary Complaint Subjects							
2016/17		**2017/18**		**2018/19**		**2019/20**	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
All Complaints	**143**	**All Complaints**	**73**	**All Complaints**	**85**	**All Complaints**	**98**
Standard of Care	88	Standard of Care	31	Standard of Care	51	Standard of Care	53
Patient Pathway	52	Communication	15	Attitude	9	Discharge	14
Communication	51	Attitude	10	Patient Pathway	8	Patient Pathway	10

In 2019/20, the top three secondary complaint subjects under the top primary complaint subject of "Standard of Care" were:

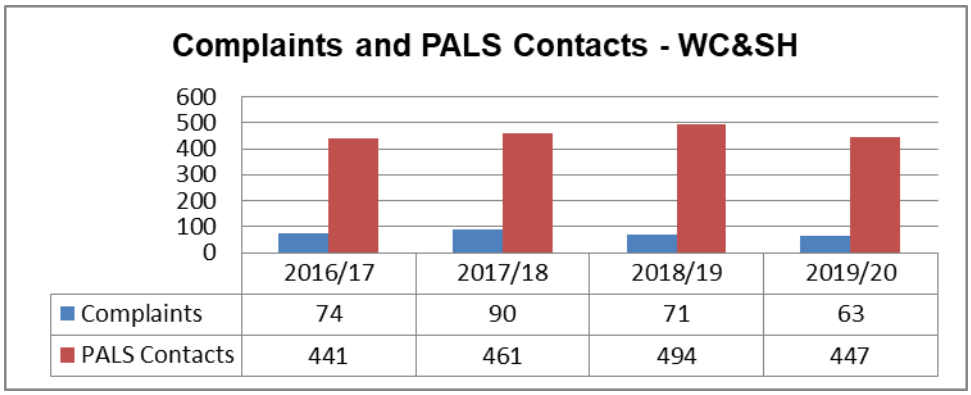
- Missed Diagnosis (n=19)
- Lack of Confidence in Delivery of Care (n=15)
- Incorrect Diagnosis (n=5)

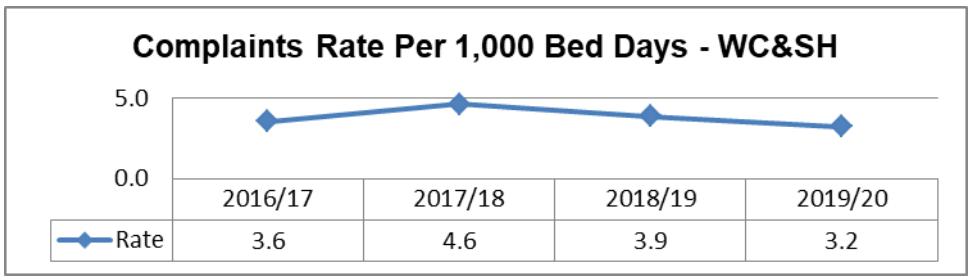
Top 3 Complaint Specialty's				
	2016/17	**2017/18**	**2018/19**	**2019/20**
All Complaints	**143**	**73**	**85**	**98**
Emergency Department	127	71	84	97
Primary Care Screening				1
General Medicine	7	1		
Frailty	6			
Ambulatory Care		1		

Top 5 Complaint Locations				
	2016/17	**2017/18**	**2018/19**	**2019/20**
All Complaints	**143**	**73**	**85**	**98**
Emergency Unit - CQ	50	32	27	48
Emergency Unit - EDGH	69	30	42	43

7.5 Women, Children and Sexual Health (WC&SH)

The number of complaints and PALS contacts recorded for WC&SH in 2019/20 has reduced compared to the previous year. The only area of noticeable change was the number of complaints relating to Out Patient activity as set out in the following tables.





Top 3 Primary Complaint Subjects							
2016/17		**2017/18**		**2018/19**		**2019/20**	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
All Complaints	**74**	**All Complaints**	**90**	**All Complaints**	**71**	**All Complaints**	**63**
Standard of Care	38	Communication	55	Standard of Care	22	Standard of Care	25
Communication	34	Standard of Care	48	Provison of Services	16	Communication	18
Patient Pathway	31	Patient Pathway	31	Communication	12	Patient Pathway	9

In 2019/20, the top three secondary complaint subjects under the top primary complaint subject of “Standard of Care” were:

- Lack of Confidence in Delivery of Care (n=7)
- Poor Bedside Manner (n=5)
- Missed Diagnosis (n=4)

Top 3 Complaint Specialty's				
	2016/17	**2017/18**	**2018/19**	**2019/20**
All Complaints	**74**	**90**	**71**	**63**
Paediatrics	25	28	28	19
Obstetrics	13	22	15	18
Gynaecology	24	32	21	16

Top 5 Complaint Locations				
	2016/17	**2017/18**	**2018/19**	**2019/20**
All Complaints	**74**	**90**	**71**	**63**
Out Patients Department - CQ				12
Out Patients Department - EDGH	18	15		8
Patients Home	6	9	16	8
Frank Shaw Ward		10	9	7
Kipling Ward	10			
Mirrlees Ward		10	7	

East Sussex Healthcare NHS Trust

Annual Safeguarding Report

2019 – 2020

Contents

Message from the Chief Nurse and Executive for Lead for Safeguarding Adults & Children
Vikki Carruth

As Executive Lead for Safeguarding Children and Adults, it is my responsibility to ensure that East Sussex Healthcare NHS Trust (ESHT) meets the statutory requirements required and is assured and updated via this report to the board.

This work includes ensuring robust governance in recruitment, up to date policies, local and Sussex wide procedures, up to date learning and development and multiagency working including representation on both local safeguarding boards. The Chief Nurse also works closely with the Chief Operating Officer and others to ensure systems and processes are in place to safeguard patients presenting with mental ill-health who also need ESHT services.

This last year the Safeguarding Team have worked hard to ensure that there are current Safeguarding Policies, Procedures and practices in place which are up to date, reviewed regularly and fit for purpose. All policies and procedures are accessible to staff via the Safeguarding Children and Safeguarding Adults pages on the trust intranet and advice and support is provided by our Safeguarding team.

1 in 3 women and 1 in 4 men experience some form of abuse by a partner.
Before the Covid19 Pandemic hit in the Spring of 2020, Domestic Violence and Abuse had already seen an increase from the year before but it was anticipated that with an imminent nationwide lockdown this would increase further. Sadly that has been the case as well as an increase in cases of child neglect and the number of children with a child protection plan. This will be reported on in next year's report. In the last year, we saw the withdrawal of the Health Independent Domestic Violence and Abuse Advisor role (HIDVA) by the CCG but I am delighted that in the last few months this has finally been reintroduced with ESHT hosting the role. More details of this will be shared with the Q&SC and will also be in next year's annual report.

We have focused upon the Trust's processes to ensure vulnerable children and adults who are not brought to appointments are recognised and that decisions with regards to appropriate follow up are made taking into account the voice of the child or vulnerable adult and the impact on their health and wellbeing as well as their safety.

Safeguarding is everybody's business and therefore it is vital that all staff members (including the board) undertake relevant safeguarding training/awareness with compliance regularly reviewed at the Trust Safeguarding Strategic Committee and via divisional IPRMs using the training database. The Trust has a training strategy in place for the delivery of safeguarding training, including Mental Capacity Assessments and caring for those patients who may lack capacity but are in need of care and treatment.

The Trust is involved in both local Safeguarding Partnerships, (ESCP for children and young people and the SAB for adults) is committed to interagency working and positively supports opportunities to work with other agencies. The team work especially closely with Local Authority colleagues and the Police. Members of the Safeguarding Team proactively participate in multi-agency audits with Discharge and Mental Capacity Assessments being a particular focus during 2019/20.

I would like to thank all staff for their continued support with this complex agenda and also thank system and multiagency partners for their collaborative and collegiate approach.

1.0 Introduction

The 2019/2020 Annual Safeguarding Report provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of the safeguarding work undertaken during the year, the work planned to further improve safeguarding practice in 2020/2021 and assurance regarding the Trust's compliance with the legislative and regulatory framework. This includes;

- Working Together to Safeguard Children (2018)
- The Children's Act (2004) - ESHT must be able to demonstrate that it safeguards children who access our care under section 11 of the act
- Safeguarding Vulnerable Adults in line with the Care Act (2014)
- Department of Health Care & Support Statutory Guidance under the Care Act (2014)
- The Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards amendment (2007)
- The Modern Slavery Act (2015)
- Safeguarding Children & Young People: Roles & Competences for Health Care Staff (2019)
- Safeguarding Adults: Roles & Competences for Health Care Staff (2018) and
- The Female Genital Mutilation Act (2003)

2.0 Safeguarding Governance

2.1 ESHT Safeguarding

Providers of NHS funded healthcare are required by NHS England to comply with the "Safeguarding Vulnerable People in the NHS Accountability Framework" (2015). ESHT must demonstrate that it is has effective arrangements to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and commissioners that these arrangements are working. These arrangements include;

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults, as appropriate.
- A suite of policies including Safeguarding & Safeguarding Supervision
- Effective safeguarding training for all staff commensurate with their role and in accordance with;
    - Safeguarding Children and Young People: roles and competences for healthcare staff. Royal College of Paediatrics and Child Health (2019)
    - Looked After Children: Knowledge, skills and competences of healthcare staff. Royal College of Paediatrics and Child Health (2016)
    - Safeguarding Adults: Roles and Competences for Health Care Staff (2018)

- Effective safeguarding supervision arrangements for staff working with children/families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies
- Named Safeguarding Professionals covering specific specialist areas
- Head of Safeguarding/Mental Capacity Act assessment Lead/Mental Health Lead posts.
- A statutory role in managing safeguarding allegations against staff, alongside Adult Social Care & HR colleagues.
- Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure any poor practice is identified and tackled.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance, including MCA (2005) and the Children's Act (2004).

The Intercollegiate Document (2019) requires NHS organisations to have structured safeguarding leadership with clinical and safeguarding expertise. The Chief Nurse is the Executive Lead and has responsibility for ensuring effective trust wide safeguarding governance, available advice and expertise, and robust arrangements and reporting are in place. The Chief Nurse supports the Head of Safeguarding and the Safeguarding team, and co-ordinates with the Divisional Associate Directors of Nursing who are responsible for ensuring robust safeguarding arrangements and practice in each of their clinical areas. The Chief Nurse also ensures there is support and development for the Safeguarding team to ensure that knowledge and practice is current with suitable supervision of cases.

2.2 Head of Safeguarding and Named Nurses attend the Annual Safeguarding Update

The governance and reporting arrangements are based on legislative changes and statutory requirements. Safeguarding Leads are required to provide support, advice, scrutiny and assurance. The Safeguarding Operational Group and Divisional Governance Meetings are held monthly and report into the bi-monthly Strategic Children and Adults Safeguarding Group, which reports to the Trust Board via the Quality and Safety Committee.

ESHT safeguarding policies for adults and children set out the key arrangements for safeguarding practice, roles and responsibilities. During 2019/2020;

- Safeguarding governance structures have been revised to improve operational understanding of safeguarding responsibilities.
- The Safeguarding Children Policy and associated training has been updated to reflect current safeguarding issues, including Domestic Violence, PREVENT (radicalisation), Child Sexual Exploitation (CSE), County Lines, Cuckooing, Modern Slavery and Human Trafficking.
- A Policy for Allegations of Abuse against Staff provides a framework (relevant to both adult and child safeguarding) to support Trust professionals when dealing with such allegations.
- Compliance with all safeguarding policies being in date was maintained at 100% throughout 2019/2020.
- The DNA/WNB policy (did not attend/was not brought) has been updated following the publication of the Child T case and this was actioned collaboratively with allied Health professionals including Dieticians.
- A policy for Looked After Children has been ratified and is accessible to staff via the extranet.
- The Chaperone policy has also been updated following investigations and relevant cases.
- The Domestic Abuse Bill 2019/20 was introduced in The House of Commons some 3 years ago will influence further the related policies and training delivered by the ESHT Safeguarding Team.

Divisional safeguarding reporting, via a standardised reporting tool, has improved visibility of safeguarding practice in clinical areas and highlighted challenges and good practice. These reports are a standing item at every Strategic Children and Adults Safeguarding Group meeting. There is increasing divisional ownership and engagement and a resulting increase in reporting and workload for the safeguarding team.

2.2 System Safeguarding

The legislative and regulatory safeguarding requirements set out duties for ESHT to co-operate and support wider system safeguarding practice with statutory partners including the Local Authority and the Police. The Chief Nurse is a member of both the Local Safeguarding Adults and the Local Safeguarding Children's Boards in East Sussex. The Head of Safeguarding and members of the team fully support the sub-committees, groups and processes of both safeguarding boards enabling ESHT to drive forward both the national and local safeguarding agenda in partnership with others. This ensures active learning from safeguarding reviews, partner agency reports, national safeguarding challenges and local issues, driving improvements in practice.

The Safeguarding team are involved in Sussex wide work developing integrated health and social care for the residents of East Sussex. The team provide safeguarding advice and expertise to a range of colleagues and Safeguarding Board members.

2.3 Care Quality Commission (CQC) Inspection

The CQC inspection of the Trust in 2019/2020 found outstanding practice in relation to Safeguarding. There was specific mention of the changes to safeguarding practices following concerns raised, (Child T Serious Case Review). An example given was that clinical staff informed the inspectors that the trust had begun to run a level 3 "Think Family" safeguarding study day. Topics covered included dealing with difficult family dynamics, female genital mutilation, forms of abuse including sexual abuse and the impact of parental mental health conditions.

2.4 NHSI Visit re: Transition Services for CYP - February 2020

The Chief Nurse and Head of Safeguarding had the opportunity to meet with the National Lead and NHSI colleagues and were able to discuss the implementation of an innovative role, that of the Safeguarding Transition Nurse. Transition was a key factor in the Child T case. It was understood that this role does not exist elsewhere and the team were able to give a short verbal presentation on how the role had developed from a pilot to a substantive post.

2.5 Joint Targeted Area Assessment (JTAI) February 2020

The purpose of the JTAI was for inspectors from Ofsted, CQC, HMICFRS and HMI Probation to undertake a deep dive into the provision of services with regards to children's and young people's mental health. The team assisted the inspectors across acute and community services as cases were audited and pathways of care and information sharing were reviewed. The inspectors also met with SPFT and Children's Social Care. Initial feedback regarding Safeguarding approach to Mental Health was positive and there was specific mention of the Looked after Children Service record keeping.

The JTAI report highlighted that there is an effective Safeguarding Children Partnership and Health and Wellbeing Board with an embedded culture of collaborative learning and development across the partnership in East Sussex.

Some of the key strengths points relevant to ESHT were:

- Assessments of children's needs are of consistently good quality demonstrating in-depth understanding of emotional well-being and mental health needs.
- Good information-sharing between partners ensuring that other professionals understand what the child has experienced, and how their responses are affected by their mental ill health.
- ESHT practitioners are well supported through robust supervision processes and their organisations' safeguarding specialists.
- ESHT has a good coverage of safeguarding training at all levels, including for staff who are providing direct support to children.
- The safeguarding team in ESHT has good oversight of children who attend the emergency department due to mental ill health. Young people deemed at high risk are reviewed at weekly meetings and this ensures that appropriate follow-up has taken place and information is shared with universal health services and primary care.
- Improved frontline practice and training regarding working with older children with both long-term health conditions and mental ill health following the Child T SCR.

The key areas for improvement relevant to ESHT were:

- Acknowledgment from the JTAI that the current arrangements for assessing the mental health of children and young people who present at hospital emergency departments in crisis are insufficient due to the limited capacity of the mental health liaison provided by CAMHS. The report highlighted that some children wait too long to be seen by specialist mental health practitioners and some are admitted to hospital unnecessarily.
- Underdeveloped communication and information sharing discharge letter from ED to GP following ED attendance potentially giving an inaccurate picture of children's needs or risks.
- Assessment documentation in use in the emergency departments does not contain a safeguarding assessment tool, and this does not support staff to be professionally curious about children's presentations.
- The mental health triage tool designed to support staff in identifying mental health needs is not being used routinely in the Conquest hospital.
- The child's voice is not consistently captured in the records, which means that practitioners cannot be assured of a holistic assessment of need, including consideration of the impact on a child, when a parent or carer attends the emergency department.

A robust system wide action plan is in place supported by the Chief Nurse and many other ESHT colleagues.

3.0 Key Achievements in Safeguarding 2019/2020;

- The Safeguarding Team were nominated for the Trusts Improvement and Development Award.
- The team actively participated in the national Domestic Abuse Awareness campaign.
- Safeguarding training has been redesigned to reflect a holistic 'Think Family' approach which combines both the adult and children's Level 3 training. There has been interest shown in this presentation by other health trusts within the country and locally from the CCG.
- The team have proactively undertaken a review of the services provided to young people between 16–18 years from a safeguarding perspective. Following a pilot in 2019, a Safeguarding Transition Specialist Nurse is now in post to oversee CYP placed on adult wards and out-patient attendances for CYP with long term medical conditions.

- The team have re-designed the Mental Capacity Act and Deprivation of Liberty training and support to staff, moving to e-solutions following a review of training and staff knowledge. ESHT staff now have access to the NHS Safeguarding app.
- Revised collaborative working arrangements with Sussex Partnership NHS Foundation Trust to ensure interventions where patients are sectioned are carefully documented, good compliance with training and improved application of the Mental Health Act (2007) where detained patients are admitted to ESHT inpatient areas.
- Colleagues have delivered training to key professionals using a risk based approach, to key teams in ESHT to ensure the rights of patients detained under the Mental Health Act are safeguarded and the trust is working within the legal framework required.
- The team has refined safeguarding governance systems and processes ensuring increased collaborative working with clinical and operational teams.
- Child Protection Information System (CP-IS) compliance in the emergency departments during 2019/20 has been maintained at 100% following 3 audits.
- With the cessation of the HIDVA post the Safeguarding Team developed a Domestic Abuse workshop which has been accessed by several clinical areas within the Trust.
- The team continue to raise the profile of the PREVENT agenda, attending the Regional Prevent Board, and sharing information across the Trust through awareness and targeted WRAP training.
- Supported the implementation of the mandatory Female Genital Mutilation Information System (FGM-IS) in maternity.
- Maternity Safeguarding Midwives continue to raise the profile of domestic abuse. They work closely with maternity staff supporting strategies to enable them to discuss the issue of domestic abuse with all pregnant women during their antenatal and postnatal care.
- In 2019, Maternity Safeguarding introduced Baby Boxes for women and their babies who have been separated by a court order. The boxes contain a teddy bear, photo album with pictures taken on the ward, a photo frame with hand/foot print impressions and a small box for a lock of hair. A baby box is provided for both mother and child.
- Maternity and Children's Social Care has established a link where midwives and social workers meet to discuss and debrief re: care provided during court ordered separations. The goal of the group is to gain a better understanding between the two professions and to improve care for families who are awaiting court decisions.
- The team worked closely with the Women's and Children's Division and Urgent Care to address concerns regarding the experiences of patients with Mental ill-health, specifically through audit, including a review of the Risks on the Trust Risk Register and development of a more robust process of monitoring the patients that are referred to Child and Adolescent Mental Health and Children's Social Care database (GDPR compliant).
- Colleagues have undertaken a GDPR based review of information sharing.
- Increase in the delivery of Safeguarding Supervision in Adult and Child Specialist areas, specifically the community which has managed self-neglect and complex caseloads.
- Contribution to LSCB Quality Assurance Subgroup in monitoring and evaluating the effectiveness of the work carried out by board partners by contributing to 4 multiagency audits (regulars case file, elective home educated, domestic abuse and fabricated or induced illness).
- Multi-agency Child Exploitation (MACE) alerts have been added to e-searcher to identify young people at risk.
- Work with ESHT ED departments to improve the quality of the safeguarding information contained in the discharge letters in order to improve communication and safety within the primary care setting.
- Quarterly meeting with Named safeguarding professionals to discuss complex cases.

Throughout 2019/2020 ESHT has supported changes in practice as a result of learning from Safeguarding Case Reviews (SCR's) including;

- Developing a Think Family level 3 training package to support staff in considering safeguarding within a broader family context.
- Developing a programme to support staff who are working with patients who self-neglect (Adult A - Safeguarding Adult Review)
- Safeguarding learning will inform the work underway regarding discharge planning (Adult C - Safeguarding Adult Review)
- A Serious Case Review (Child T) highlighted risks associated with vulnerable children who transition from child to adult health and social care services. An innovative multiagency project is now being piloted where high risk complex safeguarding cases with long term medical needs are now jointly supervised by both ESHT and the Local Area safeguarding team.
- Maternity services are improving practice in relation to the return of mother and baby hand held notes postnatally.

4.0 National Context

4.1 Child Safeguarding Arrangements

Following the publication of the Woods report (report) and Working Together 2018 the Safeguarding Children's Board roles and functions were reviewed and have been revised to accommodate National guidance in respect of Serious Case Review (SCRs) and Child Death Overview Panels (CDOPs). The LSCB is now referred to as the East Sussex Safeguarding Children Partnership Board (ESSCP).

Recommendations:

The new ESSCP board combines three key agencies, Local Authorities, Health and Police and retains existing pathways and ways of working.

The management of Serious Case Reviews has altered and there is now a national independent body to oversee a new learning framework for inquiries into child deaths to whom local boards are now accountable where children have experienced serious harm. East Sussex has now managed several Serious Case reviews within the new frameworks which highlight the importance of rapid response and transparency in publicising how an area has learned from an incident and what has changed in local practice. Also key is advising how learning can be reported through existing local accountability structures so as to ensure transparency and promote learning.

Child Death Overview Panels (CDOPs) have moved from the Department for Education to the Department of Health. A national E-CDOP database has been introduced for CDOPs, in 2020 the funding of the CDOP post moved to the CCG with the establishment of a whole Sussex CDOP team of Nurses to provide cross cover within the region.

There is a CDOP Specialist Nurse based in East Sussex who is also a member of the CDOP panel. A review is held into each death to determine whether there are modifiable factors which may have contributed to the death. The most common modifiable factor continues to be inappropriate sleeping position for babies. ESHT has undertaken a review of the work regarding safe sleep advice/strategies and has shared this with relevant colleagues within ESHT and external partners such as children's centres.

There had previously been a rise in suicide rates in young people but this has reduced locally over the last 4 years. However the mental health and resilience of young people remains a

safeguarding concern which has been raised nationally and locally through the East Sussex Children and Young People's Mental Health and Wellbeing Transformation Plan (2015-2020). Mental Health care/provision is also noted to be a risk across the system for a variety of reasons at very senior levels. This is not a criticism of local MH services but a national issue in terms of commissioning and provision. The Covi19 Pandemic has very likely put even greater strain on these services.

4.2 Learning Disabilities and Safeguarding

The Trust has a Lead Nurse for Learning Disabilities, supporting and facilitating equality, access and treatment for children and adults with learning disabilities who access ESHT services, ensuring compliance with the Mental Capacity Act (2005) and the Equalities Act (2010) through training and advice/support.

There is a network of LD champions across all sites to promote best practice, which is supported by monthly network events, role update sessions and education re: specific areas. The Lead Nurse for LD represents the Trust in the wider system and is a member of the Strategic Group.
ESHT fully participates in the LEDER programme, which ensures that all deaths of people with learning disabilities aged 4 years and over, are subject to external review following the nationally mandated processes. These reviews ensure all appropriate health and care records from all providers involved with the person are reviewed to identify learning.

The Head of Safeguarding represents the Trust on the East Sussex and Surrey STP LEDER Steering Group, which reports into the STP Transforming Care Group. The LEDER steering group ensures a collaborative commissioner and provider approach to investigation, learning across the STP and sharing of best practice to influence how services are provided to people with LD.

The Learning Disability Standards have provided a better understanding of how ESHT can better meet the needs of patients with Learning Disability and it is expected that moving forward the changes which are informed by initial findings will gain momentum such as the 'flagging' on information systems when a patient has a diagnosed LD. By flagging patients we will be better able to anticipate and meet patients' needs and enhance the quality of the care people with LD receive.

4.3 Policing and Crime Act, 2017

The introduction of the Policing and Crime Act in December 2017;

- removed the use of police cells as places of safety for under 18 year olds
- restricted the use of police cells as places of safety for adults being held under the Mental Health Act (2007)
- reduced the length of time someone can be held from 72 hours to 24 hours under Section 135/6 powers

During 2019/2020 attendances at the Emergency Departments continued to increase including patients with mental ill-health as well as acute clinical care needs As a result, it has become vital that the Head of Safeguarding is working with colleagues in closely monitoring the numbers of patients subject to sections and any incidents that occur.

Senior Trust staff and the safeguarding team continue to collaborate with the key stakeholders across the system to ensure processes and procedures are aligned to implement the revised legislation locally. ESHT have seen, alongside other healthcare providers, an increase in mental health related presentations to both emergency departments. On occasions there are no physical health needs with often challenging and on occasions violent behaviour. This picture is being reflected nationally and local partnership work continues to ensure patients are assessed and treated in the most appropriate place but challenges remain.

4.4 Multi – Agency Female Genital Mutilation (FGM) Guidance

ESHT has effective arrangements in place to meet the requirements set out in the Home Office guidance for FGM. The FGM Lead is responsible for all mandatory returns, monitoring local incidences of FGM and staff training and support to ensure staff can identify females at risk, detect FGM and report it effectively. Between April 1st 2019 and 31st March 2020 there were 16 cases of FGM reported by ESHT with data entered onto the National FGM Database. This is an increase from 9 reported cased in 2019-2020. FGM-IS has been implemented. The FGM-IS is a national IT system linked to the NHS spine that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of Female Genital Mutilation (FGM). ESHT has begun to implement the system which is led by the Named and Deputy Named Midwife for Safeguarding.

4.5 Continuing the work as a result of the Independent Inquiry into Child Sexual Abuse (Goddard Inquiry 2014)

The output from the Goddard Inquiry aimed to investigate institutional child sex abuse following the death of Jimmy Saville and resulted in safeguarding policy review in 2018. The safeguarding team have proactively worked with ESHT staff to increase awareness of child sexual exploitation and abuse by the implementation of the Allegations of Abuse Against Staff Policy.

ESHT has undertaken audits of high risk children, already known to the Missing and Sexual Exploitation Group, who attended our emergency departments. There is a weekly meeting to identify specific high risk children who are flagged with discussion and planning at the Missing and Sexual Exploitation Group to ensure they are safeguarded.

The Named Safeguarding Nurse for Community represents ESHT at the Multi Agency Child Exploitation Group (MaCE) and ensures learning is shared with the Trust. Child Safeguarding training, policies, procedures and checks have all been reviewed in response to improve awareness and action in response to these risks. Training focuses on ensuring staff are aware of the risk factors that make children and young people increasingly at risk of being missing and/or sexually exploited. It is known that these risks can increase a child or young person's risk of further exploitation in relation to being trafficked. Alerts have now been added to the e-searcher systems for those children identified as high risk of exploitation through the MACE panel discussions.

East Sussex has a sizeable population of Looked After Children. This group, particularly those placed by other local authorities into the county, are known to be particularly vulnerable. ESHT has a significant role in relation to safeguarding children from this type of organised abuse.

4.6 The impact of County Lines

During 2019/2020 Safeguarding Training and Supervision continues to include 'County Lines' which is the term used to describe the distribution of drugs from major cities into counties. ESHT continues to support Emergency Department staff, Police and other agencies to identify children at risk of being drawn into serious crime including drug dealing with pressure to carry weapons. Unfortunately Children in Care have been overly represented in the overall amount of 'County Lines' related cases presenting to our ED department bought in by Police.
Community staff are especially well placed to identify when vulnerable adults and children are exploited through 'cuckooing' where drug dealers take over the house of a vulnerable adult and supply drugs from the address, using children as a runner. The reporting of these concerns to Police and Social Care is better understood and that there is a responsibility to protect our most vulnerable service users.

4.7 Modern Slavery/Human Trafficking

East Sussex LSCB, including its partner members, has pledged to reduce the risk of children being sexually exploited, trafficked or going missing from/in East Sussex. Section 54(1) of the Modern Slavery Act (2015) places a legal requirement on ESHT to prepare our staff to identify patients at risk of modern slavery and being trafficked. Whilst it is not a mandated requirement yet to provide information centrally, ESHT continues to identify suspected cases which have been reported to the police. The Named Nurse for community is listed within the March 2019 'Stop the Traffic', single point of contact directory for Modern Slavery.

4.8 The Care Act (2014) - Making Safeguarding Personal

It has been agreed that to enable ESHT to deliver MSP focused safeguarding practice, a framework of reflection and revised training alongside the learning from complaints, safeguarding enquiries and case reviews is required. The Care Act (2014) defined safeguarding adults as 'protecting an adult's right to live in safety, free from abuse and neglect'. Making Safeguarding Personal (MSP) defines an approach to safeguarding which focuses on outcomes rather than process. It aims to answer, in partnership with the adult at risk / their advocate, three questions;

- What difference would they want or desire?
- How will you work with someone to enable that to happen?
- How will you know a difference has been made?

In 2018/2019 ESHT reviewed the way in which Adult Safeguarding cases are supported, with a particular focus on the community. Safeguarding Supervision has been implemented with a policy to support its introduction and documentation to enable practitioners to evidence that they have applied a MSP approach to their care.

4.9 PREVENT

Supported by the Chief Nurse, the Head of Safeguarding is the Trust lead for PREVENT, which supports the local and national counter terrorism strategy, and is a requirement under the Counter Terrorism and Security Act (2015).

Locally the Trust is active on the PREVENT Board and submits numbers of PREVENT (Channel) referrals from health quarterly to the CCG and NHSE. Level 2 Safeguarding training has PREVENT awareness training embedded within it for both children and adults, as radicalisation is considered comparable to other forms of abuse. WRAP training has been delivered to staff who require level 3 Safeguarding Training, and a session was delivered to the Trust Board in early 2019 with more planned going forward.

4.10 Domestic Abuse and Multiagency Risk Assessment Conference (MARAC)

MARAC is a multiagency forum managing high risk cases of domestic abuse, stalking and honour based violence. Chaired by the police, they bring together statutory and voluntary partner organisations to share information and work collaboratively to safeguard the person at risk by developing a coordinated plan of protection. ESHT are members of both MARACs in East Sussex, where specialist nurses and midwives represent the Trust.

Due to the volume of cases locally, the MARAC services have been piloting 'MARAC Hubs' to triage the cases and ensure robust safety plans are in place. The full MARAC meetings do not proceed when safety plans are evidenced through the hubs. The Specialist Health Visitors for Duty and Assessment continue to provide health research to the new forum.

As a result of this Multi-Agency engagement, it was possible that confirmed cases of domestic abuse began to be flagged on patient administration systems. Furthermore to strengthen arrangements, the “Care Grow Live” organisation and Hastings and Rother CCG funded an Health Independent Domestic Violence Advisor (HIDVA) for 12 months. This post focused on supporting staff to identify domestic abuse through the process of referral, once made. This support was highly valued by staff from different clinical areas but even more appreciated within high risk areas such as Maternity, SCBU and the ED’s. In early 2019 ESHT was informed that there was no longer funding for the post. ESHT Safeguarding Team consequently attended DV training in order to be able to continue with the work that was initiated by the HIDVA. The team took a lead in delivering training throughout ESHT. The Chief Nurse flagged this as a significant risk and was pursuing this throughout 2019/2020 and just recently has had agreement that the post is to be reinstated with ESHT hosting.

5.0 Local Case Reviews

A Domestic Homicide Review, Serious Case or Case Review is undertaken when it is identified that there is likely to be learning following a referral to the Safeguarding Board regarding the management of a vulnerable person. This is a multi-agency undertaking with ESHT contributing and undertaking investigations, report writing, identifying lessons to be learnt, making recommendations and monitoring progress and attendance at subsequent learning events. The external reviewer then writes a report which is published once it has agency sign off. The 3 cases for 2019/2020 are yet to be published however action plans will be brought to the Safeguarding Strategic Committee for assurance. Themes from the case reviews will inform practice and the team will provide briefings for all staff involved.

6.0 Section 11 Audit

In 2019/2020 ESHT completed the LSCB’s Section 11 Audit (Children Act 2004). The purpose of this is to improve the way key people and agencies safeguard and promote the welfare of children and is crucial to ensure better outcomes for all children. ESHT is required to participate as the Act places a statutory duty on key organisations to make arrangements to ensure that the trust has regard for the need to safeguard and promote the welfare of children and young people. The self-evaluation toolkit enables the Safeguarding Team to identify areas where further work is needed to meet the required standards and action plans are in place to ensure that all Section 11 standards were met. Specific areas for further development included:

- ensuring senior members of staff receive safeguarding supervision
- providing a patient safety leaflet for staying safe online
- ensuring children are seen alone in Emergency Departments
- ensuring that all staff have the required checks in line with the Disclosure and Barring Service requirements

Progress on the identified areas for development was positive with all areas achieved during 2019/20.

7. 0 Safeguarding Work Plans

The work plans for all aspects of safeguarding and learning disabilities and the processes for reviewing and reporting progress, risks and compliance were revised as part of an overall review of safeguarding governance. There is now a monthly Safeguarding Work Plan meeting to ensure it is responsive and reflective of the work undertaken by the Safeguarding team. The aim is to accurately capture the learning, mitigations, planned developments and improvements in relation to national, regional and local guidance. The Safeguarding Children and Adults Strategic Group

continues to monitor progress, compliance and risk through the Head of Safeguarding Report and the Divisional Safeguarding Reports received at each meeting. More work is required going forward regarding controlling coercive behaviour which is an emerging issue nationally.

8.0 Safeguarding Activity

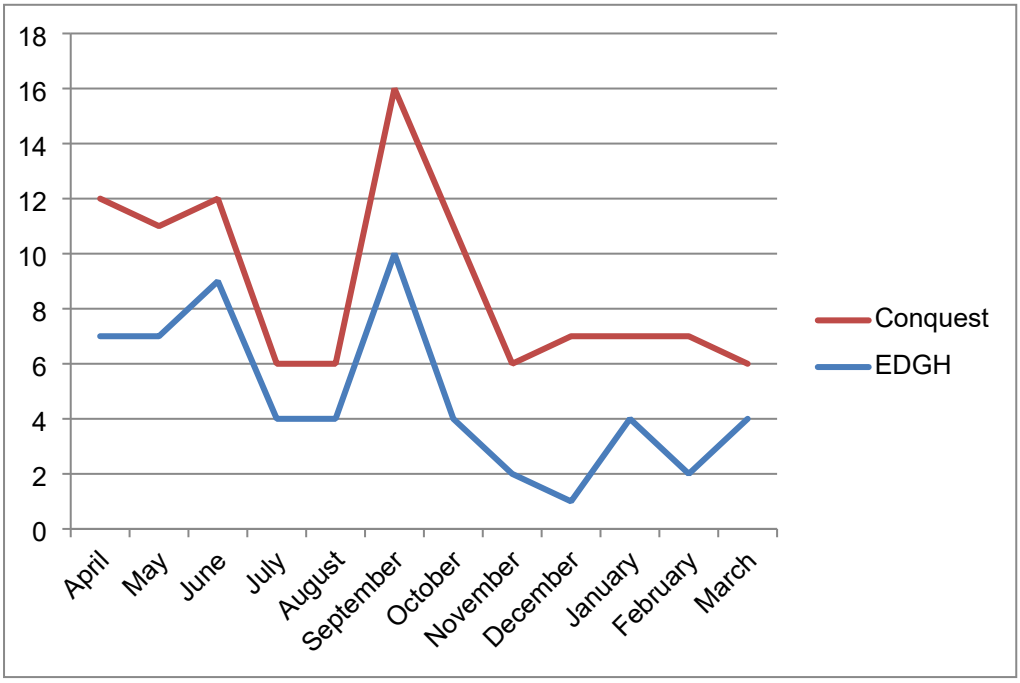
8.1 Safeguarding Adult Referrals

Safeguarding alerts/referrals can be raised by staff, patients, family members or the public and are received by Social Care, who apply three key tests to decide if the concern raised meets the threshold for a Section 42 Adult Safeguarding concern. Of the referrals ASC receive, very few result in a Section 42 Enquiry.

However this does not accurately reflect the work that is required in reaching that decision. Moving forward, there needs to be better recording of the numbers of referrals received by ASC and a focus on the cause for concern. It is also hoped that it will be possible to illustrate the specific clinical areas involved. ESHT monitors all Deprivation of Liberties (DoLS) applications for authorisation by the Local Authority. During 2019/2020 the number of referrals and authorisations remained consistent in each quarter. In 2019/20 the process of referral to the DoLS office changed and clinical staff have greater powers to request DoLS reducing the time it takes for the intervention to commence. New legislation was expected in October 2020 but is now deferred until 2021 and will be referred to as Liberty Protection Safeguards (LPS) which will replace DoLS procedures.

The LPS system introduces new structures, roles and responsibilities for NHS organisations. Training will be introduced for front line staff and managers once the code of practice has been published. A Task and Finish steering group chaired by the Head of Safeguarding has already commenced and mapping is underway. Scoping of the numbers of DoLS applications in the trust has also been undertaken and the safeguarding team are partaking in local and regional meetings regarding LPS implementation.

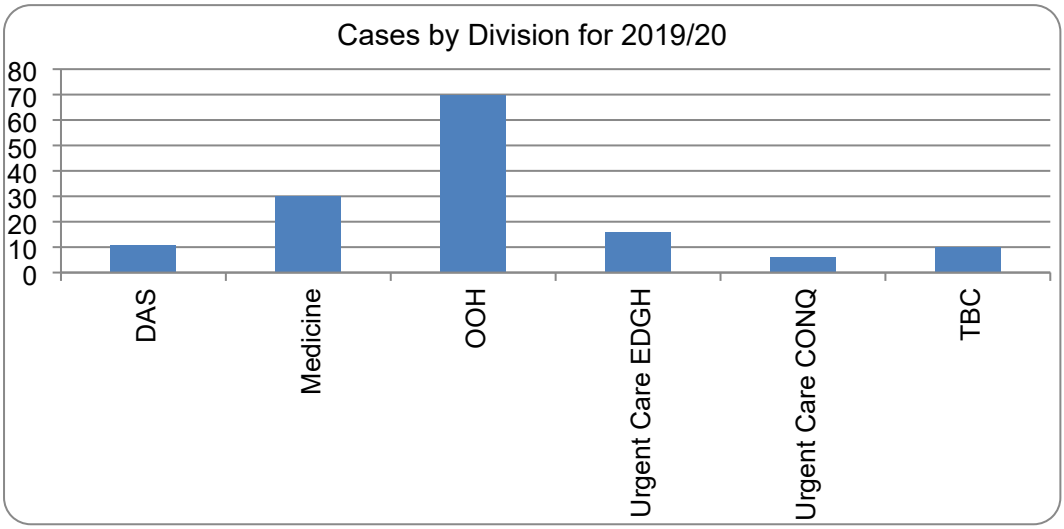
DOLS applications 2019-2020



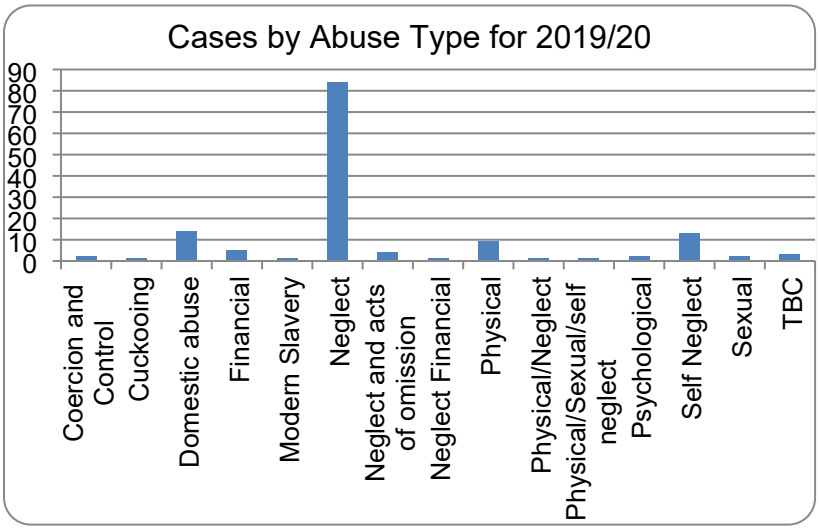
The impact of the introduction of LPS upon the workload of the Safeguarding Team professionals who will be supporting Divisions to implement the changes is difficult to anticipate. Looking at the

chart above numbers are relatively low, the Conquest being the busier site with no themes or trends in this regard.

Safeguarding Adult Referrals.



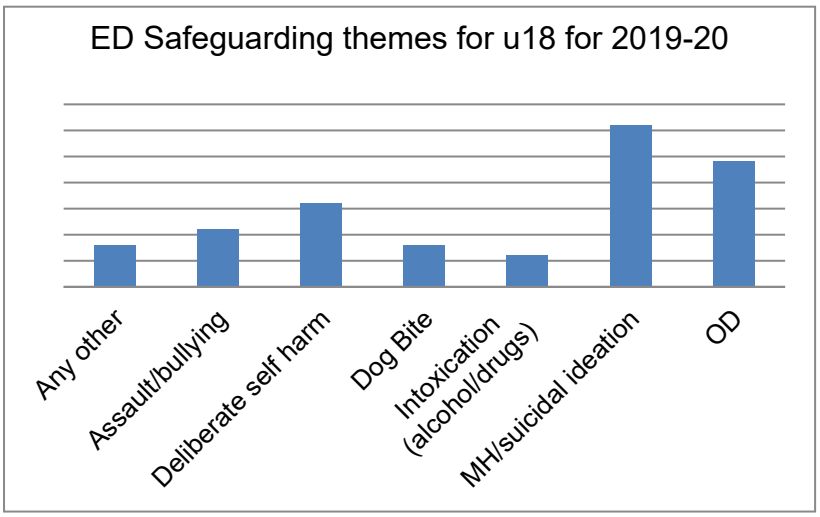
During 2019/2020 ESHT raised or was involved in 143 safeguarding enquiries. This covers both acute and community services. Neglect, self-neglect and domestic abuse are identified as themes raised as safeguarding enquiries. Safeguarding supervision has continued to expand into the community and is being developed in the acute settings. This has enabled teams to access team support whilst managing complex safeguarding cases and has also enabled the “Think Family” approach to be embedded further. The Think Family level 3 safeguarding training identifies current safeguarding themes and trends both locally and nationally and has been positively received and well evaluated.



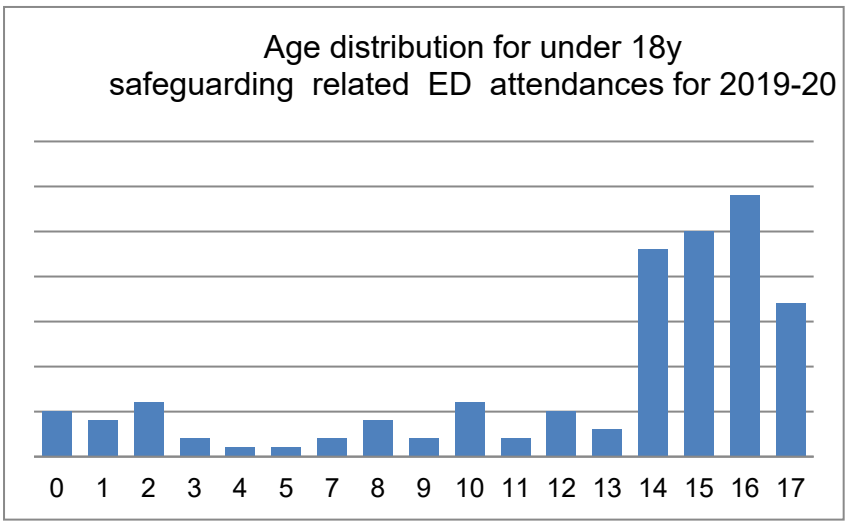
8.2 Safeguarding Children Referrals

During 2019/20 over 25,000 children presented to both ED’s. Over 3,300 required admission for different health issues. 99% of all children attendances were checked on CP-IS at first point of contact and 100% of these were checked on Liquid Logic by the safeguarding team. Around 1,800 of the overall ED attendances were risk assessed and discussed at the weekly ESHT Safeguarding Clinical Risk Meeting as they raised safeguarding concerns or were known to be vulnerable i.e. suffering from Social and Mental Health related issues.

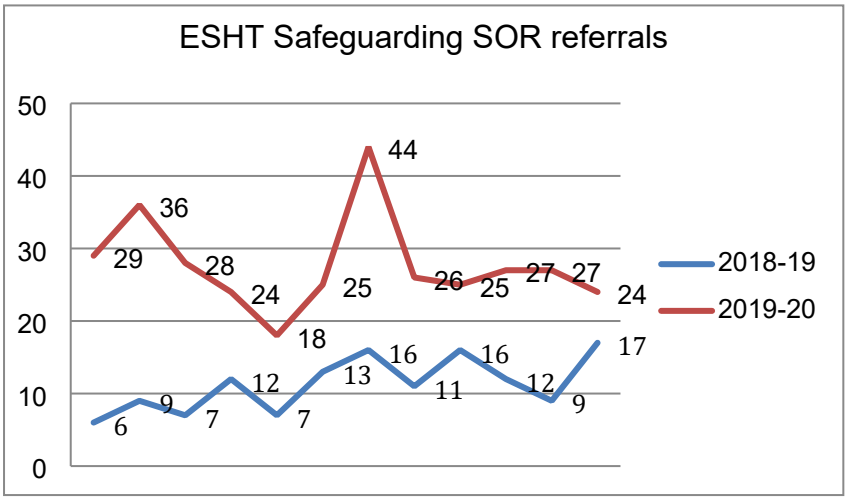
The main themes for safeguarding attendances in children during 2019/20 continue to be related to Mental Health issues followed by overdose and self-harm (as shown on the chart).



The age distribution for ESHT safeguarding attendances shows a considerable increase in cases on teenagers. Most of the attendances in this age group are Mental Health related for which ESHT sent over 300 referrals to CAMHS in 2019/2020.



Child safeguarding referrals has had a 50% increase in activity from the previous year with ongoing access and capacity challenges despite very positive multiagency working.



The main theme for referrals continues to be a family support request due to parental mental health crisis, parental overdose, substance misuse/intoxication and domestic abuse (especially for unborn referrals in Maternity). The main request for support for children continues to be regarding support with neglect.

Following discussion with the Integrated Health Visiting and Keywork Service, the Named Nurse for Community now has oversight of Health Visiting SOR referrals which will allow any ongoing themes to be addressed within training and discussions have also taken place with the Sexual Health Service to enable this.

Children referred may have a Child Protection Plan (CPP) which indicates they are considered to be in need of protection from either neglect, physical, sexual or emotional abuse or a combination of one or more of these. The CPP details the concern and actions being taken to mitigate these and the outcomes. In East Sussex the number of children with a CPP had remained unchanged at 476 as at March 2018. Since the Covid19 Pandemic there has been a significant increase in this and reports going forward will provide more detail to the Q&SC.

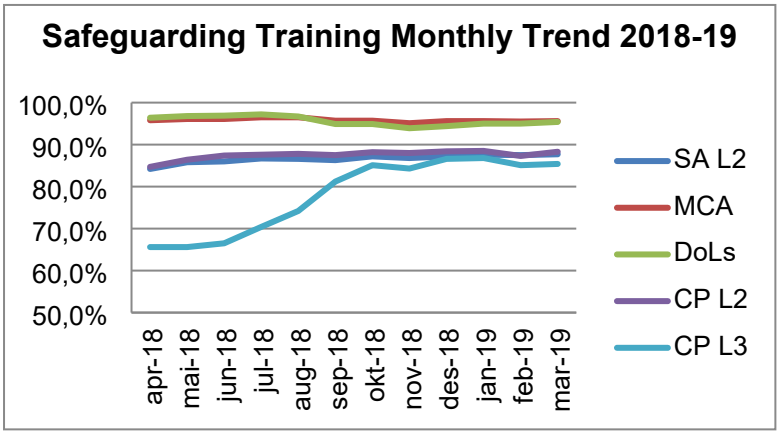
8.4 Safeguarding Training

The safeguarding team completed a training needs analysis previously, reviewing which staff needed which training to support their roles. Excellent training compliance across the Trust demonstrates commitment to training, with previous CQC feedback reporting staff knowledge was generally good.

Further audits of staff's understanding of Mental Capacity have indicated that despite face to face training sessions, clinical staff consider the concept of mental capacity assessment to be challenging, even for very senior staff. As a result, the safeguarding team continue to work with clinical staff to support capacity assessments and there has been a move away from this being perceived as a uniquely ASC/safeguarding role. The decision was made to change the one off face to face session which reached high levels of training compliance to a mandatory 3 yearly training session for Band 6's and above. Consequently it was anticipated that there would be a fall in compliance with MCA training initially through the year but this will improve over time.

MCA training is now available on line and Learning & Development are working to improve access for staff to complete the training.

Safeguarding Training compliance



In 2019/2020 the safeguarding team identified a number of staff who worked with children, whilst recognising it was not their main work, and to whom the requirement for Level 3 Child Safeguarding now applies. The teams within the divisions affected are working with the

safeguarding team to improve compliance for these staff with a target of 85% compliance in April 2019. The Serious Case Review for Child T indicated that there is a need to break away from the traditional split between Child and Adult Social Care and the Safeguarding Team have now piloted the "Think Family" approach with positive feedback. This will also incorporate the period of transition when a young person moves form child to adult services. This was due to replace existing adult and child safeguarding level 3 training from April 2020. The Pandemic has significant impacted on face to face training but the team have adapted wherever possible to video training with teams.

9.0 The Mental Health Act – ESHT Duties

There is a service level agreement with Sussex Partnership NHS Foundation Trust (SPFT) to enable the Trust to meet its legal requirements and ensure patients admitted to inpatient beds have their rights protected and their mental health care needs are met by a Responsible mental health clinician. The Head of Safeguarding attends regular meetings, escalating risk when necessary to the Chief Nurse. The team has strived to improve safeguarding governance in monitoring ESHT compliance and works collaboratively with SPFT teams to address any areas of non-compliance. This work has included the following:

- The site team have all been trained to undertake the duties of the receiving officer and maintain detained patients' rights
- Section 135/136 training for ED staff continues to be delivered
- Revision of the Policy for the Mental Health Act to support staff
- Audit arrangements to be agreed with SPFT to begin to measure compliance more systematically
- Completion and submission of the KP90 return on mental health activity

10.0 Looked After Children (LAC)

Nationally the numbers of Looked After Children continues to rise. These are children under the care of the Local Authority for more than 24 hours. In general these are children cared for by foster parents.

10.1 LAC Profile

LAC data only ever gives a snapshot of children moving in and out of the system at a fixed date each month/year and considerable activity sits beneath it. The data below is referred to as 'churn'. This cohort of children will come in and out of the system within the year, or some may come in and stay whilst others leave. It has been calculated that the churn figure East Sussex for 2019/2020 was 188 which, when added to the total number of LAC, equates to the service working with 788 children. This total figure is higher than the previous year (756 children), and the churn rate is also higher than for the previous year.

LAC nurse resource in East Sussex had not increased despite the number of LAC rising year on year and so demand had outweighed capacity but investment in the team of 0.4 WTE means the service has made considerable progress and is now meeting demand.

10.2 Performance against Statutory Requirements

Meeting the Health and Well Being Needs of Looked After Children (2015) and the Care Planning, Placement and Case Review (England) Regulations (2010) states that a child coming into care requires an Initial Health Assessment (IHA) and care plan held 20 working days after care entry. The initial health assessment must be completed by a registered medical practitioner. The review

of the child's health plan must happen at least once every six months before a child's fifth birthday and at least once every 12 months after the child's fifth birthday. Review health assessments may be carried out by a registered nurse or registered midwife.

In May 2019 the performance of the ESHT LAC team on achieving statutory timescales for IHA's and RHAs, Leaving Care Health Summaries and robustness of data being reported was challenged. The ESHT LAC team provided a response to the points raised via the Clinical Quality Review Meeting (CQRM) and the CCG provider meetings and out of this a joint action plan with shared accountability was devised between ESHT LAC and the CCG. This action plan is reviewed bimonthly at CCG provider meetings and steady and continued progress is being made in all areas with considerable improvements in response times.

During Q2 a new data monitoring tool was introduced. Some of the measures were found by the LAC team to be ambiguous and open to interpretation. The service worked with the designated nurse over Q2 and Q3 to seek further clarification. The data below demonstrates the measures introduced across the whole of the LAC team throughout 2019 which have brought about significant improvements in achievement of statutory timescales.

10.3 Initial Health Assessments (IHA)

Initial Health Assessments IHA 2019-20	IHA should be completed and report distributed within 20 days of child entering care	
	Within 20 days of entering care	Within 16 days of complete paperwork being received by ESHT
Q1	20%	6.6%
Q2	24%	33%
Q3	43%	64%
Q4	25%	100%

The factors that impacted on breaches (failure to meet statutory timescale) across all four quarters that were not attributable to ESHT included delayed notification to ESHT LAC by ESCC of a child's entry into care, incomplete paperwork, no or incorrect consent, carer or social worker declining first appointment offered, young person not attending for appointment or absconding from care. A high proportion of those absconding from care were Unaccompanied Asylum Seeking Children (UASC).

In Q2 the factors that impacted on breaches attributable to ESHT were identified as medical staff leave (some of which was unanticipated and at short notice). Many public holidays falling on the days IHA clinics were booked (Mondays), 1st appointment offered being declined or cancelled and a higher number of adoption medicals being requested which had a knock on effect on LAC clinic IHA appointment availability. Alongside this, a newly recruited NHS locum required induction and to become familiar with internal LAC processes and all of her reports required Quality Assurance (QA) by the named or designated Dr before being distributed. In response to this, LAC Drs agreed to plan requests for leave that would ensure a minimum level of cover for the LAC service. Some LAC clinics have been moved to alternative days of the week, to avoid public holidays and consideration is given to the LAC clinic capacity when reviewing Drs Job plans. The adoption team in ESCC were asked to give consideration to the number of adoption reports being requested. A corporate approach to the workload of the secretarial team was being introduced but not fully embedded and LAC reports are now flagged to all as high priority.

In Q3 in October one IHA that breached statutory timescale was attributable to ESHT LAC as the report was awaiting quality assurance. In November and December no timescale breaches were

attributable to ESHT. In Q4 none of the IHA timescale breaches were attributable to ESHT. From Q3 on there has been increased scrutiny of the data from the Designated Nurse. ESHT, the CCG, Designated Looked after Children Professionals and Commissioners are actively working with the Local Authority to identify the obstacles in the referral process and are implementing strategies to improve the pathway.

10.4 Review Health Assessments (RHA)

Review Health Assessments RHA 2019-20	RHA should be completed and distributed before expiry of the previous report (6 monthly under 5 years of age, annually between 5-18 years of age)	
	Under 5 years of age	**5-18 years of age**
Q1	19%	29%
Q2	61%	75%
Q3	71%	65%
Q4	100%	62%

Across all four quarters the factors that impacted on breaches that were not attributable to ESHT included late or overdue requests to LAC nurse administrators from ESCC for RHA, incomplete paperwork, no or incorrect consent, carer or young person declining or cancelling appointment offered, young person not attending/ no access or declining to have an RHA. The LAC nurse team have worked closely with the designated Dr, Named Nurse, ESHT information governance and ESCC to promote 'best practice' for gaining consent and there has been a marked reduction in the number of RHA requests being returned to social work colleagues due to incorrect consent. This has been challenged by one or two other local authorities that use rolling consent and the team have looked to uphold this best practice without causing any detriment to the child or young person.

In Q2 the factors that impacted on breaches attributable to ESHT were identified as lack of nurse capacity due to leave, historical requirement for 5 day turnaround of report being distributed being impacted by staff part time working patterns. In August and September 100% of RHA's were achieved by the LAC nurse team in timescale.

In Q3 two breaches were attributable to ESHT. One in November and one in December. One was due to a lack of nurse capacity and one due to the complexity of the case that required collecting of a significant amount of additional information for the LAC nurse to complete a robust report and health care plan. In Q4-100% of RHA's were achieved by the LAC nurse team in timescale.

10.5 Leaving Care Health Summary (LCHS)'Passport'

It is important that there are effective plans in place to enable Looked After Children aged 16 or 17 to have a smooth transition to adulthood so that that they are able to continue to obtain the health advice and services they need. They should have a summary of all health records. Across East Sussex, children leaving care at the age of 18 are provided with a 'Health Passport'. To ensure consistency, details on the proportion of health passports/LCHS completed is included in quarterly reports.

Leaving Care Health Summary 2019-20	All eligible children between 16-18 years of age leaving care should be provided with a health summary
Q1	62%
Q2	100%
Q3	100%
Q4	100%

In Q1 it was identified that a backlog of 'completed' Leaving Care Health Summaries had accumulated on caseloads across the nursing team. After discussion it was agreed that managing this situation and workload was a shared nurse team task. Work to clear the backlog continued throughout Q2 and has resulted in a process by which 100% of young people leaving care in Q2, Q3 and Q4 have been provided with a completed LCHS . For those young people who decline to receive the LCHS it is retained on record for access in the future.

10.6 Quality Assurance by Audit of Health Assessments 'Quality and Dip samples'

'The high quality of health assessments for Looked after Children were highlighted by Ofsted in the East Sussex inspection, where an 'outstanding' rating was achieved.' (Sussex-wide annual LAC report 2018-19).

In the Joint Targeted Area Inspection (JTAI), the inspectors commented on the high quality of the IHA and RHA assessments that were reviewed.

10.7 Supervision and Training

The Sussex wide Safeguarding Supervision policy was updated in 2019 to include Looked After Children. Supervision is in place for named/lead professionals in provider organisations delivered by designates. Within ESHT, all LAC nurses receive supervision every 6-8 weeks from the Named Nurse. Each supervision session is recorded in the child's record. All LAC nurse have received regular supervision throughout 2019/20. The Named doctor provides advice and supervision to the LAC nurses in respect of Looked after Children via a bi monthly case discussion clinic.

LAC nurse specialists offer level 3 training to HV teams 4-6 times annually. The Named Nurse for LAC offers ad-hoc training to the divisions and various teams throughout the year e.g. Sexual Health services and Urgent Care/ ED teams

A Level 4 training day facilitated by the Designated Professionals took place in May 2019. This was aimed at doctors and nurses undertaking initial and review health assessments. All LAC nurses have completed and had their LAC/safeguarding competencies signed off

10.8 LAC policy update

Following the previous CQC inspection which identified that there was an expectation to have a standalone LAC policy for ESHT, this has been developed, ratified, and is now available on the Trust extranet.

11.0 Conclusion

The last year has been another busy one for the safeguarding team and for the clinical services they support. The Safeguarding Team are a passionate, experienced and committed team and the year ahead is likely to be very challenging. Due to the ongoing Covid19 pandemic the team are reporting significant increases in abuse, neglect and need amongst our most vulnerable population.

The Q&SC and the board are asked to note the contents of this report and to continue to offer their support for what is an increasingly complex and challenging agenda.

References

Intercollegiate Document: Safeguarding Children and Young People roles and competencies for healthcare staff (2014) Royal College of Paediatric and Child Health.

Intercollegiate Role Framework: Looked After Children Knowledge, Skill and Competences of Healthcare staff (March 2015) Royal College of Paediatric and Child Health

Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018) Royal College of Nursing

Mental Capacity Act 2005 and the Deprivation of Liberties Code of Practice
https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

Equality Act (2010) HM Government

Working Together to Safeguard Children (2013,2015,2018) HM Government

Children Act (1984, 2004) HM Government

Care Act (2014) HM Government

The Modern Slavery Act (2015) HM Government

APPENDIX 1

SAFEGUARDING WORKPLAN 2019/2020

Action Number	Source	Requirement	Action	Executive Lead	Responsible PERSON	Progress
1	Children Act 1989 and 2004 and the Care Act 2014.	East Sussex Healthcare NHS Trust Safeguarding Team must ensure that it meets its statutory responsibilities identified within the Children Act 1989 and 2004 and the Care Act 2014.	Comply with the legislative guidance within the Safeguarding Acts and meet the statutory responsibilities Tranining compliance all staff all settings Documentation of MCA processes in records	DON	Head of Safeguarding	
2	Children Act (2014) Section 11 Audit	To ensure the duties of the Section 11(Children Act 2004) are complied with.	Complete section 11 action plan to address non compliances / improve pacrice.	DON	Head of Safeguarding April 2019	
3	LSCB SCR	To undertake the LSCB Child T Case Review	Investigate SCR and complete all actions to implement recommendations following publication by LSCB	DON	Named Nurses for children	
4	SAB SAAR	To undertake the Adult B Case Review	Complete all actions to implement recommendations following publication	DON	Named Nurse for adults	
5	NHSE/ NHSI	To comply with the LD Improvement Standards for NHS Trusts (2018)	Baseline assessment and action plan to address any concomplinaces with LD standards to achieve ESHT compliance	DON	Specialist Nurse Learning Disability	
6	CQC / Safeguarding Legisaltion	Competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with training and remedial action plans in place to address any non compliances	DON	Assistant Directors of Nursing April 2019	
7	CQC / Safeguarding Legisaltion	To ensure that there is a competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with safeguarding supervision and remedial action plans in place to address any non compliances	DON	Assistant Directors of Nursing April 2019	
8	Mental Health Act (2017)	To comply with the requirements set for acute NHS providers in relation to detained patients and staff competency	To comply with the legislative guidance within the Mental Health Act and meet the statutory responsibilities	DON	Deputy Chief Operating Officer	
9	Mental Health Act (2017)	To ensure the annual KP90 return is submitted for ESHT	Complete and submit the KP90 return annually	DON	Deputy Director of Nursing	
10	Prevent Statutory Duty (s26 Counter-Terrorism and Security Act 2015) to safeguard	To meet the statutory requirement to promote the national PREVENT strategy at a local level throughout the NHS	Ensure that there is a nominated lead for PREVENT, staff are trained in PREVENT Awareness and WRAP, and that the quarterly PREVENT return is submitted for ESHT	DON	Head of Safeguarding	
11	Female Genital Mutilation (FGM) Statutory Duty to safeguard	To meet the statutory requirement to promote the national FGM strategy at a local level throughout the NHS	Ensure that there is a lead for FGM, staff receive training in FGM Awareness at the appropriate level, and the quarterly FGM Return is submitted for ESHT	DON	Named Midwife	