Quality Account

2020/2021

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Part 1 – Introduction

Statement of Quality from the Chief Executive

I am delighted to introduce the Quality Account 2020/21 for East Sussex Healthcare NHS Trust (ESHT).
This report summarises the Trust's quality achievements during 2020/21 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 2021/22.

Over the last 12 months, possibly the most challenging the NHS has ever known, we saw continued focus on the quality of care we provide. The COVID-19 pandemic has presented a number of significant challenges throughout this last year and the year ahead will continue to pose challenges as the pandemic is ongoing.

Although the pandemic disrupted services, it also provided an opportunity to utilise technology to transform outpatient services through new virtual clinics. This facilitated alternative consultation with patients which may have not been possible with the national COVID-19 restrictions that were and still are in place. There has been positive feedback from patients with 89% giving a 'very good' rating for their experience.

Refurbishment of some key clinical areas was also completed during 2020/21, including Operating Theatres and the Main Entrance at Conquest Hospital and the Emergency Department at Eastbourne District General Hospital. These refurbishments have provided improved facilities and environment for patients and staff.

Throughout 2020/21, the NHS had a level 4 National Incident response in progress due to Covid-19. At the time of writing this report the organisation, along with partner organisations, has responded to a very difficult second wave over the winter and continues to help staff and services recover while the pandemic is ongoing. The impact on the Trust and on our workforce was very significant and despite significant planning and all possible mitigations there is sadly no doubt the second wave will have had an impact on quality. We are incredibly proud of all our staff and volunteers who have gone above and beyond during this time in particular, and who continue to ensure we are to provide the best possible care in this unprecedented situation.

Despite these huge challenges the Trust has made progress towards the priorities we set in the 2020/2021 Quality Account. However, there was disruption to the quality improvement work for the priorities and this has resulted in the decision to carry these priorities forward to 2021/2022.

As part of the Perfecting Discharge priority, a new mechanism for external stakeholders to report any concerns regarding discharges/transfers of care was launched. This has significantly improved communication with external stakeholders and also provided learning from investigations into the concerns. The data for the first six months has demonstrated a significant reduction in the number of concerns raised.

Patient feedback about our care continues to show that 98% of people would recommend our services to others. This is supported by the staff survey data which has shown further improvement in the number of staff recommending ESHT as a place to receive treatment and also a place to work.

We will continue to work collaboratively with system partners with a focus on inequalities and also on services for our patients who have significant mental health challenges alongside their physical ill health.

More than ever, our values continue to be the foundation of what we do. The experience of the pandemic during 2020/21 has demonstrated how improvements to patient care and our working environment can be found in 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.

During the most challenging year most of us have ever known, we would like to thank all of our members of staff, volunteers, Board members and local partners, people and organisations for supporting us and helping us achieve these high standards. The excellent improvements made during 2020/21 are testament to the commitment of the organisation to continue to strive for excellence.

Joe Chadwick-Bell
Chief Executive

About us and the service we provide

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

At ESHT we provide safe, compassionate and high quality hospital and community care to the half a million people living in East Sussex and those who visit our local area.

Our vision is to combine community and hospital services to provide safe, compassionate, high quality care to improve the health and wellbeing of the people in East Sussex

We are one of the largest organisations in East Sussex with an annual income of £535 million and we are the only integrated provider of acute and community care in Sussex. Our extensive health services are provided by over 7,000 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) rated us as ‘Good’ overall and ‘Outstanding’ for being caring and effective. The Conquest Hospital in Hastings and our Community Services were rated ‘Outstanding’ and Eastbourne DGH was rated ‘Good’

Our two acute hospitals have Emergency Departments and provide 24 hour a day care, offering a comprehensive range of surgical, medical, outpatient and maternity services, supported by a full range of diagnostic and therapy services. Our centre for urology and stroke services is at Eastbourne DGH, while our centre for trauma services and obstetrics is at Conquest, Hastings.

During 2020/21, we saw a reduction in inpatient spells as a result of the COVID-19 pandemic to 89,000 from 112,000 the previous year. We also saw 116,000 attendances at our Emergency Departments and there were over 330,000 outpatient attendances.

At Bexhill Hospital we offer a range of outpatients, day surgery, rehabilitation and intermediate care services. At Rye, Winchelsea and District Memorial Hospital we offer outpatients, rehabilitation and intermediate 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.

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 County Council 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.

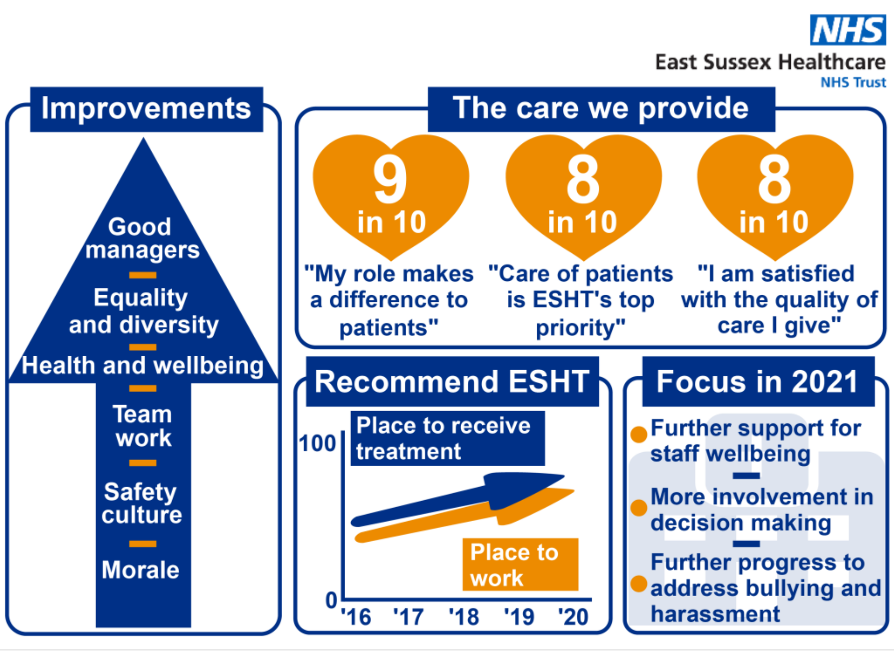
Our Vision, Values and Ambition – to be Outstanding and Always Improving

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.

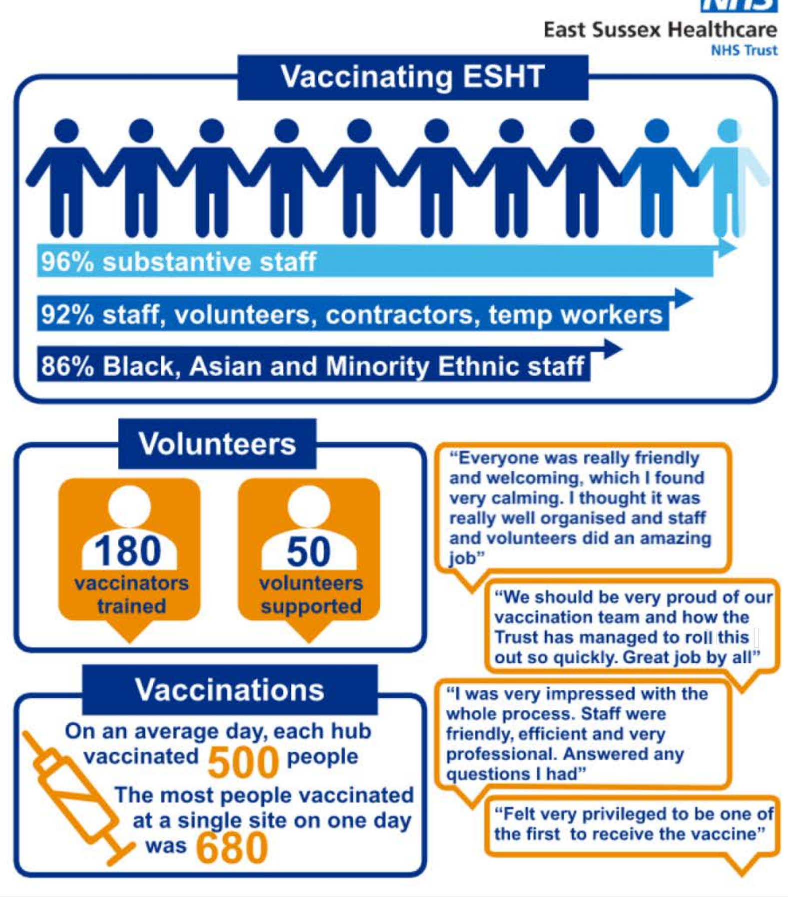
Our Objectives:

- **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

NHS staff survey
results
2020
Response rate
Over
3,700
members
of staff
51%


NHS
East Sussex Healthcare
NHS Trust
Improvements
Good managers
Equality and diversity
Health and wellbeing
Team work
Safety culture
Morale
The care we provide
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"
Recommend ESHT
100
0
Place to receive treatment
Place to work
'16 '17 '18 '19 '20
Focus in 2021
Further support for staff wellbeing
More involvement in decision making
Further progress to address bullying and harassment

Our staff
vaccination
programme
vaccinations
24,000
health and care workers recieved a first dose in weeks
11
2
vaccine hubs at:
Eastbourne DGH
Conquest, Hastings


NHS
East Sussex Healthcare
NHS Trust
Vaccinating ESHT
96% substantive staff
92% staff, volunteers, contractors, temp workers
86% Black, Asian and Minority Ethnic staff
Volunteers
180
vaccinators trained
50
volunteers supported
Vaccinations
On an average day, each hub vaccinated 500 people
The most people vaccinated at a single site on one day was 680
"Everyone was really friendly and welcoming, which I found very calming. I thought it was really well organised and staff and volunteers did an amazing job"
"We should be very proud of our vaccination team and how the Trust has managed to roll this out so quickly. Great job by all"
"I was very impressed with the whole process. Staff were friendly, efficient and very professional. Answered any questions I had"
"Felt very privileged to be one of the first to receive the vaccine"

Some of our achievements in 2020/2021

We are proud of our many innovations and improvements including:

Macmillan cancer support worker project
A two year project to assess the impact of Macmillan Cancer Support Workers was launched, supported by the Trust's Cancer Nursing and Acute Oncology teams.

First Physiotherapist in South East qualified to take blood
Helen Hunnisett, from the Trust's Frailty Practitioner Service, was the first physiotherapist in the South East trained with the skills to take blood.

First high definition MRI heart scan undertaken
The first high definition magnetic resonance imaging (MRI) heart scan was undertaken at the new MRI scanner at Conquest Hospital.

Positive experience provided by maternity service
A national survey on maternity services undertaken on behalf of the Care Quality Commission (CQC), found that maternity care at ESHT has improved across a number of areas.

RITA brought in to help out on the ward
A new digital therapy system called RITA or 'Reminiscence Interactive Therapy Activities' has been purchased by MacDonald Ward at Conquest Hospital, following successful fund raising activities on the ward. RITA is an innovative, evidence-based, state-of-the-art digital therapy system which allows patients to use apps, games and other leisure activities.

Trust welcomes over 150 new Junior Doctors
Over 150 junior doctors and other grade doctors joined our medical teams at ESHT.

ESHT maternity team launched the 'PETALS' project
Pregnant women are now able to access further support offered by the multidisciplinary 'PETALS' team, to help them maintain their perineal health as well as prevent complications during birth.

2,000th baby born at Eastbourne Midwifery Unit
The midwifery team at Eastbourne Midwifery Unit (EMU) celebrated after the 2000th baby was born in the unit in September.

New Wheelchair Tilt and Bariatric Chair
The Podiatry Department at Eastbourne District General Hospital took delivery of new wheelchair tilt and bariatric chairs thanks to a donation by the Friends of Eastbourne Hospital. The chair helps to reduce stress and afford maximum dignity to the patient.

Specialist support for people diagnosed with sight loss
The Royal National Institute of Blind People (RNIB) and ESHT launched a new service providing emotional and practical support to people newly diagnosed with sight loss.

New prenatal seasonal influenza and whooping cough vaccination clinics
A new service offering prenatal vaccinations against seasonal influenza and whooping cough for those who are pregnant has been introduced by community midwives at the Trust.

New Radioactive Iodine (RAI) treatment service for Thyroid Disorders
A new Radioactive Iodine (RAI) treatment service at Conquest hospital was set by the Endocrinology team to help treat thyroid disorders.

Refurbished Operating Theatres at Conquest	Modernised two operating theatres and their adjoining anaesthetic rooms, including mood lighting, music and calming graphics.	
New Emergency Nurse Practitioner Suite	The Suite opened in the Emergency Department at Eastbourne DGH to care for patients with minor injuries and illness.	
Modernised Emergency Department at Eastbourne DGH	Modernising work was completed, including new air conditioning, treatment cubicles, cardiac monitoring equipment, eco-friendly lighting, and waiting area	
E-consult introduced allowing patients to be seen at home	Our Digital team reduce the number of people coming into our buildings by adopting technology that allowed clinicians to see more patients by telephone or virtually.	
Covid-19 Vaccination Hubs	Despite short notice, ESHT set up 2 vaccination hubs at the Conquest Hospital and EDGH sites in late December. Almost 25,000 ESHT and local health and care staff were vaccinated	

New wayfinding signage at Conquest	New wayfinding signage dividing the hospital into coloured zones and levels was installed to help people navigate themselves around.	
Work started on a new nursery building at Conquest Hospital	Work started on a new purpose built nursery at Conquest Hospital, to replace the existing temporary nursery building. The new nursery is due to open in autumn 2021.	
New main entrance at Conquest Hospital	Work on a new main entrance at Conquest Hospital was completed following a major reconfiguration and refurbishment. A more open area for visitors and patients was created with digital booking in facilities for clinics and a new waiting area.	

Extra car parking spaces at Eastbourne DGH	Additional car parking spaces have been created and a planning application has been submitted to increase parking at Conquest	
Expanded 'Same Day Emergency Unit' opens	The newly expanded £900k Unit at Conquest Hospital has eight treatment cubicles and three treatment rooms for assessments and procedures offering patients greater privacy and dignity.	
Newly refurbished wards at Eastbourne	Two newly refurbished wards opened at Eastbourne DGH after a complete refit	
Nervecentre went live across the Trust	This new clinical system revolutionises patient safety and productivity, creating a paperless Emergency Department and alerting clinicians to deteriorating patients.	
Refurbished Residences at Conquest	The work included new bathrooms and kitchens and extensive redecoration.	

This past year has been an extraordinary one, dominated by the COVID-19 pandemic and our response to it. Everyone in the organisation stepped up and worked above and beyond their roles to support the safe care of patients. We have seen individuals and services across the organisation show great innovation and resilience. Everyone, each ward, department or service has been affected by the pandemic, but by working together we made sure that we continued to provide the best possible care for our patients, keeping them and each other safe.

Our Clinical teams worked tirelessly to care for people with COVID-19, while also making sure that people in need of urgent and emergency care were seen and treated safely. Our Community teams worked with Adult Social Care to improve discharge processes and safely care for people at home, helping to reduce the spread of the virus. Our Intermediate Care teams at Bexhill and Rye supported those recovering from COVID-19 with intense therapy and rehabilitation.
The year ends with a great deal of hope for our future. In the last few months of 2020/21 we introduced widespread lateral flow COVID-19 testing for members of staff and our Pathology team and healthcare scientists introduced a new COVID-19 testing facility, allowing us to increase the number and speed of COVID-19 testing for patients.

We also launched our two vaccination hubs at Conquest and Eastbourne DGH. These two hubs have vaccinated 25,000 health and social care workers across East Sussex, including 92% of our own staff, volunteers and temporary workforce.

Increased testing, the vaccination programme and the national lockdown in January have seen COVID-19 numbers significantly reduce and in March and April we began to recover from the impact of wave 2 and restart much of our elective programme and services. We will gradually increase activity as the pressure on our critical care services reduces, while making sure that we offer the right physical and physiological support and space to give our staff a chance to come to terms with what they have been through.
The past year has seen tremendous support from our local community, individuals, our Friends, businesses, charities and volunteers all of whom have been incredibly generous in their support and help during one of the most challenging times in the history of the NHS.

Our partnerships and collaboration

Working with the wider system

Across Sussex, the NHS and local councils look after social care and public health and continue to work together to improve health and care. The Sussex Health and Care Partnership (SHCP) brings together 13 organisations into what is known as an integrated care system (ICS). SHCP takes collective action to improve the health of local people, ensuring that health and care services are high-quality and make the most efficient use of resources.

Over the last few years the Trust and other health and care organisations across Sussex have increasingly worked together as the SHCP to make sure the experience of local people using services is more joined-up and better suited to their individual needs. This way of working is based on the priorities and outcomes that matter to local communities, allowing all organisations to work together towards the same plan to improve health and wellbeing. This will help local people to stay healthy for longer, to receive more support and treatment at home and, if they do get ill, to ensure they get the right care in the right place at the right time. A focus going forward will be on inequalities and ensuring access for all those who need it.

Healthwatch

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 need/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 conducted qualitative research on patients’ experience of virtual appointments in the Trust, identifying that two thirds of our patients found these to be a positive experience.

Purpose of the Quality Account and how it was developed

The Quality Account is an annual public report which allows us 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 have been 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 (in new and different ways due to COVID-19) 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 2021/22

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.

It was not possible to deliver all of the aims of the priorities chosen by the Trust for 2020/21 due to the pandemic causing significant operational and workforce pressures for the organisation. Therefore, the Trust has recommended that these priorities are continued into the Quality Account for 2021/22. As with the previous year, it was not possible to consultant with the public on these priorities as we would usually do due to COVID-19.

Table 1: Priorities for improvement in 2021/22

Quality Domain	Priorities for improvement 2021/22
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 moving into 2021/22

- 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
- Utilise different methodologies in conjunction with clinical teams to evidence the impact of the actions on reducing the risk of further patient safety incidents
- To take forward recommendations from the audit of serious incident (SI) actions and evidence completed in March 2021.
- Complete a pilot of the taxonomy matrix that outlines causal facets with set domains
- 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
- Methodologies for evidencing the effectiveness and impact of actions on improvement (or lack of) in areas of concern for patient safety will have been utilised to identify areas for improvement within patient safety
- 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 trends 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

In the last year, a new Infection, Prevention and Control (IPC) Board Assurance Framework (BAF) was launched nationally. It is not mandated but is accepted as good practice; ESHT was part of the design of the BAF and adopted this from the beginning. It has changed over time and is reviewed monthly via the Trust's Infection Prevention and Control Committee (TIPCG) with assurance/escalation to the Quality and Safety committee.

The purpose of the BAF-IPC 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 the key driver for infection prevention and control and continue to be implemented in the Trust during 2021/22.

What we are going to do moving into 2021/22

- ***Finalise the BAF- IPC template to ensure it is capturing all relevant detail:***

  The BAF-IPC has undergone several reiterations since September following national guidance.

- ***Identify key gaps in the BAF- IPC and develop actions plans to address them:***

Previous work regarding initial assessment and 'flow' of patients is being reviewed and will be updated to ensure moves are clinically imperative. Pre-pandemic, typical pathways involved many moves for patients from front door attendance, usually via gateway areas, until final destination in a specialty downstream bed.

All related policies and Standard Operating Procedures will now be reviewed by the IPC team and other relevant colleagues to reflect commitment to reducing patient moves that are not clinically imperative.

Another review of ventilation has been undertaken by Estates colleagues in light of more recent World Health organisation (WHO) and UK guidance. This will present significant challenges with the recommendation of 12 air changes per hour in areas of high risk/Aerosol Generated Procedures (AGP's). It is proposed that more HEPA filtered mobile units (type of air purifier unit) are purchased and placed in the high risk areas if ventilation is sub optimal. Other areas will also require a review with more discussion about mitigation needed if ventilation is insufficient. This will be monitored and reported on via the TIPCG with support from senior colleagues.

Documentation and formal auditing of Personal Protective Equipment (PPE) compliance by staff and patients remains a challenge, but work is underway to support this.

More work is required to ensure robust monitoring/auditing of cleaning of some shared equipment in clinical areas such as telephones and some computer equipment etc.

The amount of in-house testing for COVID-19 has increased considerably over the latter part of the year but challenges with rapid testing in terms of accuracy remains as prevalence is now low, even with PCR (Polymerase Chain Reaction) testing.

Compliance with day 3 (and beyond) COVID-19 testing is not always 100% and requires monitoring and actions to ensure greater compliance.

Re-establish clinical ward rounds to support best practice for antimicrobial prescribing and care of patients with *Clostridioidies difficile* infections.

Identify key learning from outbreaks and agree any actions required to reduce future occurrence.

- ***Monitor infection rates and identify and incorporate emerging themes:***

These are being monitored continuously and reported via the TIPCG. COVID-19 has been the predominant infection. All mandatory surveillance of other healthcare associated infection requirements have been met.

Performance against limits is reviewed at the TICPG and the annual report will highlight emerging themes and any actions required to align Healthcare Acquired Infection (HCAI) rates with national standards.

- ***Complete serious incident RCA investigation reports into outbreaks and identify learning with appropriate actions:***

Several COVID-19 outbreaks were initially reported but due to the extent of outbreaks during the second wave, subsequent outbreaks have been clustered by site and four serious incidents raised; one for each site.

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
- Any learning from outbreak serious incidents will be identified on the BAF-IPC and taken forward to ensure high standard of practice is maintained to support patient and staff safety.

- Trust will be compliant with all national guidance relating to COVID-19 unless there is good reason for exceptions.
- The trust will achieve low levels of hospital transmission in relation to national rates and local prevalence.
- Healthcare associated infection rates will align with national limits set.

How we will monitor progress

- The BAF-IPC will be reviewed monthly at the TIPCG 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 highlighted a number of areas where improvements could be made to discharge processes, including around communication and information provided to patients about the discharge process.

Last year as part of a Quality Account priority, a Multidisciplinary Strategic Discharge Improvement Group (MSDIG) was established to take the plans forward to improve the discharge process.

The changes to the Trust's discharge processes during the COVID-19 pandemic contributed to an increased focus with short actions being taken and longer term plans being developed.

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

What we are going to do moving into 2021/22

- 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 four work streams have been identified as areas of focus - communication, process, medication and training and education
- Key projects under the four workstreams will be rolled over from 2020/21, and re-initiated to deliver improvements in discharge
- The strategic group will meet monthly to report back on the progress of the work streams
- We will gain feedback from patients 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 tell us that they receive high quality (safe, effective, timely, good experience) discharge and return home
- Patients/carers/relatives understand their care needs and follow-up actions that need to be taken
- Patients and their relatives/ carers feel involved, active and informed during the discharge process
- An improved score for questions in section 9 of the National Inpatient Survey by one point
- Develop effective feedback mechanisms which are understood by both staff and patients and their families/carers to measure impact to inform improvements in patient experience in relation to their discharge
- Expected dates of discharge are met as planned

- Demonstrate how improvements in our discharge process, alongside continued support in the community reduces re-admissions
- Primary Care feel better informed and involved and discharge communication with GP is accurate and timely

How we will monitor progress

- Progress from the discharge workstreams will be reported to the MSDIG.
- Escalation of issues and barriers will be taken through relevant governance processes
- The Quality and Safety Committee will be provided with a bimonthly progress report.

Part 2.2 – Statements of Assurance from the Board of Directors

Services provided and income

During 2020/21 ESHT provided and/or sub-contracted 76 NHS services.

ESHT 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 2020/21 represents 100% of the total income generated from the provision of NHS services by ESHT 2020/21.

Participation in Clinical Audit and National Confidential Enquiries

Clinical audit is used within ESHT 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 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.

ESHT 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.

As part of the reducing burden on the NHS, national audit participation was predominantly paused during 2020/21 due to the COVID-19 pandemic with no consequences in place for non-participation (there were no penalties for non or partial data submission). The only exceptions were the Child Death Database, MBRRACE-UK perinatal surveillance and ICNARC (adult intensive care) which were required to continue. ESHT has continued to successfully submit data to these studies over the past year.

Data submission was accepted on a discretionary basis to all other national audits where it did not impact on clinical capacity.

As data submission has been largely interrupted during the past year, the Trust will not have a true understanding of clinical performance in many of the national audit areas; this will be the same for all Trusts nationally. Once data is reviewed and reported upon it is likely to be unreliable due to partial data submission. It will not be until full data submission resumes that a true assessment can be made of ESHT's performance locally and nationally in comparison to other similar Trusts, and for any necessary improvements to be identified.

Although there has been no official restart date, there is an expectation that Trust's will resume data submission from April 2021.

The national clinical audits and national confidential enquiries that ESHT was eligible to participate in during 2020/21 are detailed below.

National Audit and National Confidential Enquiries Programme

During 2020/21, 48 national clinical audits and 3 national confidential enquiries covered relevant health services that ESHT provides.

During that period, ESHT participated in 94% of national clinical audits (partially in some cases) and 100% of 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 ESHT was eligible to participate in during 2020/21 can be found in Appendix 2.

The national clinical audits and national confidential enquiries that ESHT participated in are listed in Appendix 3. Information regarding the number of cases submitted is unavailable for 2020/21 due to the national pause on the mandatory clinical audit programme throughout much of the pandemic.

The Trust also participated in 15 additional (non-mandated) national audits in 2020/21, which can be found in Appendix 4.

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)

NCEPOD issued one report in 2021/22:

- 'In Hospital Care of Out-of-Hospital Cardiac Arrests: Time Matters' was published in February 2021.

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 foetal 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 2020/21 include:

- Amniotic Fluid Embolism (0 cases reported)
- Anti-thrombin in Pregnancy (3 cases reported)
- Protein C Deficiency in Pregnancy (4 cases reported)
- Cirrhosis in pregnancy (0 cases reported)
- Diabetic Ketoacidosis (DKA) in Pregnancy (3 cases reported)
- Extremely pre-term, pre-labour rupture of membranes (3 cases reported)
- Fontan and Pregnancy (0 cases reported)
- Peripartum Hyponatraemia In Pregnancy (0 cases reported)
- Pregnancy Following Bone Marrow Transplant (0 cases reported)
- New Therapies for Influenza (0 cases reported)
- Covid-19 in Pregnancy (38 cases reported)

National Clinical Audit Reports in 2020/21

The reports of 24 national clinical audits were reviewed by the Trust in 2020/21. 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 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/

Surgical Site Infection Surveillance in Orthopaedic Surgery

Report ref. and name: Surgical Site Infection Surveillance in Orthopaedic Surgery
Date of publication: May 2020 (reporting on April 2018 – March 2019 data)

Rationale

All the NHS Trusts undertaking Orthopaedic surgery are required to complete the mandatory surveillance program devised by the Surgical Site Infection Surveillance Service (SSISS) by the Public Health England (PHE) formerly known as the Health Protection Agency (HPA). This remains a Department of Health (DOH) Chief Medical Officer (CMO) directive since 2004. SSI criteria must be classified according to case definitions formulated by the Centres for Disease Control and Prevention (CDC). In line with protocol, a standardised set of demographic and operation-related details were 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) and the study covered surgical procedure, in-patient stay, post-discharge reports and a detailed data of any case readmitted with a SSI during the first year after the operation. All cases of SSI were reviewed by the Orthopaedic Consultants to see if there were any improvements/lessons to be learnt and any actions taken prior to submission to the PHE. Data was analysed by the PHE SSISS and the results were returned to each individual Hospital for comparison against the relevant benchmark derived from all participating Hospitals for each category, so that the results could be used to review clinical practice and implement changes to enhance needed patient care.

Key Results

Hip Replacement surgery including Revisions (excluding 1st stage revision) from 1st April 2018 to 31st March 2019.
(SSI % - inpatient and readmission)

Site	Total operations	SSI occurrence and %
Conquest	**275**	**1 (0.4%)**
EDGH	**120**	**1 (0.8%)**
ESHT wide total	**395**	**2 (0.5%)**
National Average SSI incidence (April 2014 to March 2019) : - 0.5%		

Knee Replacement surgery including Revisions (Excluding 1st stage revision): From 1st April 2018 to 31st March 2019.
(SSI % - inpatient and readmission)

Site	Total operations	SSI occurrence and %
Conquest	**312**	**1 (0.3%)**
EDGH	**185**	**1 (0.5%)**
ESHT wide total	**497**	**2 (0.4%)**
National Average SSI incidence (April 2014 to March 2019) : - 0.5%		

Identified risks or concerns

It has been noted that studies based on a small population adversely affect the rates in comparison to those studies on a large population. A single case of infection in a small study will produce a higher percentage rate, which will in turn trigger a high outlier status. Infection rates constantly change due to mandatory reporting of SSI readmissions over each twelve month period. Annual infection rates are more reliable than quarterly reports for comparison purposes.

Good practice identified

The multidisciplinary team investigated the reason for ESHT being the outlier in the past year. No clear trend or pattern was identified for the concerned SSIs.
SSI surveillance has been undertaken in accordance with the PHE SSISS protocols from 1st April 2018 to 31st March 2019 for both Hip and Knee prosthetic surgery. In doing so ESHT has fulfilled the DOH requirement.

During the period from 1st April 2018 to 31st March 2019, the SSI rate for Hip prosthetic surgery was at the National benchmark at 0.5%. The Knee prosthetic surgery SSI rate was 0.4% which is below the National benchmark of 0.5%.

Any hospital identified as having an infection rate above or below the 90th percentile will receive a high or low outlier notification respectively and be asked to investigate reasons and feedback conclusions to the PHE SSISS, taking into account results arising from small numbers and varying risk factors. The relevant Regional Epidemiology Units (REU) will then be informed and be asked to work directly with any outlier hospital, supporting and monitoring their investigations. REUs may share this data with any other colleagues in the region, which the PHE claim is acceptable, due to the mandatory data already being in the public domain.

Local Action Plan:

Recommendation	SMART Action Point	Comments	Status
To reduce the risk of MRSA/MSSA and other cross infection in patients undergoing Hip or Knee joint replacement surgery.	Provide single room for patients identified as MRSA positive and prevent un necessary bed movements post-surgery (make use of the alert system on e-Searcher and MRSA stickers on the Integrated Patient Documents)	• All patients are screened for MRSA pre-operatively. • Decolonisation treatment is given to all patients identified as MRSA positive. • Need to reduce bed shortages and patient transfers to different wards by carefully planning the timely discharge of patients.	**COMPLETE / ONGOING**
To ensure that patients are aware of the methods to reduce SSI.	Provide information to patients about the SSI with the available resources.	All patients having Hip or Knee joint replacement are given an information leaflet about wound monitoring at the pre-assessment clinic. Every opportunity to meet the patients and give health advice by the healthcare professional will be utilised to advise patients.	**COMPLETE / ONGOING**
To ensure optimal awareness and adherence to the most current National and Local SSI policies and guidelines for the Healthcare professional.	Make sure that all the staff involved are aware of the NICE Guidance No. NG125. A copy of the guideline will be given to each Orthopaedic ward at both sites of the Trust along with the local guidelines.	Make sure that all the staff involved are aware of the NICE Guidance No. NG125. A copy of the guideline will be given to each Orthopaedic ward at both sites of the Trust along with the local guidelines.	**COMPLETE / ONGOING**

National Diabetes in Pregnancy Audit

Report ref. and name: National Diabetes in Pregnancy Audit 2018
Date of publication: October 2019 (reporting on January 2018 – December 2018 data)

Rationale

The National Pregnancy in Diabetes Audit (NPID) is a workstream of the National Diabetes Audit (NDA) and is managed by NHS Digital under an agreement with the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. The NDA is delivered by NHS Digital, in partnership with Diabetes UK and the National Cardiovascular Intelligence Network (part of Public Health England).

The audit is a measurement system to support improvement in the quality of care for women with diabetes who are pregnant or planning pregnancy and seeks to address three key questions:

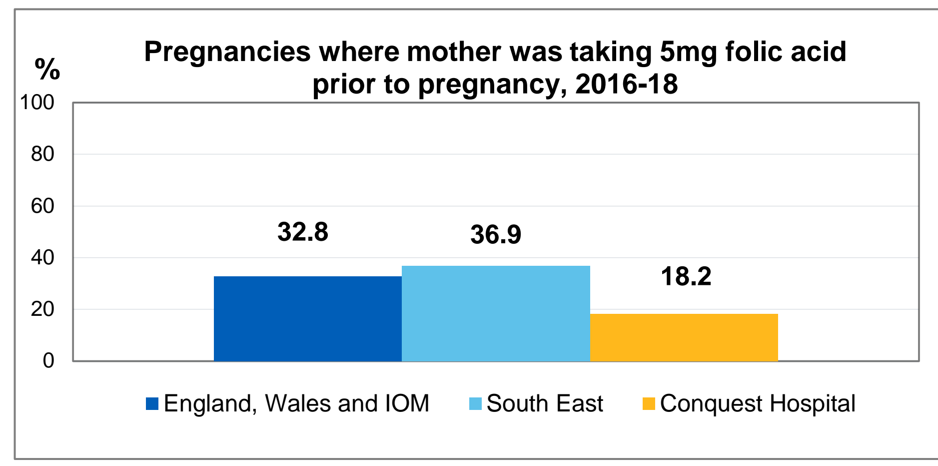
- Were women with diabetes adequately prepared for pregnancy?
- Were adverse maternal outcomes during pregnancy minimised?
- Were adverse fetal/infant outcomes minimised?

NPID is the largest continuous audit of pregnancy in women with diabetes in the world (more than 4,400 pregnancies in 2018). This has allowed a depth of analysis not previously possible, including the development of locally relevant standardised ratios for key outcomes.

Key Results

Folic acid supplement prior to pregnancy
Women with diabetes have an increased risk of having a pregnancy affected by a neural tube defect. NICE guideline NG3 recommends advising women with diabetes who are planning to become pregnant to take 5mg/day folic acid up to 12 weeks gestation to reduce this risk. The 5mg dose is available on prescription.

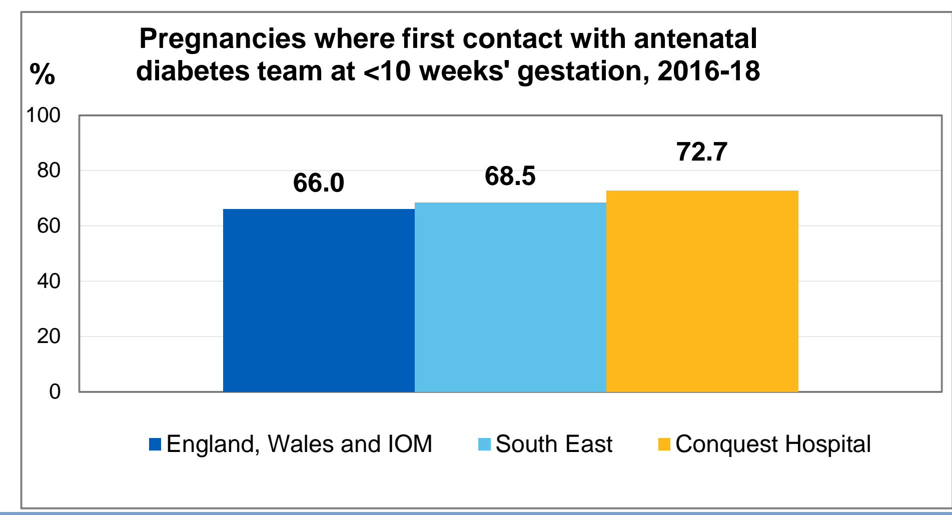
The percentage of women taking the recommended 5mg dose of folic acid prior to pregnancy for Conquest Hospital as well as the South East and England, Wales and Isle of Man values:



Antenatal care

The NICE guideline NG3 recommends offering immediate contact with a joint diabetes and antenatal clinic to women with diabetes who are pregnant.

The percentage of pregnancies where first contact with the antenatal diabetes team was before 10 weeks' gestation for Conquest Hospital as well as the South East Region and England, Wales and Isle of Man values.



Identified risks or concerns
Poor compliance with NICE Guideline NG3 recorded for *'mothers taking 5mg folic acid prior to pregnancy'.*

Good practice identified
'First contact with the antenatal diabetes team before 10 weeks gestation' for Conquest Hospital was higher than the national average.

Local Action Plan:

Recommendation	SMART Action Point	Comments	Status
Increase the number of pregnant women taking Folic Acid prior to and at the beginning of pregnancy	Write to the GP's across the two sites (Conquest and EDGH) with findings from the audit and a reminder to ensure pregnant women are being made aware of the importance of taking folic acid	Email communication sent from Consultant Lead to local GPs.	**COMPLETE**
	Deliver teaching sessions for GP's across the two sites	Women's Health Audit Lead has conducted a full presentation with local GPs and is in contact with lead.	**COMPLETE**

National Audit of Inpatient Falls

Royal College of Physicians

Report ref. and name: National Audit of Inpatient Falls 2020
Date of publication: March 2020 (reporting on 1st January 2019 – 16th August 2019 data)

Rationale
The National Audit of Inpatient Falls (NAIF) audits the delivery and quality of care for patients over 60 who fall and sustain a fracture of the hip or thigh bone in acute, mental health, community and specialist NHS trusts/health boards in England and Wales. NAIF reviews the care the patient has received before their fall as well as the post fall care. The audit also looks for evidence of examination for other injuries for patients who are found to have a fracture, which is recommended by the National Institute for Health and Care Excellence's (NICE) clinical guideline CG161 - and quality standard QS86.

Falls are the most frequently reported incident affecting hospital inpatients, with 247,000 falls occurring in inpatient settings each year in England alone. Reported falls among older patients are more likely to result in some degree of harm and, where harm does occur, it is three times more likely to be severe. One such severe harm is hip fracture. It is the commonest reason for emergency surgery and injury related death in older people.

Inpatient falls are costly, even where life-changing injuries are not sustained. Such events lead to increased length of stay, loss of confidence, restriction of physical activity, functional impairment, diminished independence and an increased risk of further falls, all of which affect patients' quality of life.

Key National Results

Good participation: All health boards in Wales and nearly all acute English trusts participated in the audit. This was the first time community, mental health and specialist trusts were fully included in this programme. The inclusion of all such trusts is encouraged in future.

Excellent completion: This new continuous system of audit is proven to be feasible, with excellent completion rates for the 901 cases captured in the first 8 months of 2019.

The challenge of inpatient hip fracture: Older people who sustain a hip fracture after a fall in hospital face obstacles including a longer wait for surgery, longer periods in bed after surgery and a greater risk of post-operative delirium.

Poor outcomes: Older people who sustain a hip fracture after a fall in hospital have significantly poorer outcomes, including a two-fold increase in risk of dying compared to those who fracture outside of hospital.

Post-fall management: Prompt checks for injury, use of flat lifting equipment and rapid access to medical assessment could improve the care and outcome for older people who sustain a hip fracture after a fall in hospital.

Risk screening tools: We found that 32% of trusts and health boards are still using risk screening tools to identify those at risk of falls, despite the fact that this is specifically not recommended by NICE (CG161).

Areas for improvement: There is variability in the availability of walking aids for newly admitted inpatients, and access to flat lifting equipment for those who have fallen.

Local Action Plan:

Recommendation	SMART Action Point	Comments	Status
Provide walking aids to all newly admitted patients who require one, with appropriate assessment being made available 7 days a week.	To scope the project and review resources and funding – Develop a business case	Achieved and ongoing.	**COMPLETE / ONGOING**

Do not use screening tools to identify those as high risk of falls. Instead everyone aged over 65, and others aged over 50 who may be at higher risk, should be offered a multi-factorial risk assessment (MFRA).	Amend Falls Policy	The Trust Policy and Risk Assessment reflect the guidance. The inclusion of the risk assessment with the new wording in the bedside book B is under review by the falls group.	**COMPLETE**
	Redesign Risk Assessment	The multi factorial risk assessment states to be completed for patients >65, >50 with underlying conditions, had a fall in the last year and admitted having fallen.	**COMPLETE**
	Communicate new risk to Divisions	The inclusion of the risk assessment with the new wording in the bedside book B is under review by the falls group.	**To be confirmed**
Regularly review data and trends on falls, harm and deaths per 1,000 occupied bed days (OBDs).	Secure Business Intelligence Unit (BIU) support to assist in analysing data	BIU support data analysis and trends are regularly reviewed via: • Trust Integrated Performance Report (IPR) slides – we report overall falls by bed data and individual SI's for harm and death are indicated in the slides but not the harm per 1,000 bed days, the information is presented monthly • Quality and Safety Committee governance report – receive the falls rate per 1,000 bed days bi-monthly. • Patient Safety and Quality Group triangulation report – receive monthly falls rate per 1,000 bed days • Falls Steering Group quarterly reports – monthly falls rate per 1,000 bed days in a quarterly report. Harms data is available for review as required but not included in a formal report.	**COMPLETE / ONGOING**
Ascertain the gap between the number of reported falls and actual falls as an indicator of each trust and health board's reporting culture, to help interpretation of data on falls per 1,000 occupied bed days.	Scope development of Gap analysis	A review of the data entered into the National Falls Audit versus the number of falls reported as incidents on Datix and STEIS has been completed. There is a difference in the numbers as the collation of information for the National Audit includes all falls to fracture seen by the Trauma and Orthopaedics (T&O)	**COMPLETE**

		team even if they occurred out of hospital. However, incidents reported on Datix are predominantly for those patients who have fallen whilst in ESHT care. For those who have sustained a fracture, an SI or Amber investigations will be undertaken.	
Ensure that flat lifting equipment is available on all sites and is always used to move patients when a hip fracture is suspected, in order to avoid causing pain and / or further injury.	Ensure that flat lifting equipment is available on all sites and is always used to move patients when a hip fracture is suspected.	While the correct equipment is not always used to lift patients from the floor, from the SI's completed over the last year the patients are either assisted from the floor without the equipment because no injury is initially suspected or the equipment is used where injury is either suspected or evident. Where equipment has not been used it is always highlighted in the report and included in the recommendations and action plan. This will continue to be monitored via SI investigations.	**COMPLETE / ONGOING**
Include safe manual handling methods in a post-fall protocol that is followed for all people who fall during a hospital stay. Document the handling method used in the patient's record.	Update the post-fall protocol to include safe manual handling methods – to be followed for all people who fall during a hospital stay.	The Prevention and Management of Patient Slips, Trips and Falls Policy states *"if no injury suspected the patient can be moved using appropriate moving and handling devices if needed as described in the Trust Moving and Handling Policy and within staff moving and handling training. Where there is injury depending on the nature of the injury, careful movement will be required.* The Emergency Department have a spinal board if required. The method to move the patient must be determined by the clinical team. For community hospital settings the Ambulance Service may need to be contacted if complex injury and difficulty to move the patient. The Moving and Handling Policy states "*M&H training includes the procedures (all staff) and*	**COMPLETE / ONGOING**

		equipment which enable clinical staff to support and recover patients who have fallen. Staff should not try "to catch" and take the weight of a patient." Techniques recommended are detailed on Clinical Skills.net, which all staff can access through the Extranet. Equipment available at ESHT includes the Flat Lift Kit (HoverJack ©) and Raizer ® Clinical Skills includes details on encouraging the patient to get themselves up from the floor, using a chair to help and instructions on using the equipment.	
	Document the handling method used in the patient's record.	**Compliant** - The method of helping the patient from the floor following a fall is reviewed as part of the SI process and where inappropriate this is included in the recommendations and action plan.	**COMPLETE / ONGOING**
Assessment by a medically qualified professional should take place within 30 minutes of a fall where serious injury is suspected. In sites without access to medical cover, transfer to an emergency department should be arranged within 30 minutes.	Assessment by a medically qualified professional should take place within 30 minutes of a fall where serious injury is suspected. In sites without access to medical cover, transfer to an emergency department should be arranged within 30 minutes.	3. Medical assessment within 30 minutes of a fall 30 mins 100% NAIF overall: 72%	**COMPLETE / ONGOING**
Commence hip fracture management without delay. This *may* require the development of local policies that ensure expedited care for those who sustain a hip fracture following a fall in hospital.	Commence hip fracture management without delay – ensure local policy is in place and followed if necessary.	Assurance provided by the T&O Lead that all hip fractures are treated with the minimum amount of delay that the service provision allows. However, a local policy is not in place. Outcomes are additionally tracked via the National Hip Fracture Database audit.	**COMPLETE / ONGOING**

Further identified risks and concerns

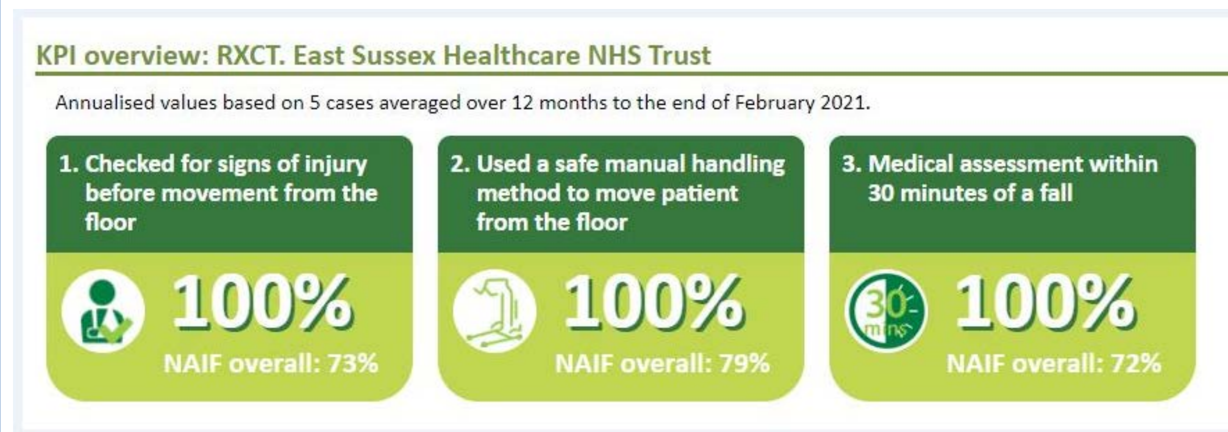
Analysis of falls within the Medicine Division highlighted that there was a high rate of falls recorded at EDGH in the Emergency Department (ED), Acute Medical Unit (AMU) and certain medical wards. The Division began improvement work by developing an understanding of how falls risk was being managed through the whole care pathway at EDGH from ED, through to AMU and onwards to priority medical wards. AMU was identified as the area within Medicine to focus on the initial falls quality improvement

Ongoing good practice

Quality Improvement (QI) work throughout Covid-19 Pandemic: Covid-19 First Wave March – May 2020
Covid-19 QI work continued as there were low attendances in the Emergency Department and a high staffing fill rate with the addition of redeployments to the wards from cessation of services which resulted in AMU having the capacity to continue with the quality improvement work.

In October 2020 the Chief Nurse requested a deep dive of highest severity falls within Medicine.
The Medicine Division undertook an analysis of the four highest falls areas to identify any themes and learning. This showed that risk assessments including lying and standing blood pressures were not being completed; all of these falls occurred in the evening with patients mainly with capacity and either in a bathroom or using a commode.

Falls risk assessments have been revised and are currently being piloted within AMU. The bathrooms in AMU have been risk assessed, equipment removed to ensure clutter free and a falls patient information leaflet has also been piloted.



Taken from the National Audit for Inpatient Falls 2020

Second wave of Covid -19 December 2020 - February 2021

Due to high numbers of Covid-19 patients admitted with high acuity, significant staff absence, minimal redeployment to support wards, additional escalation areas open and a poor fill rate, the division had to pause the quality improvement work on falls as a result.

Medicine Restarting Falls Quality Improvement

- Quality Improvement work restarted in February 2021. The Medicine Division are continuing with piloting the revised multifactorial risk assessment/care plan and the patient information leaflet.
- A teaching video is being developed to support staff in completing the revised multifactorial risk assessment/care plan.

Local Clinical Audit Reports in 2020/21

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.

Local audit activity was paused during Q1 2020/21, with the exception of COVID-19 related projects. The Trust is now encouraging local audits to be registered again and these are going through the standard divisional approval process.

The reports of 80 local clinical audits were reviewed by the Trust in 2020/21. 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.

Urgent and out-of-hours CT Brain for subarachnoid haemorrhage and subsequent Lumbar Puncture

Audit Number: 4892
Completion date: November 2020

Rationale

A Subarachnoid haemorrhage (SAH) is a life threatening event associated with high morbidity and mortality which necessitates timely detection and management. Unenhanced Computerised Tomography (CT) brain scans are highly sensitive in the detection of subarachnoid blood but the sensitivity declines over time, from 95-100% in the first 24 hours to around 50% after 5-7 days. Initial investigations and efficient management of patients with suspected or confirmed SAH is necessary to avoid missing the diagnosis and to reduce the mortality and morbidity.

The aim of the this audit was to analyse the compliance to lumbar puncture (LP) subsequent to CT, in patients presenting with suspected SAH / sudden severe headache and altered Glasgow Coma Score (GCS). Analyse the proportion in which LP is not performed despite having no contraindications to LP, and thereby bring about changes so that initial management of SAH is according to the NICE guidelines.

Key Results

In 47 CT normal patients, only 7 had subsequent LP performed (14.8% compliance) no earlier than 12 hours to 14 days of symptom onset against a set target of 100%. This shows a significant non-compliance to the guidelines.

Clinical Standard	Exceptions	Result
100% adults with presentation of sudden severe and unexplained headache should have an 'immediate' CT brain and, If normal, Lumbar puncture after 12 hours-14 days.	None	7/47 (14.8% compliance)

Recommendations

Awareness of failure of compliance to the guidelines and education on the risks of not performing LP would be helpful in improving the quality of care.

- The audit result to be discussed with Radiologists and clinical referring teams and emphasise that a normal CT cannot exclude subarachnoid bleed completely.
- Clinicians must also be aware that a normal CT does not exclude raised intra-cranial pressure and clinical findings need also to be taken into account
- Agree with clinicians that only a consultant or a specialist registrar at year 3 or higher can request an urgent CT scan in these circumstances
- Ensure appropriate clinical details are included in the request (e.g. timing of headache onset, sign of raised intracranial pressure, GCS, focal neurological deficits)
- Proper record of the timing of LP if done.
- To assess the outcomes of these proposed recommendations, a re-audit in 4 months' time should be carried out.

Lessons Learnt

Relying solely on an imaging investigation such as CT is not adequate in SAH. Omission of performing an invasive investigation can lead to misdiagnosis. Performance of invasive investigation is necessary in certain cases and performed without failure. The timely investigation is also important, as certain invasive investigations are beneficial only when carried out in a stipulated time (Example: LP done after 12 hours of symptom onset).

- The data collection should be improved to include data on the time of investigations.

Local Action Plan:

Recommendation	SMART Action Point	Comments	Status
Audit outcomes presented at the next available Multidisciplinary meeting (MDM)	Identify the next MDM; 20-30 minute presentation of the audit outcome points and concerns	This is due to be presented at the June meeting (22/06/21)	
Reinforce the importance of performing LP, among the foundation years and medical trainees.	Reinforce the importance of performing LP, among the foundation years and medical trainees. Via Email	This has been done and also while reporting the CT any contraindications for LP has also been mentioned.	**COMPLETE**
Flyer campaign to commence in Acute Medicine, and ED	Flyers/posters distributed in Acute Medicine, and ED	Please see Poster.	**COMPLETE**
Notification to improve the recording of time duration of symptoms and timing of investigations	Via Email	This has been also done with the help of poster where we have notified the duration on when to do the LP	**COMPLETE**
Re-audit	Conduct a re-audit to assess improvements.	Due to begin July 21	

Urgent and out-of-hours CT Brain for subarachnoid hemorrhage and subsequent Lumbar Puncture

Note:

- A normal CT does not exclude raised intra-cranial pressure and clinical findings need also to be taken into account.
- Agree with clinicians that only a consultant or a specialist registrar at year 3 or higher can request an urgent CT scan in these circumstances

For each patient ensure:

- Whether appropriate clinical details are included in the request (e.g. timing of headache onset, sign of raised intracranial pressure, GCS, focal neurological deficits)
- The time of the CT examination
- Whether a SAH is demonstrated
- Whether the CT reveals a contraindication to LP
- If and when the LP was performed
- The result of the report on the LP
- The result and time of the report on the LP

Antibiotic prescribing in acute sore throat in Paediatrics

Audit Number: 4662
Completion date: October 2020

Rationale

Most children presenting with sore throat will have a self-limiting and often viral cause of illness. The withholding of antibiotics in these cases is unlikely to cause harm. This can be triaged using the Centor and or FeverPAIN criteria and if these are low carers can be given verbal advice and safety netting. However, the inappropriate use of antibiotics can lead to undesirable side effects, such as gastrointestinal symptoms. There is also the greater issue of antibiotic resistance that needs to be considered.
The aim of this audit is to see whether children presenting to paediatrics with acute sore throat are being managed as per the NICE 2018 guideline NG84 entitled: 'Sore throat (acute): antimicrobial prescribing.

Key Results

Clinical Standard	Exceptions	Result
100% of children presenting with sore throat should be assessed using the FeverPAIN and or Centor score.	None	0% of children were assessed with FeverPAIN and or Centor.
100% of children with either a FeverPAIN score of 0 or 1 or Centor score of 0, 1, 2 should not be offered antibiotics.	None	0% of children were assessed with FeverPAIN and or Centor.
100% of children with either a Fever score of 2 or 3 should not be offered antibiotics or should be given a backup prescription.	None	0% of children were assessed with FeverPAIN and or Centor.
100% of children with either a FeverPAIN score of 4 or 5 or Centor score of 3 or 4 should be given an immediate antibiotic or back up prescription.	None	0% of children were assessed with FeverPAIN and or Centor.
100% of patients should be given advice regarding length of symptoms and use of self-care.	None	0% of children were given advice regarding length of symptoms and use of self-care.
100% of patients should be given advice to seek medical help if their symptoms worsen rapidly or significantly, or if the person becomes very unwell.	None	Unclear how many children were given advice on safety netting from the notes, only explicitly mentioned a few times.
100% of patients who are systemically very unwell, or, had symptoms and signs of a more serious illness or condition, or, has high risk of complications should be offered an immediate antibiotic prescription.	None	FeverPAIN and or Centor was not used, unclear to see how many of the children given antibiotics were systemically unwell.
Of patients given antibiotics, 100% of patients should receive either first choice antibiotics or alternative choices for penicillin allergy/intolerance.	None	46.2% of children given first choice of antibiotic, phenoxymethylpenicillin 18/40 cases.

Conducting this audit report has identified that the FeverPAIN and or Centor score criteria hasn't been used, and is at 0%.
From August 2019-October 2019, 50 patients presenting with sore throat were audited. It was found that although the majority of children were managed with the 1st line antibiotic, 18/40, as stated in the NICE guideline. However, there was a lack of documented evidence that the FeverPAIN and or Centor criteria had been used to help make this clinical decision. The guideline states that the FeverPAIN and/or Centor criteria should be used to guide whether antibiotics are required, and if so which one is to be used.

Recommendations

- The clinical staff should be informed on the importance of adhering to the NICE guideline when managing children with acute sore throat. They should also clearly document FeverPAIN and or Centor criteria to explain their rationale for treatment.
- To improve the use of FeverPAIN and or Centor criteria from 0% to 100%, in line with the NICE guideline on antimicrobial prescribing in acute sore throat. This will be achieved by having the guideline easily visible in the Senior Housing Officer office as well as presenting this audit at the paediatric grand round, as well as to the ED and Ear, Nose and Throat (ENT) teams. This is important to prevent the inappropriate use of antibiotics in children who do not need them. It will also be beneficial to add a reminder in the admission notes in the ENT section, to write the FeverPAIN and or Centor score.
- To re-audit in 6 months after the implementation of the changes to see if raising awareness of this guideline has led to an increase in use of the FeverPAIN and or Centor criteria to manage these patients as per the NICE guideline on acute sore throat.

Lessons Learnt

Completing this audit has highlighted the importance of using and clearly documenting use of FeverPAIN and or Centor criteria in children who present with sore throat. The aim is to use this 100% of the time and ensure that when antibiotics are needed either the first line or appropriate second line antibiotic treatment is given.

Local Action Plan:

Recommendation	SMART Action Point	Comments	Status
Improve the use of CENTOR / FeverPain criteria from 0% to 100%	Display the guideline with flow chart from the NICE guidance in the Senior Housing Officer office.	Flowchart has been shared & displayed.	**COMPLETE**
Improve the use of CENTOR / FeverPain criteria from 0% to 100%	Present this audit at the paediatric grand round, Paediatric audit meeting, to the ED and ENT teams for learning.	Presented to multiple specialties as required. Agreed to use FeverPAIN instead of Centor across the relevant divisions.	**COMPLETE**
Improve the use of CENTOR / FeverPain criteria from 0% to 100%	Add a reminder in the admission notes in the ENT section to write the FeverPAIN and or Centor	Sticker regarding the completion of the scoring being created, this will be added to the IPD. FeverPAIN score sheet will be added to the CAS cards, displayed in Room 6 where Paediatric patients are seen. Discussions taking place regarding adding this to A&E Induction.	**UNDERWAY**

Re-audit to see if raising awareness of this guideline has led to an increase in use of the FeverPAIN and or Centor criteria to manage these patients as per NICE guideline.	Re-audit in 6 months of implementation of the changes	Due to begin June 21	

Delirium Audit

Audit Number: 4798
Completion date: April 2020

Rationale
Delirium is a common clinical syndrome (20-30% of patients admitted to a hospital medical ward are affected).

(1) It is a condition that is associated with poor outcomes including falls, pressure sores, longer admissions and death. If those at risk are appropriately managed, it can be prevented. If it is recognised early, it is more successfully treated. It is therefore recommended nationally that those 'at risk'* should be screened.
(2) The '4AT' test is a widely recognised tool used for identifying those with delirium.
(3) It is recognised that if 4AT is 1-3 it could indicate cognitive impairment. If 4AT is 4 or greater it is suggestive of delirium +/- cognitive impairment. We therefore have reviewed all those who scored at least 4 using the 4AT tool.

In August 2018, an audit was carried out in order to review the diagnosis of delirium within EDGH. This audit revealed that in fact '0% of patients with indicators of delirium had a delirium assessment carried out using a validated delirium assessment tool.' In order to improve this figure, it was proposed that a delirium assessment tool be inserted into the next version of the medical Integrated Patient Document (IPD).

This change has now taken place and has been in place since March 2019.
The rationale for this audit is to review how successfully this tool has been utilised in particular to aid in the diagnosis of delirium.

Key Results

Clinical Standard	Exceptions	Result
The 4AT test must be completed for 100% of patients aged 65 and over who are admitted to the medical take.	None	**22.5%**
100% of patients who scored >0 (possible cognitive impairment/delirium) had this highlighted in the clerking doctors diagnosis/co-morbidities	None	**43%**
100 % of patients who scored >0 (possible cognitive impairment / delirium), had this highlighted in the Post take ward round	None	**14%**

Although only 22.5% of at risk patients (>65 years) were screened for delirium over the time period that was audited, this was an improvement and a step in the right direction from 0% seen in the previous audit (carried out in EDGH August 2018). It is, however, far from the target suggested by NICE who advise we should be screening all those at risk of delirium with clinical indicators as a means of preventing and treating it urgently and systematically.

Recommendations

- To continue to run training sessions for existing/new trainees (induction) on delirium assessment and management.
- Discuss the findings at the geriatric departmental meeting in order to explore ways to approach improving our delirium screening. This should be then re-audited when improvements are in place.
- As previously stated on 2018 audit recommendations: *"consider annual data collection/full time database of delirium assessment & management with monthly analysis and review (to be directed by elderly care Doctors and dementia nurse team)."*

Lessons Learnt

- The 4AT was poorly utilised. 77.5% of those 'at risk' of delirium as defined by NICE, were not screened using the available 4AT tool.
- Even if the 4AT was correctly filled, a positive result was not always recorded within the plan and less so in the post take ward round.

If any significant diagnosis is not recorded clearly within the notes, current and future management of that patient cannot be carried out successfully. Although outcome measures were not researched in this audit, it is likely if a patient does not receive a diagnosis, delirium focused treatment/prevention could not take place. This would lead to poor clinical outcomes as highlighted by NICE.

Local Action Plan:

Recommendation	SMART Action Point	Comments	Status
To continue to run training sessions for existing / new trainees (induction) on delirium assessment and management.	To continue to run training sessions for existing / new trainees (induction) on delirium assessment and management.	Consultant Lead regularly provides training.	**COMPLETE**
Discuss the findings at the geriatric departmental meeting in order to explore ways to approach improving our delirium screening.	Discuss the findings at the geriatric departmental meeting in order to explore ways to approach improving our delirium screening.	This has been delayed due to the COVID-19 pandemic	**OUTSTANDING**
Re-audit of the use of the 4AT tool in 12 months.	Re-audit of the use of the 4AT tool in 12 months.	Re-audit complete	**COMPLETE**
As previously stated on 2018 Audit recommendations: "consider annual data collection / full time database of delirium assessment and management with monthly analysis and review (to be directed by elderly care Doctors and dementia nurse team)."	As previously stated on 2018 Audit recommendations: "consider annual data collection / full time database of delirium assessment and management with monthly analysis and review (to be directed by elderly care Doctors and dementia nurse team)."	This has been delayed due to the COVID-19 pandemic	**OUTSTANDING**

Participation in Clinical Research

The Trust acts as a participating site for national and international research studies, recruiting patients to take part in novel treatments. All research in the NHS is approved centrally by the Health Research Authority.
ESHT usually delivers research recruitment to around 60 National Institute of Health Research (NIHR) Portfolio studies but early in the pandemic were instructed to pause current studies, and open urgent public health (UPH) as priority. We maintained the safety of patients already on active treatment trials.

On 28/1/2020 DoH requested activation of the UPH response in relation to Wuhan nCoV 2019, and asked Trusts to open an UPH study (ISARIC - CPMS 14152) as a matter of urgency. This was the first of many study requests and opened at ESHT on 11/02/2020.

Other UPH priority requests were selected on the basis that these could be offered successfully, and were confirmed and opened rapidly
These included several studies which were cited as part of Downing Street briefings.

Project Short title	Disease area	Project site status	Recruited (org)	Project site date open to recruitment	Project site Planned closing date	UK Sample Size	Principal Investigator
Clinical Characterisation Protocol for Severe Emerging Infection ISARIC	Infection	Open	1,642	11/02/2020	28/02/2023	200,000	Carruth, Vikki
COVID-19 infection in patients with haematological disorders	Blood	Open	Anon data only	07/10/2020	01/04/2022		Cowley, Dr Anna
COVID19-OR	Respiratory	Open	10	27/05/2020	08/05/2022	266	Highgate, Dr J
GenOMICC	Critical Care	Open	12	15/05/2020	28/02/2030	40,000	Highgate, Dr J
RECOVERY - Respiratory Support failed to recruit -equipoise re CPAP / HFNO arms	Respiratory	Open	0	05/05/2020	20/04/2021	4,002	Kankam, Dr Osei
RECOVERY trial	Infection	Open	133	08/04/2020	31/12/2021	42,000	Marshall, Dr Andrew
SARS-COV2 immunity and reinfection evaluation (SIREN)	Infection	Open	207	24/08/2020	27/11/2021	40,000	Cowley, Dr Anna
The PROMISE Study Version 1	Mental Health	Open	14	26/03/2020	28/02/2021	2,000	Still, Mrs Liz
UKOSS: Pandemic Influenza in Pregnancy	Womens Health	Open	tbc	01/04/2020	01/03/2023	500	Still, Mrs Liz
Pregnancy and Neonatal Outcomes in COVID-19	Womens Health	Closed	8	11/06/2020	31/03/2021	100	Mason, Dr N

The Clinical Research Network (CRN) for Kent, Surrey and Sussex (KSS) has identified regional information, along with thanks for our collective responses.
With the exception of 1 trial cited (REMAP-CAP) – ESHT has participated in ALL the studies for which we were eligible.

Study title	KSS regional information
RECOVERY – a randomised controlled trial with many treatment arms that changed often and rapidly during the pandemic	Eleven acute hospital trusts contributed to the success of this study. Early results confirmed dexamethasone as an effective and safe treatment. Tocilizumab, an anti-inflammatory drug, was also demonstrated to be beneficial.
SIREN:	Ten acute trusts in KSS recruited between 200 and 417 staff to this intensive study seeking to evaluate the immune response to COVID-19. Staff are being followed up for at least a year with trusts providing ongoing data and regular antibody and PCR testing.
CCP-UK/ISARIC – in depth data collection for every admission	Most KSS trusts were engaged in this study, and achieved significant recruitment.

with suspected / confirmed infection	
Pregnancy and Neonatal Outcomes in Covid-19	Nine KSS acute trust maternity teams have made a significant contribution to the success of this important study.
GenOMICC:	Ten acute trusts in KSS have made a major contribution to this study, seeking to find the genes that cause susceptibility to COVID-19, which will help to prioritise treatments in the future.

The number of patients receiving relevant health services provided or sub-contracted by ESHT in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 2,048 participants. This is an increase from 2019/20 where 1,533 patients were recruited to participate in research studies and was in most part due to the data collection associated with CCP-UK/ISARIC.

Commissioning for Quality and Innovation (CQUIN)

Although CQUIN schemes were identified for 2020/21, the pandemic outbreak led to a refocus away from the proposed schemes.

In summary, the approach to CQUIN was as follows:

- The block payments were deemed to include CQUIN.
- The operation of CQUIN (both Clinical Commissioning Group (CCG) and specialised) for Trusts was suspended for the period from April 2020 to March 2021; providers were advised that it was not necessary to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. It should be noted that this approach applied to both the CCG and PSS (Prescribed Specialised Services) CQUIN schemes, inclusive of all nationally mandated, and locally agreed indicators.
- Commissioners and Trusts also took a pragmatic approach to the agreement of the final payment amounts for the 2019/20 CQUIN scheme, and this was on the basis of all currently available data at the time

Statements from the Care Quality Commission

ESHT is registered with the Care Quality Commission (CQC) to carry out eight legally regulated activities from 15 registered locations with no conditions attached to the registration. During the first wave of the COVID-19 pandemic we temporarily added an additional site external to the hospital to safely accommodate our infusion unit and during the second wave we added an extra rehabilitation facility for a limited time. Some elective surgery was also carried out using facilities at the Sussex Spire Hospital, the Horder Centre and Benenden Hospital.

Following the publication of our latest inspection report in February 2020, where the overall rating for the Trust was Good an action plan was developed to address any recommendations. A total of 34 'should do' actions were identified to improve on service quality and throughout the year significant progress has been made in addressing these. There are eight issues not yet fully resolved all of which have been curtailed due to many staff being redeployed in responding to the pandemic, the actions are regularly monitored and will be completed in due course. Examples include:- ensuring that patients are able to access the community frailty team for support in a timely manner; formalising the major incident plan for mortuary services; managing waiting times from referral to treatment in line for non-admitted pathways within national standards; ensuring play specialists are available to support inpatient children, and working with the Children and Adolescent Mental Health Services (CAHMS) team to review access for children presenting with mental health concerns at weekends in line with national guidance.

Throughout this year the CQC have adapted their methods for monitoring services by using a transitional approach focusing on safety; how effectively a service is led; how easily people can access the service and targeting inspection activity only where they have concerns. They monitor and review information from all available sources and then have a conversation with us either online or by phone to discuss any issues identified.

The Trust has not participated in any special reviews or investigations by the CQC in the reporting period and throughout 2020-21 the CQC found no breaches that justified regulatory action, no requirement notices have been issued and no enforcement actions have been taken.

Data Quality

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

During 2021/22 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 action targeted reports to capture errors and data anomalies
- 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

ESHT submitted records during April 2020 to March 2021 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:

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 99.5% 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 organisations to measure their performance against the National Data Guardian's data security standards. The CQC 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 42 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 2020/21 was submitted with 110 pieces of evidence provided and all standards graded as met. This is a self-assessment, but is reviewed by our internal auditors to provide assurance of accuracy to the Trust. The Trust's auditors report gives 'substantial assurance' that the Trust's submission is robust for 2020/21.

Clinical Coding Error Rate

ESHT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the accuracy rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 96.11%

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 DSPT Audit conducted by a Clinical Classifications Service Registered Auditor.

Results of the DSPT Audit

We achieved advisory level in all the fields (primary diagnosis, secondary diagnosis, primary procedure fields and in secondary procedure fields). Advisory level is the maximum an organisation can achieve. Attainment levels are summarised in the table below.

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%

Overall Audit Results Summary – August 20 (200 FCE's)

Primary Diagnosis Correct	Secondary Diagnosis Correct	Primary Procedure Correct	Secondary Procedure Correct	Unsafe to Audit
95.50%	95.17 %	97.52%	96.25%	0

ESHT achieved an overall accuracy percentage of 96.11% highlighting 3.89% 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 inconsistencies in documentation
- Clinician awareness in coding terms and in recording co-morbidities is limited.

ESHT 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 availability of electronic notes on Evolve by implementing robust Health records policies
- 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 or have occurred but has not contributed to or led to 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 2020, 1,816 ESHT patients died. The table below summarises the number of deaths which occurred in each quarter of that reporting period:

Number of deaths per quarter (January 2020 to December 2020)

Reporting period	Number of deaths
Q4 2019/20: January 2020 to March 2020	501
Q1 2020/21: April 2020 to June 2020	391
Q2 2020/21: July 2020 to September 2020	379
Q3 2020/21: October 2020 to December 2020	545
Total: January 2020 to December 2020	**1816**

Number of case record reviews or investigations
By 12/05/2021, 1,698 case record reviews and 120 investigations had been carried out in relation to the 1,816 deaths. In 110 cases, a death was subject to both a case record review and an investigation.

Number of case record reviews or investigations per quarter (January 2020 to December 2020)

Reporting period	Number of case record reviews or investigations
Q4 2019/20: January 2020 to March 2020	457
Q1 2020/21: April 2020 to June 2020	361
Q2 2020/21: July 2020 to September 2020	345
Q3 2020/21: October 2020 to December 2020	545

Three deaths representing 0.165% of the patient deaths between January and December 2020, were judged to be more likely than not, to have been due to problems in the care provided to the patient.

Estimated deaths per quarter considered likely to have been avoidable (January 2020 to December 2020)

Reporting period	Number of patient deaths considered likely to be avoidable	Percentage of the patient deaths considered likely to be avoidable
Q4 2019/20: January 2020 to March 2020	1	0.20%
Q1 2020/21: April 2020 to June 2020	1	0.256%
Q2 2020/21: July 2020 to September 2020	0	0%
Q3 2020/21: October 2020 to December 2020	1	0.183%

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.

A summary of what ESHT has learnt from case record reviews and investigations conducted in relation to the deaths identified:

- The importance of accurate recording of weight on admission and of reducing the dose of paracetamol accordingly in low weight adults
- The importance of adjusting the dose of low molecular weight heparins in patients with marked renal impairment
- Lack of a policy specifically covering detail of the treatment of hypokalaemia (low levels of potassium).

A description of the actions which ESHT has taken in the reporting period, and proposes to take moving forward in consequence of what has been learnt during the reporting period:

- Each of these deaths was subject to a detailed internal “amber” investigation. The results and recommendations were shared with the Weekly Patient Safety Summit, Divisional governance teams and Divisions
- Further Education has been given to medical and nursing staff on the Trusts prescribing policy. Specific guidance on prescribing in low weight adults
- Electronic checks and safety measures are being incorporated into the Trust’s electronic prescribing and pharmacy management system to prevent inappropriate dosing of weight-sensitive and renal function-sensitive medications
- Specific guidance on treatment of hypokalaemia is being produced.

An assessment of the impact of the above actions described which were taken by the provider during the reporting period.

- Revision of the current policy on administration of potassium, with strong solutions to be delivered by only syringe drivers, not through standard intravenous infusion sets.

- The new ePMA (electronic prescribing system) development, roll-out of which is scheduled for later this year, will protect patients against incorrect dosing of medications sensitive to weight and renal function. Its internal algorithms will also provide protection against a wide variety of prescription errors.

- The guidance on treatment of hypokalaemia and the revised policy on the administration of intravenous potassium should prevent any similar incident of hyperkalaemia (high potassium levels) due to inadvertent administration of bolus infusions.

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

30 case record reviews and 4 investigations were completed after 14/05/2020 which related to deaths in the previous reporting period (January 2019 to December 2019).

No deaths in the previous reporting period, which were reviewed or investigated after 14/05/2020, were 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 2019 to December 2019) judged more likely than not to have been due to problems in the care provided to the patient, remains the same.
There were four deaths representing 0.222% of the patient deaths between January 2019 and December 2019 judged more likely than not, to have been due to problems in the care provided to the patient.

Seven Day Hospital Services

The Seven 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 NHSE/I process for providers to record a single consistent report for the dual purpose of assurance from their own boards and national reporting.

ESHT achieved compliance with all four clinical standards at the end of 2019/20.

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 and one at the EDGH. 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 improvements will be made. The GOSWHs provide quarterly and annual reports to the People and Organisational Development (POD) Committee, and are also involved in the meetings in the table below.

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 – Doctor's Assistant and a Physician Associate have been appointed to and are now helping to cover ward areas.

Staff who speak up

The National Guardian's Office (NGO) and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

Five years have passed since the publication of the Francis Freedom to Speak Up Review in 2015. The speaking up culture of the health sector in England has changed with a network of over 600 Freedom to Speak Up Guardians (FTSUG) in over 400 organisations.

Freedom to Speak Up Guardians are now well established in every trust in England, with increasing numbers in Clinical Commissioning Groups, regulators and NHS England and Improvement.

What is a Freedom to Speak Up Guardian?
Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken. Guardians also work proactively to support their organisation to tackle barriers to speaking up. ESHT have two Freedom to speak up Guardians covering acute and community sites across the organisation. They support and abide by the guidance issued by the NGO. They follow the ''universal job description' issued by the NGO.

The NGO has worked with the CQC to ensure that an assessment of speaking up is at the heart of inspecting the Well Led domain.

When things go wrong, we need to make sure that lessons are learnt and things are improved. If we think something might go wrong, it's important that we all feel able to speak up so that potential harm is prevented.
Even when things are good, but could be even better, we should feel able to say something and should expect that our suggestion is listened to and used as an opportunity for improvement.

ESHT have a named non-executive lead for FTSU, demonstrating the Trust Board's commitment to creating an open and honest culture where workers feel safe to speak up.

FTSUG's

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

The role of the FTSUG is promoted through meetings, team huddles, the staff induction process and regularly circulated newsletters; a range of materials and information is also available on the Trust extranet.

The FTSUG are contactable by email, on the telephone and through social media. Contact is offered to suit the needs of the staff member. During COVID-19 staff have also used MS Teams to speak with the FTSUGs.

Proactive

- Communicating the role
- Inductions
- Training for managers and staff
- Developing partnerships
- Looking for trends and triangulating data
- Aligning FTSU with corporate priorities

Facing the Board

- Writing and presenting Board reports

Reactive

- Listening to and supporting staff
- Ensuring investigations happen well
- Providing feedback

Facing the frontline

- Walking the floor
- Working with staff groups ensuring easy access for vulnerable staff group

Training is now available on-line at ESHT through HEE and forms part of all staff induction

Speak Up: Core Training for all Workers - covers what speaking up is and why it matters.

Listen Up – for managers at all levels - focuses on listening and understanding the barriers to speaking up.

Follow Up, for senior leaders – including Executive and Non-Executive Directors will be launched later this year.

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 FTSUG 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 FTSUG, if required, and followed up for reassurance and any learning shared
- Monthly meetings are held between the FTSUG 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 Freedom to Speak Up Raising Concerns (Whistleblowing) policy supports staff to raise and share concerns.

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.

Staff Survey 2020 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:

- Equality Diversity and Inclusion
- Health and wellbeing
- Staff engagement and involvement
- Safety Culture
- Job satisfaction
- Team working and support from managers

Our results and priorities for 2021

Research demonstrates that those organisations with high levels of staff engagement also have better patient outcomes/experience. In 2020, the Trust was delighted that, in the middle of the global pandemic 3712 staff members at ESHT took time to complete the survey. This constituted an overall response rate of 51%, compared with a national response rate of 46.3% for similar organisations.

Feedback from Quality Health, who are an independent company who collate the survey data on behalf of the NHS, has indicated that the results at ESHT are particularly good compared to other similar organisations.

We were particularly pleased that:

- Our Quality of Care score has significantly improved
- The Trust performs well and is significantly above sector average in terms of:
  - Equality Diversity & Inclusion
  - Immediate Managers
  - Team Working

We also scored in the top 20% of trusts on the following questions –

ESHT 2020 Staff Survey Top 20% scores	Trust Score	Sector score	Top 20%
Theme 2-Health & Wellbeing			
11a. Does your organisation take positive action on health and wellbeing?	38%	33%	38%
Theme 3-Immediate Managers			
5b. (How satisfied are you with) The support I get from my immediate manager	72%	69%	72%
8c. My immediate manager gives me clear feedback on my work	65%	61%	64%
8d. My immediate manager asks for my opinion before making decisions that affect my work.	57%	55%	57%
8f.My immediate manager takes a positive interest in my health and wellbeing	72%	69%	72%
8g. My immediate manager values my work	75%	72%	74%
Theme 4-Morale			
8a. My immediate manager encourages me at work	72%	69%	72%
Theme 8-Safety Culture			
16a. My organisation treats staff who are involved in an error, near miss or incident fairly.	66%	62%	65%
16d. We are given feedback about changes made in response to reported errors, near misses and incidents	65%	62%	65%
Theme 10- Team Working			
4h. The team I work in has a set of shared objectives	75%	72%	75%
4i. The team I work in often meets to discuss the team's effectiveness	62%	57%	60%
Theme- Additional-Job Satisfaction			
5a. (How satisfied are you with) The recognition I get for good work	61%	57%	60%
5f. (How satisfied are you with) The extent to which my organisation values my work	51%	47%	51%
Theme-Additional-Managers			
8b. My immediate manager can be counted on to help me with a difficult task at work.	73%	70%	73%

The results of our Staff Survey are shared with our staff members to agree which areas they would like to work on together to bring about improvement. Progress is monitored regularly through quarterly Pulse surveys and with the Divisions and their identified staff survey lead. We have also put on a number of digital panel forums for all staff to attend with a focus on engagement, why staff surveys are important; how to focus on improvements and the importance of staff involvement including those working from home and new staff to our organisation

Based on the feedback that we have received, we have identified three corporate priorities that link to the key findings and recommendations from the Staff Survey 2020:

To demonstrate we care about our staff members and their Health and Wellbeing by:

- Carrying out focussed work on Stress and Musculoskeletal (MSK) issues
- Developing a framework outlining the basic fundamental needs that all staff members should expect at ESHT to feel psychologically safe
- Give tools for self-management for own health and wellbeing

To reduce the incidents of harassment, bullying and abuse by colleagues, by:

- Drilling down into data, to identify specific areas of concern
- Develop a range of actions which will support a positive and inclusive culture, where Harassment, Bullying and Abuse (HBA) is not tolerated

To continue to develop the Trust as the 'Best Place to Work', by:

- Developing a Partnership Forum that involves many of our staff members in decisions that impact them and they can be involved in the wider business of the trust
- Understand and act upon how we improve job satisfaction amongst staff members with a particular emphasis on receiving high quality feedback

Living our Values

Our Trust values were developed by our staff and shape our beliefs and behaviours. They are fundamental to how we undertake our everyday work. The importance of positive behaviours is led by our Chief Executive and Executive 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. During 2020, we have been successful in gaining Disability Confident Employer status and are aiming to become a Disability Leader organisation in the next three years.

As part of our work on the Workforce Disability Standard we have introduced our (Dis) Ability and Health passport. This has been co-produced with key stakeholders and staff groups across the Trust for optimal impact for staff. To support the passport, a number of supporting documents have been produced regarding Reasonable Adjustments and Access to work.

We continue to hold ourselves to account to all of the nine Workforce Race Equality Standards indicators. The Trust has also been part of the Sussex Healthcare Partnerships – Black, Asian and Minority Ethnic (BAME) Disparity Programme and Turning the Tide Transformation Board. Partner organisations have a system-wide approach to Workforce Race Equality Standard (WRES) and jointly share best practice.

Key internal stakeholders meet through a monthly WRES task and finish group to ensure progress on the action plans. The key focus areas have been about COVID-19, international nurses and recruitment and leadership development. As of 31 December 2020 the Trust was on track with our trajectory targets for BAME representation in leadership roles in AfC (Agenda for Change) Band 8a and above roles.

We are continuing to develop our staff networks at ESHT. These have been historically chaired by a member of the Trust Board and played a pivotal role in raising the profile of minority groups within the Trust. The networks have also previously been, and continue to be, the driving force in all national requirements such as; WRES and Workforce Disability Equality Standard (WDES) and the Public Sector Equality Data (PSED). With the appointment of the new Workforce Equality, Diversity & Inclusion Lead in 2020 it was timely to rebrand the role of our three main staff networks, BAME, Disability and LGBTQI+.

Our staff networks have now been re-branded into independent staff groups with elected Chairs supported by a Trust Board sponsor. The new structure includes; celebrating difference, inspiring staff, helping to transform the organisation with the inclusion agenda and a governance structure to amplify the voices of staff with lived experience at all levels of the Trust.

Health and Wellbeing - looking after our staff

The emotional and physical wellbeing of our staff is really important to us as a Trust, especially during the past year. We have worked closely in partnership with our Human Resources (HR) and Occupational Health colleagues to ensure that we have provided the best and most appropriate care and support to all our colleagues, in particular our patient facing staff groups.

Physical wellbeing

We have provided all patient facing ward based staff with snacks and daily meals to support their physical and nutritional health delivered 7 days a week from March 20 to June 2020 and from December 2020 to April 2021. We have also delivered 567 wellbeing boxes to teams at our acute and community sites as well as nutritional snacks. We have focused our communication on staying

active, physical activities outside of the workplace and also regularly reminded staff about outdoor spaces on site. We have also updated weekly and promoted the free ‘apps’ linked to physical wellbeing as well as communicating out #top tips for staying active if working at a desk. Our occupational health team has also invested in support for MSK.

Emotional wellbeing

From the outset of the pandemic, a review of the emotional support available to staff was undertaken, resulting in a comprehensive psychological wellbeing plan including enhanced interventions in recognition of the increased and different challenges impacting on the emotional wellbeing of our staff. The Trust, with support from charitable funds, has invested in many of these programmes in order for them to be sustainable in the long term as it is recognised that the impact of the pandemic on the psychological wellbeing of staff may be felt for some years to come. These include the following:

- TRiM – (Trauma Risk Management). TRiM is an evidence based, peer led intervention, whereby staff experiencing a potentially traumatic event at work, are offered support by a trained TRiM practitioner, comprising of a structured risk assessment to identify any staff who may be showing signs of post traumatic trauma. The intention is to support staff immediately after an event and for up to three months following an event, in recognition that although the majority of staff will ‘normalise’ the circumstances they have experienced, there are some who may require specialist interventions to enable them to overcome this. The TRiM training will be delivered over the next 12 – 18 months, with 6 cohorts of TRiM practitioners and 3 cohorts of TRiM practitioners receiving the training. In total approximately 90 staff will be trained in TRiM at the end of this time. The first cohort of TRiM practitioners completed their training in March with the second cohort starting in May. The first cohort of TRiM managers starts in June. The roll out of TRiM interventions to some teams who have experienced a potentially traumatic event; started in April.
- Psychological team support – we have now recruited 6 trauma therapists via temporary workforce services, to facilitate further psychological wellbeing interventions for staff. Teams of staff have the opportunity to meet face to face or virtually with a trauma therapist to talk through their experience of the pandemic over a structured time line. The therapist will be alert to any staff who may exhibit significant distress and will support them accordingly. Although uptake of this intervention was gradual after the first wave, we are now witnessing more interest from teams as they emerge from the second wave and start to pick up their substantive work. To date 19 teams have accessed this support, with a further 6 booked in to start and 4 having initial discussions with their teams about accessing this. Another 10 teams showed an initial interest in this but have not yet taken up this offer. This is indicative of the ‘readiness’ of staff to access to support which will differ and further supports the need for these interventions to be available over the longer term.
- GTEP – Group Traumatic Experience Protocol: as a follow on from the psychological team support, the trauma therapists offer GTEP, an EMDR (Eye Movement Desensitization and Reprocessing) based therapy, aimed at reducing levels of distress and occurrence of PTSD – Post Traumatic Stress Disorder. Initially this was again to be offered as a team intervention but it was found that teams struggled to commit to three booked dates due to operational pressures. GTEP is now offered as rolling programme that individual staff members can access. Staff from 16 teams have accessed GTEP but the new approach with individual bookings has only just commenced so figures for this are not yet available. Evaluations and screening outcomes from both of these interventions demonstrate that distress and anxiety levels of staff reduces and that resilience improves.
- Individual Trauma Therapy: in order to provide an end to end pathway for staff psychological support, we have secured access for staff to individual trauma therapy for those who experience work based trauma. Since this was initiated in January 2021, 19 staff have been referred through for individual therapy which they are offered within two weeks of referral.
- Care First Employee Assistance programme - This service has continued to be well utilised throughout the year though surprisingly there has not been a significant increase in demand during the pandemic as might have been anticipated. The majority of contacts to this service are from staff who are in work with approximately a third of contacts coming from

staff who are absent from work. Care First have provided a weekly pack of resources and webinars around a range of issues that have been disseminated to staff throughout the year. With the forthcoming potential relaxation of COVID-19 restrictions, plans are underway for possible on-site sessions and seminars from Care First with groups of staff and managers in order to further promote this service

- *MHFA, (Mental Health First Aid),* equipping leaders to understand and recognise the impact of mental health on every one of us and considering how we can create an inclusive and supportive culture in which to work. We have trained 56 managers since August 2020 and have sourced additional funding from Health Education England (HEE) for additional extra trainers to deliver the programme.
- Working collaboratively with Sussex Partnership NHS Trust to launch of the 'Staff in Mind' programme in December 2020. Current figures indicated that 55 ESHT staff have self-referred to this service for support which leads on to individual therapy if indicated. Further work as to how our two Trusts can work together is being explored.
- Stress Risk Assessment for teams: A review of the approach as to how stress risk assessments are completed and reported for teams is underway, with a new option being piloted with three clinical teams. The aim is to allow individual staff members to submit their own responses to questions, but for these to then be collated providing overall results for the team. These results are then RAG (Red Amber Green) rated so that the line manager has a clear view of what areas and aspects are creating the most work related stress for their team. The line manager will then work with their teams in finding solutions to these issues with support from relevant support services within the Trust if needed. Early results from this pilot are showing that staff engagement in this process is very high. The pilot of all areas will be completed by the end of May.
- Focus on sickness absence due to stress/mental health: Through the pandemic various approaches have been trialed regarding prioritising and supporting staff who are absent from work due to stress/mental health issues. Overwhelmingly, staff have been grateful for this support and having the opportunity to reinforce where and how staff can access further assistance has been beneficial. This work is being reviewed and developed as part of an overall workforce objective around reducing the incidence of absence due to stress/mental health.
- The Schwartz Rounds have continued on a virtual basis and we have also held a number of Schwartz rounds with individual teams
- Time to Talk and Wobble rooms - staff have been supported in a safe space via telephone delivered during COVID-19 with focus on their emotional wellbeing. Spaces within our on-site chaplaincy areas have been created to allow staff to take time and reflect. These have been staffed by the wellbeing and chaplaincy teams. These spaces will continue to be provided 24 hours a day, seven days a week
- Mental Health First Aid (MHFA) is being offered in house to any staff member by our trained colleagues from our wellbeing and occupational health team. This is a training course which teaches people how to identify, understand and help someone who may be experiencing a mental health issue, teaching staff to listen, reassure and respond, even in a crisis. Staff learn how to empower someone to access the support they might need for recovery or successful management of symptoms and skills can be used to support colleagues, teams and friends and family
- Employee support – 98 individual staff have been supported with a range of issues linked to flexible working, childcare and financial wellbeing, which has been critical to staff retention. The onsite nurseries have remained open throughout the pandemic and supported an additional 56 emergency places during this time
- Our Health and Wellbeing team have implemented a number of programmes to support our staff through COVID- 19 and recovery stage and examples of the offerings included: COVID-19 health clinics to the at risk staff across our different sites, Individual support to staff, Wellbeing Assessments for COVID-19 vulnerable staff to include; Blood pressure check, Body Mass Index (BMI), waist measurement, exercise, eating and alcohol advice
- COVID-19 Risk Assessments**:** Since NHS England made it mandatory for COVID-19 Risk Assessment to be undertaken for all staff groups, the Trust has developed a robust process to ensure that meaningful Risk Assessments are available to all staff working at ESHT. We have worked on the ethos that Risk Assessments are meaningful and have our workforces'

health and safety at the forefront in delivering the best care to our patients and service users. A high level COVID-19 Risk Assessments task and finish group was established that initially met five times a week at the height of the first wave. The group now meets bi-weekly overseeing quality and compliance of all Risk Assessments. A weekly dashboard has been created by division to include compliance with fields that include; all Staff, staff at risk and BAME staff. As of 9 March 2021, 7,467 risk assessments have been completed (98.2%) for all applicable ESHT staff. 3,626 of those Risk Assessments have been completed (97.9%) for staff at-risk. The figure can be further broken down to 1,269 risk assessments (96.3%) for BAME staff

- COVID-19 Vaccination Programme**:** To protect and achieve maximum uptake of vaccinations amongst our most vulnerable staff groups, the Trust took positive action to ensure that there were no barriers to accessing the Pfizer or AstraZeneca vaccines. The Chief People Officer and Chief Pharmacist held staff networks engagement events during December 2020, offering staff the opportunity to ask questions and raise concerns in a confidential space. Not only did we produce films aimed at addressing vaccine hesitancy but also provided fact sheets and links to trustworthy medical information to address misinformation. We took positive action and engaged with our disabled and BAME staff to ensure that there were no barriers around accessibility to a vaccine. As of 4 March 2020 we had 1,543 BAME staff of which 1,281 had a first dose of vaccine. We are proud to say that by taking positive action, ESHT was within the top five Trusts in the South East for vaccination take up from its BAME staff at 83%.

Leadership and Culture

As a result of COVID-19 we have been experimenting with new ways of reaching out to support our leaders who have played a key role during the pandemic and in supporting colleagues.

Our aim is to encourage, promote and create the spaces where our leaders, both profession and function oriented, can explore and deepen their understanding of the importance of developing connections with colleagues through conversations that matter; where voices are heard and productive, conflict is encouraged in the spirit of engendering positivity, inclusivity and innovation. COVID-19 restrictions have presented a unique challenge to the team who have grappled with and ultimately exploited the potential of online platforms to continue to create virtual spaces for us to collaborate, learn and share.

- In response to the emerging need to support our Leaders in an accessible and flexible way, we have introduced a range of short focussed and targeted Leadership Support Circles, an NHSE/I initiative where we explore the 10 individual components of Compassionate Leadership in one hour online segments. This creates a space to think, explore and deepen our leadership practice. Since launching the circles in February 2021 their popularity has grown and we are running two further series from May 2021, reaching approximately 70 leaders.
- During the summer of 2020, we developed and experimented with an online series aimed specifically at 'Supporting People who Manage People' where, together with a panel of resident in-house experts, our operational people managers collaborated on topics generated through surveys and conversations. Themes included 'Rapid response to managing stress related absence during COVID-19 a line manager's responsibilities' and 'Bringing the Staff Survey to life'. The panels are designed to be short, accessible, practical, thought provoking and a space to share what works well. Several hundred people including managers have attended the panels so far.
- Launch of our Foundations in Coaching development programme delivered in a virtual setting. Cohort 2 is now underway with a further two cohorts planned for later this year. Several participants have now progressed to become certified Institute of Leadership & Management ILM Level 3 practitioners in coaching. Our aim is to build an internal coaching network accessible by all colleagues at all levels.
- In collaboration with the BAME network and in response to nationally recognised challenges of BAME colleagues securing a promotion; we have created a full-day Career Development Workshop. Following attendance, the progress of participants is

tracked over 18 months and supplemented with a series of bitesize virtual sessions such as ‘Utilising Feedback’ and ‘Increasing Corporate Awareness’, as well as the offer of individual career and interview preparation coaching. 20 staff from our BAME community have participated so far with four being promoted since attending the session. The sessions have proved so popular that we are now offering this programme virtually for all colleagues. By the end of 2021 we expect to see more than 100 delegates attending the sessions.

- Working together in networks, developing connections and supporting one another in the workplace are important to the Trust and the team has created a peer supervision network for in-house Mediators and conversation facilitators to support early disputes resolution across the Trust. This will reduce the need for recourse to formal procedures and increasing the likelihood of reaching an amicable, workable outcome.
- Led by ESHT Organisational Development (OD), the Sussex system-wide OD Practitioners’ Practice Development Series commenced in April 2021 bringing together 25 colleagues from across health and social care who work with teams in various roles including OD, HR, QI and Transformation to explore and augment their skills, knowledge and expertise in OD, build connections and a network to collaborate on change projects.
- Launch of our first Aspiring Leaders programme with ten participants joining in May 2021 aimed specifically at people who wish to explore their leadership and management capacity and capability. OD, in collaboration with our Workforce Lead and McCrudden Training, have created this blended learning programme delivered in both classroom and virtual settings which places equality, diversity and inclusion at the front and centre of the leadership role. Participants are guided through a number of activities intended to encourage reflection and develop insight into their own appetite for, and ability to undertake, a leadership role in the future including intra and inter personal processes; conflict; and engendering the team dynamics associated with effective services. A second cohort will commence in September 2021.
- Continuation of our bespoke in-house Courageous Conversations Workshop developed in collaboration with Trust stakeholders including the Speak up Guardian, Staff Side Chair and HR colleagues and are continuously developed through information gathered from colleagues in surveys before, after and several months post-workshop attendance. These are designed specifically to encourage conditions in the workplace whereby every voice is valued and heard, and conflict is reframed as healthy and necessary in order to progress our service improvements. We explore how we show up under stress; how to increase our confidence as well as a model to keep conversation open even when at its most challenging.

Part 3 - Review of Quality Indicators and our Priorities for Improvement in 2020/21

Part 3.1 – Our Priorities for Improvement in 2020/21

The Trust identified three quality improvement priorities for 2020/21 to contribute towards the delivery of our Quality and Safety Strategy. Due to the COVID-19 pandemic and the operational impact on the Trust, it was not possible to achieve all the aims as outlined for 2020/21 in the Quality Account for 2019/20. However, some progress was made and the priorities have been selected again for 2021/22 to ensure the maximum potential for improvement.

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

Priorities for improvement 2020/21

Quality Domain	Priorities for improvement 2021/22
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

Patient Safety Improvements 2020/21

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 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.

Our aims

- 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 two areas of patient safety and assess whether methodology is being applied correctly and consistently; 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 by 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

How have we done?

The impact of the COVID-19 pandemic had a detrimental impact on the progress of improvement work to support the embedding patient safety. Some of the aims are being addressed but some will require further focus during 2021/22.

There is a Serious Incident action tracker which is updated monthly to identify which actions are outstanding. The leads for those actions are contacted to check for progress on actions and for them to indicate if there are any barriers to completing them. This is an ongoing process.
An audit has been undertaken to review the completed Serious Incident Root Cause Analysis reports over a 12 month period to ascertain if actions have been completed and if there is evidence available to demonstrate achievement and, where possible, that there has been a positive impact. When this audit analysis has been completed, this will be assessed in relation to the draft Patient Safety Response Framework.

The Trust was keen to identify a methodology that could be used to assess and evidence the impact of the actions that are undertaken as a result of a Serious Incident. The aim was to identify 2 methodologies and then incorporate them into the incident management process. However, following communications with patient safety teams in other organisations, there is no specific methodology in existence that can be utilised. Therefore, it was decided to utilise different approaches that may support this aim. The intention was to review all closed serious incident RCA reports to look specifically at the root causes and learning to assess if there were hidden themes and trends that may not have come through when looking at an individual reports. It was not possible to complete this before March 2021 and so will be undertaken during 2021/22.

There was also a plan to pilot utilising a taxonomy matrix developed by a Trust vascular surgeon in conjunction with the Kent Surrey Sussex Academic Health Science Network which also helps to identify themes from multiple reports. The taxonomy matrix has been developed using causal facets and set domains. This pilot was started but had made slow progress due to the pandemic. This will continue into 2021/22.

In response to the Patient Safety Strategy published by NHSE/I in 2020, the Trust identified two staff members to be Patient Safety Specialists. These Patient Safety Specialists are now linked in with the NHSE/I Future Collaboration programme which aims to support organisations with the roll out of the new Patient Safety Response Framework and implementation of the strategy.

2. Infection Control Excellence

Why this has been chosen as priority

In the last year a national Board Assurance Framework for Infection Prevention and Control (BAF-IPC) was introduced. The purpose of the BAF-IPC 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 be 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 a key driver for infection prevention and control and will continue to be used during 2020/21.

Our aims

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

How have we done?

All patients are triaged for infection risk including risk of COVID-19 and the outcome is recorded on patient documents. Triage tools have been updated to reflect changing COVID-19 risks as advised by local authority and PHE.

Individual patient documentation dedicated IPC assessment page.

Nervecentre has been developed to include infection control advice and COVID-19 status. Smart lists show detail on COVID-19 positive/suspected/exposed/recovered patients. This provides live information on the 'burden' of COVID-19 in our hospitals to support IPC and support operational decisions for patient pathways.

Patient admission and discharge pathways have been agreed and guidance on related risk assessed use of personal protective equipment has been revised, to reflect changing prevalence, emerging evidence and/or national guidance and support safe provision of services.

Perspex screens have been installed between bed spaces to support social distancing and reduce transmission of infection.

A dynamic approach to communicating changes in COVID-19 guidance has been maintained through the use of the extranet; web based training resources, face to face clinical visits and online training events. There has been a sustained focus on the Hands, Face, Space and Clean air message with posters updated regularly in high traffic areas.

Bespoke dispensers have been installed at all entrances to Trust buildings to support compliance with hand hygiene and face mask wearing.

Surveillance of all COVID-19 patients and contact tracing has been undertaken to try to reduce the risk of onward transmission and gain valuable epidemiological information. An electronic database of this information has been maintained for future reference.

Robust processes have been developed for provision and assessment of personal protective equipment via procurement and introduction of a respiratory mask fit team.

IPC induction and mandatory training has been provided via e-learning. Additional training and information on donning and doffing of PPE and the safe use of powered respiratory equipment has been provided.

IPC has maintained very close working with the operational and incident management teams to inform operational decisions.

IPC has met all requirements for reporting and surveillance of mandatory reporting of healthcare associated infection. Risk assessments and post infection reviews of healthcare associated infections have taken place as and when staffing allowed and those not yet complete are underway.

Outbreaks have been managed in line with national guidance and multiagency outbreak control groups were convened. Daily COVID-19 outbreak reporting requirements were maintained during second wave of COVID-19.

Hand hygiene promotion for both staff and patients has been maintained and WHO global hand hygiene day was fully supported.

3. Perfecting Discharge

Why this has been chosen as priority

Data from the national inpatient survey, our own internal complaints and inpatient questionnaires highlighted a number of areas regarding communication and information provided to patients about the discharge process where we could make improvements.

The Trust recognises that there are a number of areas in the patient journey where communication could be improved and these surveys identified that 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 rapid actions being taken and longer term plans being developed. A MSDIG 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.

Our aims

- 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 patient experience
- From data analysis, four workstreams have been identified as areas of focus: communication, process, medication and training/education
- The strategic group will meet monthly to report back on workstream 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

How have we done?

The MSDIG was set up in August 2020 with the aim to ensure the delivery of high quality discharge through acute hospital and community services.

The MSDIG set up four workstreams for 2020/21:

Workstream 1 Communication, (systems and processes)

Four wards undertook a detailed process mapping exercise to understand current processes, including when and who undertook the various steps. This has resulted in some changes:

- Development of a new Transfer of Care document
- The integrated discharge checklist used by the Multidisciplinary Team (MDT) on the ward was reviewed and is now being updated.
- Development of criteria led discharge protocol for medicine which is now being piloted
- The order of patients being reviewed on the wards has changed to expedite discharge or care for patients who are requiring urgent review as they have deteriorated overnight.
- A review of the discharge summary structure against national guidance was completed.

Discharge hubs were introduced in March 2020 as part of the Trust's response to COVID-19. The

hub has responsibility for supporting discharges on Pathways 1-3 with a focus on discharging medically fit patients to an onward destination as safely and efficiently as possible.

Multidisciplinary teams are making more use of digital technology to support planning of discharge. Nervecentre is being used as the central tool to assist in board rounds on several wards, and the roll out continues.

Workstream 2 Discharge Medication (systems and processes)

An initial analysis of data was completed to identify where improvements needed to be made specifically relating to medication on discharge.

A helpline was established for healthcare professionals to contact the Trust with queries from transfers of care. Data analysis from a review of the calls received has indicated:

- Most issues were following discharge from an acute site
- Issues related to discharge outside of normal hours
- Issues related to the 3 point check which should be undertaken on discharge
- Issues with the discharge summary being incorrect

The data collection from medication incidents reported showed 4 key areas:

- preparation of the discharge medications to take out (TTO)
- prescribing incidents
- dispensing incidents
- post discharge arrangements

As the preparation of TTO's on the ward was the main source of error and this is the last point check before the patient is discharged, a review of the current Trust procedure for performing discharge checks on the ward was undertaken. This relates to the three point check where the inpatient drug chart, discharge letter and medicines for discharge are all compared to ensure they are the same or any anomalies identified and rectified prior to discharge.

Unfortunately, this review was paused during the second wave of COVID-19 but has now restarted.

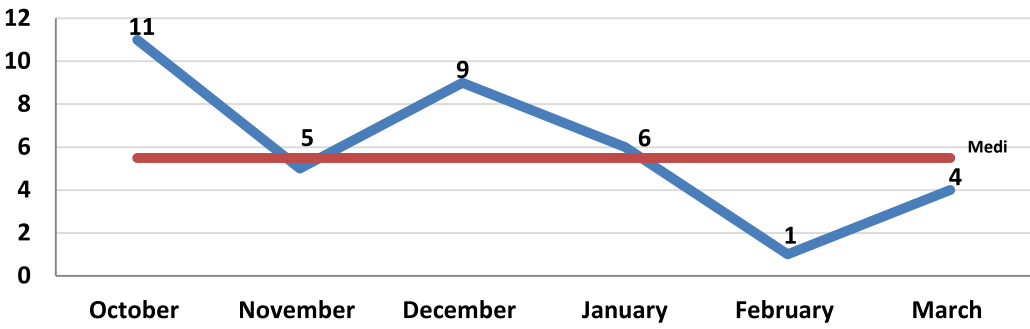
The pharmacy department also undertook a gap analysis of the service against the rapid improvement guide from NHSI: Emergency Care Improvement Programme. Overall the gap analysis identified that out of 39 potential improvements that could be made to optimise medicines discharge, 24 had been implemented, 12 were opportunities that were being worked on or considered and 3 would be challenging to implement without further enablers.

Achievements so far to facilitate these improvements are:

- New weekend pharmacy services rolled out in April 2020 focused on medicines reconciliation to gateway areas, support for high risk patients, urgent medicines supply and discharge support.
- Piloting, during COVID-19, the testing of remote pre-admission medicines reconciliation for elective surgical patients.
- A two week pilot and feasibility study into 12 hour pharmacy services to Emergency Departments and acute medical units in November 2020.
- Commissioning of a review into pharmacy discharge processes to effectively position resources to support discharge.
- Development and roll-out of Nervecentre workflows to direct proactive pharmacy support to discharges.
- QI project related to three point check.

Workstream 3 Quality of discharge feedback (Formalising and triangulating feedback mechanisms)

In October 2020 a reporting mechanism (raising discharge/ transfer of care concerns) for external organisations was launched. This has proved a rich source of feedback and is fed back into the relevant workstreams to drive improvement. Quarterly reports are presented to the MDDIG and Patient Safety and Quality Group which demonstrate less concerns being sent into ESHT over the last 6 months.



Workstream 4 Education and Training

Discharge process mapping work identified that there was lack of clarity and potential gaps / duplication in who did what in relation to discharge. To date the following pieces of work have been undertaken:

- A review of national training packages related to discharge has been undertaken. Following this review it was identified that a training needs analysis was required to map and design an appropriate training package so that all staff understood their roles and responsibilities. This was paused during the second wave and will roll over to 2020/21.
- In August 2020, all junior doctors were provided with a bespoke training session on the importance of discharge planning and the discharge summary, and this will be carried forward to this 2021/22.
- A short video has been produced to support medical teams to understand the impact of getting the discharge summary accurate for the patient and the GP.

Part 3.2 - Sign up to Safety pledges

Although the National Sign Up to Safety campaign ended in March 2019, the Trust is committed to ongoing improvement in the Sign Up to Safety indicators through 2021/22. To achieve this, the falls improvement work is monitored and reported by the Falls Steering Group. Pressure ulcer improvement is monitored and reported through the Pressure Ulcer Review Group. Improvement in recording of Duty of Candour 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.

Our progress and achievement for these areas is outlined below:

Sign up to Safety – Reduce patient falls

Although the last agreed Royal College of Physicians national average rate for falls is 6.6, our aim was to reduce the number of falls to no more than 5 falls per 1,000 bed days; during 2020/21 the rate of falls was 6.6 per 1,000 bed days which was slightly higher than the year before.

2020/21 has been an exceptional year due to the COVID-19 pandemic. During the second wave over winter 20/21 staffing was severely compromised despite significant planning and possible mitigations, and falls increased during this time. However, once the second wave subsided and staffing returned to normal the falls rate did reduce back to our baseline with many other months at or close to our aim.

There were 1,487 falls incidents reported in 2020/21, compared to 1,453 reported in 2019/20. There has been a decrease in the number of serious incidents (SI) relating to falls, 13 SI's (severity 4 and 5) were reported in 2020/21, compared with 21 reported in 2019/20.

A falls steering group meets and supports both community and in patient areas to reduce the number of falls. Several quality improvement projects are underway in areas where there has been a higher number of falls reported.

Falls remains one of our priority areas for further improvement in 2021/22.

Sign up to Safety – Reduce pressure ulcers

The rate of all Pressure Ulcers (PU's) per 1,000 bed days has remained within expected control limits during 2020-21 with the exception of April 2020 which was directly linked the peak of the first surge of the COVID-19 pandemic and a dramatic reduction of inpatient admissions, except for emergency admissions only.

The number of category 3 and 4 PU's continues to reduce and remains very low. Two PU's were reported in 2020/21 with peaks noted in August 2020 and during the second surge of COVID-19 linked to the significant increase in inpatient activity, including additional escalation beds opened in January – March 2021.

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 during the COVID-19 pandemic.

COVID-19 has been an automatic trigger for sepsis six pathway tool.
We will continue to review and assess the use of the sepsis screening tool and develop a Trust wide approach to using 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 Nervecentre which is currently being rolled out Trust-wide.

Sign up to Safety - Duty of Candour (DoC)

The Patient Safety Team within the Trust continues to monitor compliance with Duty of Candor and report on progress against key performance indicators. For 2020/21 we have achieved DoC verbal 73% and written 77%. The Patient Safety Team continues to support the Divisions and staff that need to complete this aspect.

The Patient Safety team continues to deliver 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.

Sign up to Safety - Improve patient experience

NHSE suspended Friends and Family Test (FFT), in April 2020 due to the COVID-19 pandemic until December 2020. Where appropriate and possible, ESHT continued to collect some FFT surveys and the recommendation scores below are an average for 2020/21:

Inpatient: 98.17%
A&E: 93.60%
Maternity: 97.57%

We continue to explore new options for collecting this feedback from our patients.

Part 3.3 – Review of our Quality Indicators

Amended regulations from NHSI require trusts to include a core set of quality indicators in the Quality Account. The data source for all indicators is NHS Digital.

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

For some of the quality indicators, data submission on a national level was suspended due to the COVID-19 pandemic.

Patient Safety Indicators

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

ESHT considers that this data is as described because the Trust has robust data quality assurance processes in place.

The national VTE data collection and publication of the VTE risk assessment data has been suspended throughout 2020/21.

However, Trust data has indicated **92.1%** compliance.

Rate of C. Difficile Infection

ESHT 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	ESHT 20/21	National average 19/20	Best performer	Worst performer 19/20
Rate of C. difficile HAI Infection per 100,000 bed days (aged 2 or over) *Including prior healthcare exposure	19.2	17.6	15.4	22.8	16.8 *21.2	13.5	14.9	1.7	64.0

Source: ESHT 20/21 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 the annual 20/21 surveillance report had not been published.

Clostridioides difficile **Infection (CDI) mandatory surveillance from 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 from 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).

Performance
Publication of the annual surveillance report for 2019/20 was delayed until December 2020 due to COVID-19 pandemic. The published rate was 16.8 for hospital onset healthcare associated C. difficile infection. When prior healthcare exposure is included the rate increases to 21.2.per 100,000 bed days.

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

Official data for 2020/21 has not yet been published due to the Covid-19 pandemic. The PHE data capture system shows ESHT has a hospital onset healthcare associated (HOHA) rate of 13.48 for 2020/21. There is no ability to show a rate that includes prior healthcare exposure. The rate represents 35 *C. difficile* infections that are HOHA. There were also 12 community onset healthcare associated infections related to prior healthcare exposure within 28days of the result. This means that 47 cases are ESHT attributable which is a further reduction (8%) since last year.

Rate of patient safety incidents reported per 1,000 admissions and the proportion of patient safety incidents they have reported that resulted in severe harm or death

ESHT considers that this number and /rate is as described because the Trust has robust data quality assurance processes in place. The data from National Reporting and Learning System (NRLS) is only available for the time period up to 31st March 2020.

Indicator – NRLS Data	ESHT 19/20	National Average	Best Performers	Worst Performers	ESHT 19/20 Q1 & Q2	ESHT 18/19
	01/10/19 – 31/03/20	**01/10/19 – 31/03/20**	**01/10/19 – 31/03/20**	**01/10/19 – 31/03/20**	**01/04/19 – 30/09/19**	**01/10/18 – 31/03/19**
Rate of patient safety incidents reported per 1,000 admissions	40.41 (4976 incidents reported)	51.0 (6552 incidents reported)	110.2 (11787 incidents reported)	15.7 (1271 incidents reported)	38.03 (4594 incidents reported)	39.62 (4795 incidents reported)
% of patient safety incidents reported that resulted in severe harm or	Severe 0.46% (23 incidents)	Severe 0.2%	Severe 0.1%	Severe 0.8%	Severe 0.46% (21 incidents)	Severe 0.27% (13 incidents)

death – This is the National and Reporting and Learning system Data between 01/04/2019 and 30/09/2019	Death 0.06% (3 deaths)	Death 0.1%	Death 0.1%	Death 0.6%	Death 0.02% (1 death)	Death 0.13% (6 deaths)

ESHT 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.
- SI's are all managed in accordance with national legislation and timescales.
- Amber (moderate) and SI's (severe and catastrophic) are monitored by the Weekly Patient Safety Summit
- Actions resulting from SI's and amber investigations continue to be monitored with updates on the number outstanding provided to the Patient Safety and Quality Group
- All Amber and SI RCA reports are distributed widely as appropriate to share the lessons learnt.

An audit has been completed of SI's actions to determine if the learning has been embedded in clinical practice. The results will be utilised as part of the Embedding Safety priority for 2021/22.

Clinical Effectiveness Quality Indicators

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

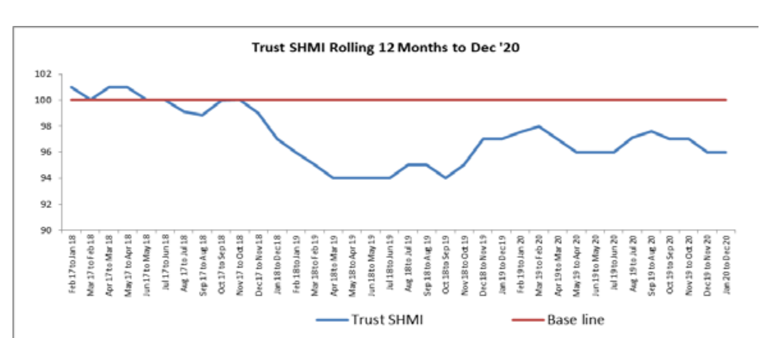
ESHT considers that this data is as described because the Trust has robust data quality assurance processes in place.

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.

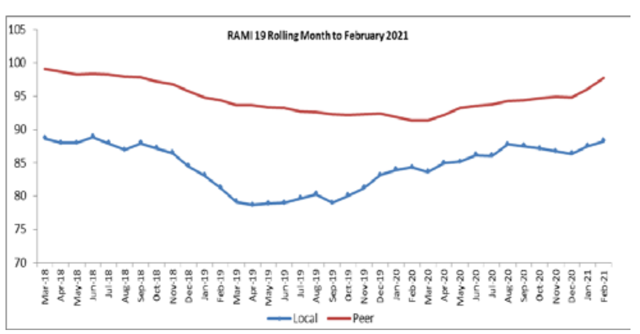
Indicator	ESHT Jan 15 – Dec 15	ESHT Jan 16 – Dec 16	ESHT Jan 17 - Dec 17	ESHT Jan 18 - Dec 18	ESHT Jan 19 - Dec 19	ESHT Jan 20 - Dec 20
SHMI value	1.14	1.09	1.04	0.97	0.97	0.96
Banding	1 (higher than expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)
% of patient deaths with palliative care coding by speciality and/or diagnosis	17.7	18.9	22.7	32.00	35.28	38.30

Source: NHS Digital

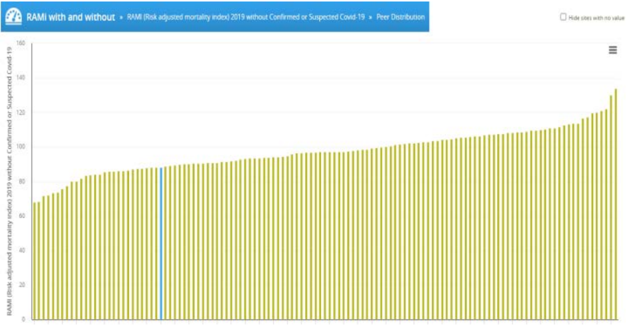
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



Risk Adjusted Mortality Index (RAMI)



RAMI v Peer This shows our position against other acute trusts



ESHT has taken the following actions to improve mortality and the quality of its services:-

- Improved consultant staffing in our emergency units and acute medicine departments so we can provide optimum care when patients are acutely ill, with consultant presence on Medical Assessment Units every day for around 12 hours.
- Increasing the number of doctors resident at night.
- Improved provision of ambulatory emergency care (AEC), with new units open on both sites, taking patients from ED and allowing more rapid senior input.
- Maintaining focus on the recognition and rapid treatment of Sepsis and Acute Kidney injury (AKI)
- Extensive infection control measures and streaming, especially during the pandemic.
- Providing timely senior decision making at ward level through multidisciplinary daily board rounds, led by the consultant.
- Improving handover for acute teams using Nervecentre for handover, task allocation, and patent tracking.
- Increasing recognition of frailty, with specific documentation of this in the Integrated Patient Document (IPD). Rockwood scoring being introduced in the gateway areas.
- Better access to endoscopy for acute gastrointestinal bleeding.
- Nervecentre for clinicians to support hospitals as they tackle their most resonant challenges; patient safety and patient flow 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 introduced this year as an extension of the initial Nervecentre package (and to replace VitalPac).
- The Trust's Deteriorating Patient Improvement Group (DPIG) has introduced Recommended Summary Plan for Emergency Care and Treatment (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 by Morbidity and Mortality review as having poor quality of care, deaths involving serious clinical incidents or complaints, to re-assess avoid ability and promote learning.
- An independent Medical Examiner system has been introduced to provide independent review of all deaths.
- The Trust Board is sighted on our mortality performance with formal quarterly reporting of "Learning from deaths", which includes the number of avoidable deaths and regular updates on indices such as SHMI.
- Improving clinical coding of patient information to ensure mortality indicators are based on accurate clinical information.

Patient Reported Outcome Measures /Scores (PROMS)

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.

The collation and publication of the national PROMs data was suspended throughout 2020/21.

Emergency readmissions to hospital within 30 days of discharge

ESHT 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 30 days of discharge is shown below.

Indicator	ESHT	ESHT	ESHT	ESHT	National Average	HES Acute Peer 5th Percentile	HES Acute Peer 95th Percentile
	17/18	18/19	19/20	20/21 (Apr '20 to Feb '21)			
Emergency readmissions to hospital within 30 days of discharge Age 0-15	13.81%	15.10%	13.75%	11.78%	11.09%	4.90%	17.53%
Emergency readmissions to hospital within 30 days of discharge Age 16+	14.29%	15.81%	15.72%	18.03%	15.11%	11.86%	18.15%

Source: CHKS

ESHT has taken the following actions to improve the rate and therefore the quality of its services by:

- Virtual Board Rounds are being rolled out across the Trust which allows the Discharge Hub direct access to the information included in the Board Rounds. This ensures clear and effective communication so that patients follow the correct pathway for their needs so preventing readmission.
- The Acute Frailty Practitioners in the gateway areas attend the Board Rounds and assess patients to support safe and appropriate discharge.
- Regional East Sussex Pulmonary Service (RESPs) Team undertake admission avoidance phone calls which facilitates support for patients

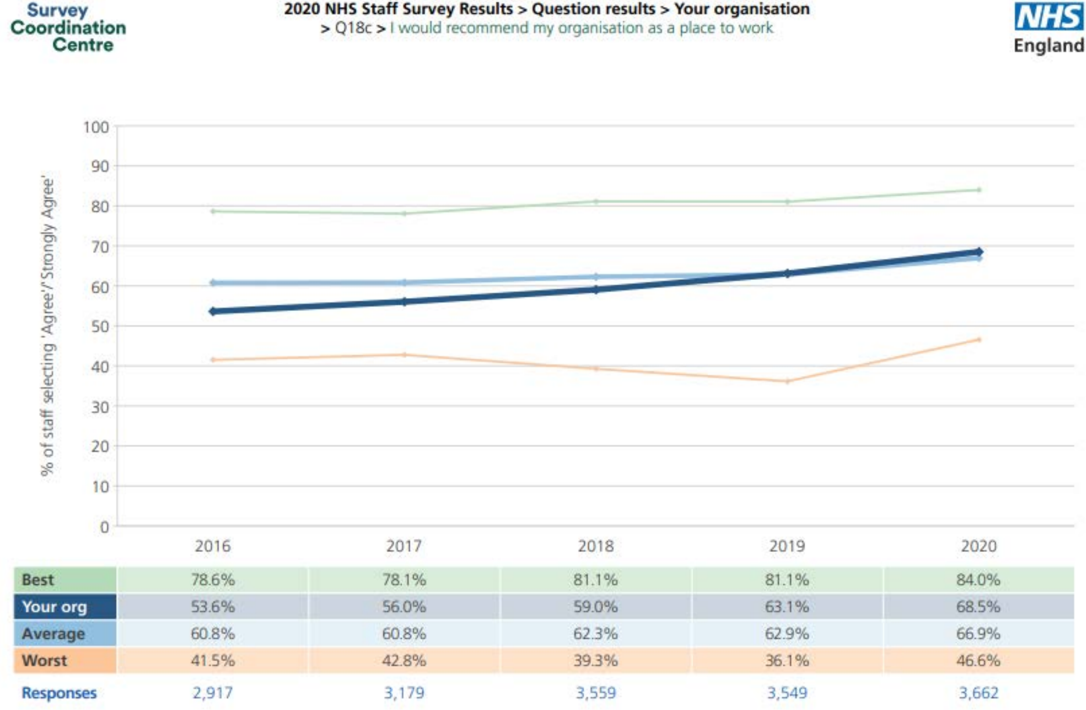
Staff and Patient Experience Indicators

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

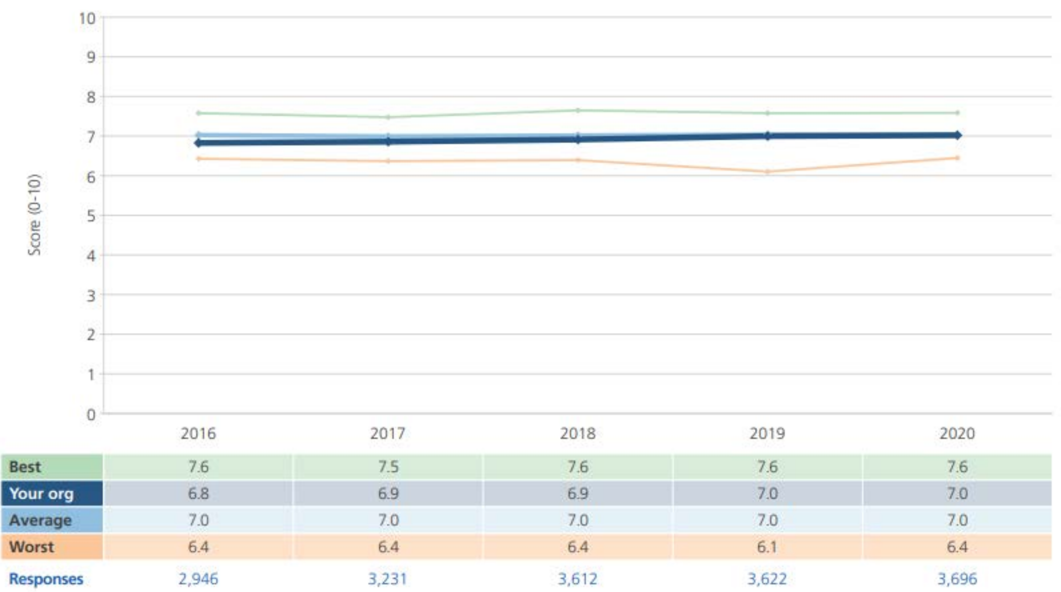
ESHT considers that this data is as described because the Trust has robust data quality assurance processes in place.

Indicator	ESHT 2016	ESHT 2017	ESHT 2018	ESHT 2019	ESHT 2020	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	62%	65%	67.3%	69.1%	74.5%	74.3%	91.7%	49.7%

Source: NHS Digital



2020 NHS Staff Survey Results > Theme results > Trends > Staff engagement



	2016	2017	2018	2019	2020
Best	7.6	7.5	7.6	7.6	7.6
Your org	6.8	6.9	6.9	7.0	7.0
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.4	6.4	6.1	6.4
Responses	2,946	3,231	3,612	3,622	3,696

ESHT 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 is 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.
- Embedding 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 Organisational Development and Staff Engagement and Wellbeing Team are working with the Human Resources Business Partners / Occupational Health/ Divisional and Service leads to increase awareness and develop capability for continuous improvement across the Trust.

Responsiveness to inpatients’ personal needs

Responsiveness to inpatients’ personal needs data cannot be provided as the publication date of the National Inpatient Survey is November 2021.

Annexes

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

Statement from Commissioners

Thank you for giving Sussex NHS Commissioners the opportunity to comment on the ESHT Quality Account for 2020/21. The CCG appreciate and value the on-going collaborative working and communication with the Trust's senior clinicians throughout the COVID-19 pandemic and acknowledge during these difficult and challenging times this collaborative working has been maintained and strengthened.

Recognising because of the COVID-19 pandemic, ESHT had to pause work to finalise and implement all key priorities, it is good to see some of your achievements in 2020 including; having first physiotherapist trained and qualified in South East to take blood within the Trust's Frailty Practitioner Service; implementing the new digital therapy system, 'Reminiscence Interactive Therapy Activities' on MacDonald Ward allowing patients to access and use apps, games and other leisure activities; Launching the 'PETALS' multidisciplinary team project within maternity so that pregnant women are able to access further support to help them maintain their perineal health and prevent complications during birth and celebrating the 2,000th baby born at Eastbourne Midwifery Unit in September 2020.

Alongside these achievements, the CCG acknowledges the positive quality and safety work which the Trust which has continued to focus on:

- **Safe Care:** Embedding Patient Safety and progressing improvement by having a serious incident action tracker which is updated monthly to identify which actions are outstanding; undertaking an audit to review the completed Serious Incident Root Cause Analysis reports ascertaining if actions have been completed and evidence is available to demonstrate achievement.

- **Patient Experience:** Perfecting Discharge by setting up the Multidisciplinary Strategic Discharge Improvement Group and through four workstreams, improving communication by developing a new Transfer of Care document; developing a criteria led discharge protocol for medicine and introducing discharge hubs in response to COVID-19 to focus on discharging medically fit patients to an onward destination safely and efficiently; improving discharge medication processes with a new weekend pharmacy service.

- **Effectiveness:** Ensuring Infection Prevention Control (IPC) Excellence by triaging all patients for infection risk including risk of Covid-19; updating Triage tools to reflect changing COVID-19 risks; having an individual patient documentation dedicated IPC assessment page and providing IPC induction and mandatory training via e-learning.

Sussex NHS Commissioners recognise the importance of ESHT priorities for 2021/22 and will continue to review the Trusts progress against these including:

- **Safe Care:** delivering on the continued ambition to embed Patient Safety by identifying a methodology that will measure and support the effectiveness of key actions taken forward and their impact on reducing the risk of any further incidents.

- **Patient Experience:** continuing with Perfecting Discharge through the Multidisciplinary Strategic Discharge Improvement Group, focusing on changes to the Trust's discharge processes during the COVID-19 pandemic which contributed to increased focus with short actions being taken and longer term plans being developed and taking a quality improvement approach to identify the specific areas to target, test new approaches and ensure improvements are sustained.

- **Effectiveness**: using the Board Assurance Framework for IPC as a key driver and improvement tool for IPC.

NHS Sussex Commissioners look forward to the continued collaborative working over the coming year.

Yours sincerely

Allison Cannon

Allison Cannon
Chief Nursing Officer
On behalf of Sussex NHS Commissioners

Statement from Healthwatch East Sussex

As a local Healthwatch we have worked positively and collaboratively with ESHT since our inception in 2013 to improve to the quality of care their patient's, families and carers experience. Finding ways to continue those collaborative working relationships during the pandemic proved challenging as demands on the Trust increased and opportunities for patient engagement diminished.

We support the Trust in acknowledging it has been an extraordinary year dominated by COVID-19 and their response to it. We recognise it has not been possible for the Trust to deliver all the aims and priorities for 2020/21 due to the pandemic and support their plans to continue the agreed priorities into the Quality Account for 2021/22. The Trust should also be complimented for the achievements they have been able to progress in such a difficult year.

On behalf of patients and the public we have maintained regular dialogue with the Chief Executive Officer and Chair of the Trust's Board via bi-monthly virtual meetings as well as sharing independently captured patient, families, and carers experiences through the various projects we have been involved with.

Our work with the Trust in 2020/21 focussed on the Trust's Priority; Perfecting Discharge.

We worked with the East Sussex Clinical Commissioning Group (CCG) and the Trust to co-design a 'safety net' level of support for patients discharged (on 0-Pathway) from hospital by providing an additional 'check in call' to patients 2 -3 weeks after leaving hospital (building on the Trust's already established discharge check in project).

We knew patients being discharged from hospital during the pandemic encountered more vulnerabilities in the community because of the COVID-19 restrictions in place, such as reduced family contact, restricted access to familiar networks of support and increased risk of social isolation. The wellbeing checks, undertaken by a team of Healthwatch volunteers and staff, were designed to help alleviate some of those anxieties and provide a friendly call; How are you? Do you have everything you need/ did everything go ok with your discharge?

The wellbeing checks were extremely well received by patients and families alike, even if patients did not have any further health or support needs. Someone checking in to say 'are you ok' in very difficult times was hugely appreciated and valued.

The Wellbeing checks team at Healthwatch contacted over 1400 patients between August and November in 2020. Discussions continue with the Trust on how the learning from the recommendations and action plans of this project and other related work can continue to improve the discharge experience for patients. Key findings in the Healthwatch report corroborate where the Trust have identified a number of areas in the patient journey where communications can be improved with patients, families and with primary care.

Healthwatch will continue to monitor closely this Perfecting Discharge workstream throughout 2021/22. Representatives have joined the Multi-Disciplinary Discharge Improvement Group (MDDIG) and continue to share evidence and insight gathered through our own engagement with the public and via the Independent Health Complaints Advocacy Service (IHCAS).

We look forward to strengthening our engagement with Trust in the year ahead through building relationships with the new chief executive officer and with the Board to ensure patient and carers' voices are heard at all levels.

Healthwatch East Sussex

June 2021

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. HOSC has heard updates from the Trust at all of its meetings over the past year on its performance in tackling the COVID-19 pandemic and its plans for the restoration and recovery of its services as the pandemic subsides. The Committee thanks the Trust and all of its staff for the excellent job it has done in dealing with the impact of the pandemic and looks forward to a degree of normality resuming in the coming months as the vaccine roll out nears completion.

The Committee expects to hear formal proposals from the Trust over the next few months on its plans for its Cardiology and Ophthalmology services.
HOSC also hopes to hear more about the plans for the considerable capital investment being made in the Trust's hospital sites when the time is right.

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.

Finally, the HOSC welcomes the recent appointment of Joe Chadwick-Bell as Chief Executive and looks forward to working with her over the coming years.

2020/21 Priorities for Improvement

We recognise that ESHT has been unable to achieve its Priorities for Improvement for 2020/21 due to the unprecedented impact of the COVID-19 pandemic and believe that whilst this is not ideal it is understandable.

2021/22 Priorities for Improvement

The Committee believes it is sensible for the Trust to bring forward last years' priorities in light of the impact of COVID-19, but we would expect them to be achieved by the end of the 2021/22 financial year.

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) fully implemented in the Trust in the coming months and any identified gaps in infection control addressed. This includes improving ventilation in the hospital and reviewing hospital pathways and patient flows to reduce movement of patients unless clinically imperative. We hope this will help to ensure the Trust is compliant with national guidance and achieve low levels of hospital transmission of COVID-19 and other infectious diseases compared to national rates.

As we identified last year, 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 continue to 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
28th June 2021

Steve Phoenix
Chairman
28th June 2021

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 2020/21.

Appendices

Appendix 1 – Integrated Performance Report

Safety and Quality

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-20	Mar-21	Var	2019/20	2020/21	Var		
Total patient safety incidents reported	M	794	838	5.5%	11568	11088	-4.1%	924	
% Patient safety incidents with no harm or near miss	70.0%	76.4%	72.0%	-4.5%	79.4%	75.8%	-3.6%	75.8%	
Number of Patient safety incidents with no harm or near miss (1)	M	607	603	-0.7%	9181	8400	-8.5%	700	
Number of Patient safety incidents with low harm (2)	M	181	218	20.4%	2210	2529	14.4%	211	
Number of Patient safety incidents with moderate harm (3)	M	4	14	250.0%	119	122	2.5%	10	
Number of Patient safety incidents causing severe harm or death (4&5)	M	2	3	50.0%	57	37	-35.1%	3	
% Patient safety incidents causing severe harm or death	0.0%	0.3%	0.4%	0.1%	0.5%	0.3%	-0.2%	0.3%	
Number of Serious Incidents	M	3	4	1	68	46	-22	4	
Number of Never Events	0	0	2	2	4	5	1	0	
Number of medication administration incidents	M	15	23	53.3%	237	277	16.9%	23	
Total falls	M	121	97	-19.8%	1441	1481	2.8%	123	
Number of no-harm falls	M	87	69	-20.7%	1042	1094	5.0%	91	
Number of minor/moderate falls	M	33	28	-15.2%	378	374	-1.1%	31	
Number of major falls	0	1	0	-1	21	9	-12	1	
Number of catastrophic falls	0	0	0	0	0	4	4	0	
All patient falls per 1000 Beddays	5.5	6.1	5.0	-1.1	5.5	6.5	1.04	5.8	
All patient falls with harm per 1000 Beddays	M	1.7	1.4	-0.3	1.5	1.7	0.19	1.5	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	2.8	2.9	1.9%	2.3	2.8	22.4%	2.9	
Number of grade 2 pressure ulcers	M	54	56	3.7%	583	622	6.7%	52	
Number of grade 3 to 4 pressure ulcers	M	2	0	-2	15	10	-5	1	
Pressure ulcer assessment compliance	M	96.8%	93.8%	-3.1%	96.1%	95.7%	-0.3%	95.7%	
VTE Assessment compliance	95.0%	94.5%	92.5%	-1.9%	95.3%	92.1%	-3.2%	92.1%	
Number of MRSA Cases	0	0	0	0	3	2	-1	0	
Number of Cdiff cases	4	5	6	1	50	45	-5	4	
Number of MSSA cases	M	1	2	1	21	23	2	2	
Emergency Re-Admissions within 30 days	10.0%	15.0%	13.2%	-1.8%	14.0%	13.0%	-0.9%	13.0%	
Crude Mortality Rate	M	1.9%	1.2%	-0.7%	1.5%	2.2%	0.7%	2.0%	
HSMR (CHKS)	M								
SHMI (NHS Digital)	M								
Number of complaints received	M	33	33	0.0%	583	365	-37.4%	30	
Inpatient FFT response rate	45.0%	38.6%	24.3%	-14.3%	43.7%	21.2%	-22.6%	21.2%	
Inpatient FFT score	96.0%	98.8%	99.5%	0.7%	97.7%	99.4%	1.7%	99.4%	
A&E FFT response rate	22.0%	7.6%	2.1%	-5.4%	6.2%	3.6%	-2.6%	3.6%	
A&E FFT score	88.0%	96.9%	96.1%	-0.8%	93.7%	96.4%	2.7%	96.4%	
Outpatient FFT Score	M	98.2%	98.1%	0.0%	97.7%	97.4%	-0.3%	97.4%	
Maternity FFT response rate	45.0%	26.5%	11.0%	-15.5%	24.6%	10.6%	-14.0%	10.6%	
Maternity FFT score	96.0%	95.2%	100.0%	4.8%	97.0%	98.9%	1.9%	98.9%	
Accommodation and Moves									
Mixed Sex Accommodation breaches - patients affected	0	89	7	-82	984	183	-801	15	
All ward moves	M	1861	2134	14.7%	26387	22813	-13.5%	1901	
Night ward moves	M	367	547	49.0%	5044	5744	13.9%	479	

Some of the data represented in the dashboard has been affected by disruption to data collection during the pandemic. For example, the FFT surveys and the complaints process were paused for the majority of 2020/21 and so the data reflect a lower level than would usually be expected. Also the significant operational and workforce pressure experience particularly in the second wave of the pandemic greatly affected the accommodation and bed moves data.

Leadership and Culture

TRUST WORKFORCE SCORECARD 2020 / 2021

Budgeted fte & total fte usage includes all staff types including waiting list and vacancy factor

TRUST 2020 / 2021													
WORKFORCE CAPACITY	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend line
Budgeted fte	7343.5	7345.3	7384.7	7387.2	6881.4	6885.9	6899.1	7048.4	7069.0	7081.1	7082.7	7082.3	
Total fte usage	7163.0	7095.2	7120.7	7178.5	7184.1	7226.9	7202.7	7286.7	7361.5	7366.4	7505.5	7816.1	
Variance	-180.5	-250.1	-264.0	-208.7	302.6	341.0	303.7	238.3	292.5	285.3	422.8	733.8	
Substantive vacancies	732.6	716.8	714.4	745.4	-13.3	-61.9	37.1	124.9	142.7	18.1	-10.8	-31.7	
Fill rate	89.9%	90.1%	90.1%	89.7%	100.2%	101.0%	99.4%	98.1%	97.9%	99.7%	100.2%	100.5%	
Bank fte usage (as % total fte usage)	8.4%	7.4%	7.1%	7.5%	8.0%	8.5%	8.4%	8.5%	8.4%	8.3%	8.9%	12.4%	
Agency fte usage (as % total fte usage)	2.4%	2.2%	2.9%	2.9%	2.6%	2.5%	2.3%	2.1%	2.2%	2.3%	2.6%	2.7%	
Turnover rate	9.7%	9.8%	9.8%	9.9%	10.1%	10.6%	10.7%	10.7%	10.7%	10.5%	10.5%	10.3%	
Stability rate	92.0%	92.2%	92.4%	92.6%	92.5%	92.9%	92.3%	92.3%	92.4%	92.5%	92.4%	92.7%	
SICKNESS ABSENCE	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend line
Annual sickness rate	4.7%	4.7%	4.7%	4.6%	4.6%	4.6%	4.6%	4.5%	4.6%	4.8%	4.8%	4.8%	
Monthly sickness rate (%)	5.4%	4.6%	4.0%	4.1%	4.1%	4.3%	4.2%	4.4%	5.9%	7.7%	4.0%	4.1%	
Short term sickness (<28 days)	46.0%	34.5%	38.8%	45.8%	41.4%	44.7%	47.9%	51.0%	54.9%	58.3%	7.0%	44.2%	
Monthly long term sickness (28 days+)	54.0%	65.5%	61.2%	54.2%	58.6%	55.3%	52.1%	49.0%	45.1%	41.7%	93.0%	55.8%	
MANDATORY TRAINING & APPRAISALS	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend line
Appraisal rate	74.6%	73.2%	76.6%	76.2%	75.8%	75.0%	74.8%	76.4%	74.9%	72.5%	71.2%	73.1%	
Fire	85.1%	84.8%	85.9%	86.2%	85.6%	85.6%	84.1%	84.7%	83.8%	84.1%	84.6%	85.5%	
Moving & Handling	85.2%	83.7%	80.7%	79.3%	79.0%	78.8%	92.9%	92.0%	92.1%	90.8%	90.7%	91.3%	
Induction	95.7%	95.6%	95.5%	94.1%	97.0%	100.0%	97.5%	100.0%	96.5%	99.6%	99.9%	99.9%	
Infec Control	88.6%	88.9%	89.1%	89.5%	89.4%	89.0%	88.0%	88.1%	87.7%	87.8%	88.1%	88.4%	
Info Gov	81.7%	80.9%	83.5%	84.1%	84.0%	85.4%	84.5%	84.2%	82.4%	82.9%	83.0%	84.7%	
Health & Safety	93.0%	92.9%	93.5%	93.8%	94.2%	93.5%	93.3%	92.9%	93.3%	93.0%	93.2%	93.0%	
MCA	75.1%	76.4%	78.4%	80.0%	82.1%	82.1%	82.4%	82.3%	82.2%	81.5%	81.4%	83.0%	
DoLs	72.9%	74.4%	76.9%	78.9%	81.0%	81.0%	81.2%	81.9%	82.0%	81.5%	81.7%	83.9%	
Safeguarding Vulnerable Adults	88.6%	88.8%	90.0%	90.9%	91.8%	92.3%	92.2%	91.8%	91.7%	91.1%	91.3%	91.4%	
Safeguarding Children Level 2	87.1%	86.9%	87.6%	88.5%	89.4%	88.6%	88.0%	87.8%	87.8%	86.9%	87.2%	87.8%	

The establishment month on month for 2020/21 reflects a mid-year budget reset (August 2020) compared to the start of the year therefore showing that the Trust had a higher substantive fte than in budget. In October, additional restore and recovery funded positions were included which in turn created additional vacancies. In the following months, budgeted substantive continued to increase along with successful substantive recruitment.

The Trust had a negative vacancy rate value from February 2021 however, this report ends march 2021 and does not show the new budget reset for 2021/22 as this is outside the timeframe. April 2020 started with 7,343.5 fte (Full Time Equivalent) as budgeted establishment and concluded in March 2021 with 7,082.3 fte. The new budget for April 2021 is 7,383.0 fte which is a year on year increase of 39.5 fte at a Trust level.

Appendix 2 – National Clinical Audit and National Confidential Enquiries Programme

National clinical audits and national confidential enquiries we were eligible to participate in during 20/2021.

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
National Clinical Audit	**ESHT Eligible**	**ESHT Participation**
Mandatory Surveillance of HCAI	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 Diabetes Inpatient 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 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**
Society for Acute Medicine's Benchmarking Audit (SAMBA)	**Y**	**Y**
Serious Hazards of Transfusion (SHOT)	**Y**	**Y**
Pain in Children - Emergency Departments	**Y**	**Y**
Fractured Neck of Femur in Emergency Departments	**Y**	**Y**
Infection Control in Emergency Departments	**Y**	**Y**
National Ophthalmology Audit	**Y**	**Y**
BAUS – Nephrectomy Audit	**Y**	**Y**
BAUS – Renal Colic Audit	**Y**	**Y**
BAUS – Stress Urinary Incontinence Audit	**Y**	**Y**
British Spine Registry	**Y**	**Y**

Appendix 3 – Participation in Mandatory Clinical Audits

This information is unavailable for 2020/21 due to the national pause on the mandatory clinical audit programme throughout much of the pandemic.

Appendix 4 – Other Non-Mandated National studies

The Trust participated in 15 non-mandated national studies in 2020/21, as follows:

National Study	Specialty
National Potential Donor Audit (PDA)	Critical Care
BASHH national audit: times to appointment, test results and treatment	Sexual Health
B-MaP-C Study	Breast Surgery
The ABCD Nationwide COVID-19 Audit	Diabetes
INTEGRATE COVID-19 Emergency Care Audit	ENT
COVIDTrach; a UK national service evaluation of mechanically ventilated COVID-19 patients undergoing tracheostomy	ENT
British Rhinological Society COVID-19 Safety of Rhinological Surgery Audit	ENT
Outcomes of surgery in COVID-19 infection: international cohort study (CovidSurg)	General Surgery
ReCap: Rectal Cancer Management during the COVID 19 Pandemic`	General Surgery
A National Service Evaluation of paclitaxel pre-medication regimes for the prevention of hypersensitivity during a period of ranitidine shortage	Pharmacy
Sussex Rehab Survey Sept 2020	Rehabilitation
UK Foot and Ankle COVID-19 National Audit (UK-FALCON)	T&O
UK Corona TRAUMA Surge (UKCoTS) - Part of the COVID Research group, Royal college of surgeons (England)	T&O
CovidSurg: an international cohort study, aiming to assess the outcomes of surgery in patients during the COVID-19 pandemic.	T&O
Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	Urology

Appendix 5 – Equality Impact Assessment

	☺ 😐 ☹	**Evidence:**
Will the proposal impact the safety of patients', carers' visitors and/or staff? ***Safe:*** *Protected from abuse and avoidable harm.*	Positive	Embedding Patient Safety is a key priority for the Quality Account. The actions set to achieve this priority highlight that there is a need to review the serious incident investigations root cause analysis reports and subsequent actions and identify barriers. Utilise different methodologies in conjunction with clinical teams to evidence the impact of the actions on reducing the risk of further patient safety incidents. There are several working groups that support the QI priorities including the Violence and Aggression group which looks at protecting both patients and staff. The Trust is exploring how to link systems with Datix (incident reporting system) to allow the collection of characteristics data. This will help us identify if there is a relationship between a particular characteristic and their experience and enable the Trust to identify different way to target change.
Equality Consideration *Highlight the protected characteristic impacted*		**Race** ☒ · **Gender** ☒ · **Sexual orientation** ☒ · **Age** ☒ · **Disability & carers** ☒ · **Gender reassign ment** ☒ · **Marriage & Civil Partnership** ☒ · **Religion and faith** ☒ · **Maternity & Pregnancy** ☒ · **Social economic** ☒
Is the proposal of change effective? **Effective**: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics	Positive	The Trust has robust systems in place to report, investigate and identify learning in order to 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 all three priorities 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. The priorities aim to the improve effectiveness of patient discharge with an inclusive understanding of patient and carer involvement and communication.

Equality consideration – protected characteristics (detail of nested table):

Race	Gender	Sexual orientation	Age	Disability & carers
☒	☒	☒	☒	☒
Gender reassign ment	**Marriage & Civil Partnership**	**Religion and faith**	**Maternity & Pregnancy**	**Social economic**
☒	☒	☒	☒	☒

Equality Consideration *Highlight the protected characteristic impact*		

Race	Gender	Sexual orientation	Age	Disability & carers
☒	☒	☒	☒	☒
Gender reassign ment	**Marriage & Civil Partnership**	**Religion and faith**	**Maternity & Pregnancy**	**Social economic**
☒	☒	☒	☒	☒

What impact will this have on people receiving a positive experience of care?	Positive	One of the themes emerging from engagement with patients and carers are challenges with discharge. As such Perfecting Discharge continues to be a priority for the Trust. The data analysis will continue to 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. We have identified four work streams to focus on recurring themes including communication, process, medication and training and education. 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. The EDHR team are engaging with the organisation about all nine protected characteristics to ensure feedback from patients/carers/relatives demonstrates how well the discharge process is meeting their needs to ensure improvement. 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. The organisation is committed to improving inclusive engagement and is currently reviewing our current practices and identifying areas of improvement. The implementation of the carer's passport will support the identification and communication with carers about their experiences which will feed in the priorities. The Trust is proactively committed to being inclusive and supportive of those who identify with their birth gender and those who do not. Staff are working to accommodate all patients on a case by case basis if required, as well as identifying any systemic inequalities that may impact them.

Equality Consideration *Highlight the protected characteristic impact*		

Race	Gender	Sexual orientation	Age	Disability & carers
☒	☐	☒	☒	☒
Gender reassign ment	**Marriage & Civil Partnership**	**Religion and faith**	**Maternity & Pregnancy**	**Social economic**
☒	☐	☒	☐	☐

<table>
<tr>
<td>Does the proposal impact on the responsiveness to people's needs?</td>
<td>Positive</td>
<td>The priorities recognise issues around BAME employment mobility and the Trust is working collaboratively with the BAME network.

The proposal recognises that communication and engagement with carers and patients from all 9 protected characteristic is need to ensure improvement in responsiveness to patient and delivering care in a patient centred and inclusive way.

This includes a roll out of training on caring for people where English is not their first language. This is a targeted and blended approach across the whole Trust.</td>
</tr>
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<td>Equality Consideration

Highlight the protected characteristic impact</td>
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<tr>
<td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td>
<td>Positive</td>
<td>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 experien at work around key Equality Diversity and Inclusion.

The Trust has also been part of the Sussex Healthcare Partnerships BAME Disparity Programme and Turning the Tide Transformation Board. Partner organisations have a system wide approach to WRE and jointly share best practice.

Our staff networks have now been re-branded into independent staf groups with elected Chairs and supported by a Trust Board sponsor The new structure includes; celebrating difference, inspiring staff, he transform the organisation with the inclusion agenda and a governance structure to amplify the voices of staff with lived experience at all levels of the Trust.</td>
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<td>Equality Consideration

Highlight the protected characteristic impact</td>
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<tr>
<td colspan="3">Access
Could the proposal impact positively or negatively on any of the following:</td>
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<tr>
<td>• Patient Choice</td>
<td>Positive</td>
<td>Enabling patient choice through engagement across all 9 protected characteristic.

This includes a proactive commitment from the Trust to be inclusive and supportive of those who identify with their birth gender and those who do not. Staff are working to accommodate all patients on a case by case basis if required, as well as identifying any systemic inequalities that may impact them.</td>
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<table>
<tr><td>• Access</td><td>Positive</td><td>There is no evidence that the quality improvement priorities will affect some groups differently. We recognise the need to target objectives for those who have needs relating to protected characteristics and these are considered in respect of each priority e.g. in respect of access, use of interpreters, making information available in different formats.

There will be Trust wide training to support the embedding of equality in access for the deaf community, education on carers and improving communication with people from the BAME community to enable their experiences to improve quality of services and support the delivery of the QI priorities.</td></tr>
<tr><td>• Integration</td><td>Neutral</td><td></td></tr>
<tr><td>Equality Consideration

Highlight the protected characteristic impact</td><td></td><td><table>
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<tr><td>Engagement and Involvement
How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:</td><td>Positive</td><td>Key stakeholders were engaged throughout the process.
This included staff and wider system engagement and third sector organisations.
Insights for our existing engagement mechanism such as complaints and FFT were incorporated.
*Details of stakeholder mapping available on request.</td></tr>
<tr><td>Equality Consideration

Highlight the protected characteristic impact</td><td></td><td><table>
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<tr><td colspan="3">Human Rights
Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998</td></tr>
</table>

Articles		Y/N
A2	Right to life	**No**
A3	Prohibition of torture, inhuman or degrading treatment	**No**
A4	Prohibition of slavery and forced labour	**No**
A5	Right to liberty and security	**No**
A6 &7	Rights to a fair trial; and no punishment without law	**No**
A8	Right to respect for private and family life, home and correspondence	**No**
A9	Freedom of thought, conscience and religion	**No**
A10	Freedom of expression	**No**
A11	Freedom of assembly and association	**No**
A12	Right to marry and found a family	**No**
Protocols		
P1.A1	Protection of property	**No**
P1.A2	Right to education	**No**
P1.A3	Right to free elections	**No**

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.

Aerosol Generating Procedures

This is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.

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.

Amniotic Fluid Embolism
This is a very uncommon childbirth emergency in which the amniotic fluid (the fluid that surrounds the baby in the uterus during pregnancy) enters the bloodstream of the mother and triggers a serious reaction.

Anti-thrombin in Pregnancy
Anti-thrombin (AT) is a natural anti-coagulant (prevents blood clots) which plays a potentially important role in whether women who develop thromboembolism (an obstruction of a blood vessel by a blood clot) during pregnancy. Multiple reports have documented an association between inherited deficiency of AT and an increased rate of venous (vein) thromboembolism.

BAME

Umbrella term used to describe non-white ethnicities

C

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

Centor Criteria
This is a clinical scoring tool which may be used to identify the likelihood of a bacterial infection in children complaining of a sore throat.

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.

Cirrhosis in Pregnancy
Cirrhosis is defined as permanent scarring of the liver as a result of continuous long term damage. Some small studies have suggested that there is an increased incidence of adverse maternal and perinatal

outcomes in women with cirrhosis.

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.

Computerised Tomography (CT) scan
This is a test that uses x-rays and a computer to create detailed pictures of the inside of the body. It takes pictures from different angles. The computer puts them together to make a 3 dimensional (3D) image.

COVID-19
The term used to refer to the disease caused by SARS-CoV-2, the coronavirus that emerged in December 2019. Visit: www.dh.gov.uk/en/

Culture
Learned attitudes, beliefs and values that define a group or groups of people.

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.

Diabetic Ketoacidosis in Pregnancy
This is an infrequent complication of pre-gestational or gestational diabetes

mellitus during pregnancy (high blood sugar levels that develops during pregnancy).

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 specialties 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

F

FeverPAIN criteria
This is a clinical scoring tool which may be used to identify the likelihood of a bacterial infection in children complaining of a sore throat.

Fontan
This refers to women with fontan circulation which is a congenital heart defect/condition.

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.

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.

Glasgow Coma Scale
This is a tool used to assess and calculate a patient's level of consciousness. The range is from 3 (lowest) to 15 (highest). A score of 15 is considered normal and fully conscious.

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.

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.

Integrated Performance Review (IPR)
Meeting attended by members of Trust board, senior leads from the division, Finance, HR, Knowledge Management

ICNARC
The Intensive Care National Audit and Research Centre.

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.

Lumbar Puncture
A procedure performed in the lumbar region (lower back). A needle is inserted between 2 lumbar bones to remove a sample of cerebrospinal fluid. This is the fluid that surrounds the brain and spinal cord to protect them from injury.

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.

Methicillin Sensitive Staphylococus Aureus (MSSA)
MSSA is a type of bacteria that is not resistant to antibiotics.

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

NerveCentre

A digital system that creates a live bed state to support bed management and patient flow.

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

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.

Peripartum Hyponatraemia
Hyponatraemia occurs when the levels of sodium in the blood are low which can result in excessive levels of water in the body. Very little is known about the occurrence of this in late pregnancy.

Personal Protective Equipment (PPE)
This is a term used for any equipment that will protect the user against health and safety risks at work. It helps to prevent injury or infection.

Polymerase Chain Reaction (PCR)
This is a technique used to 'amplify' small segments of DNA. The DNA can then be used in many different laboratory procedures e.g. to identify bacteria or viruses.

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.

Protein C Deficiency in pregnancy
Protein C is a natural anticoagulant (blood thinner). Women with protein C deficiency have a higher risk of developing clots both during and after pregnancy. It may also increase the risk for miscarriages in the early and late terms of pregnancy.

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.

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.

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.

Rupture of Membranes
This is when the amniotic sac which surrounds the baby break at the start of labour. Rupture of the membranes is known colloquially as "**breaking the water**" or as one's "**water breaking**".

ReSPECT
Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

S

Schwartz Round
This is a forum where all staff can come together regularly to discuss the emotional and social aspect of working in healthcare.

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.

Speak Up Guardian
A person who supports staff to raise concerns.

SPINE
NHS Spine is the digital central point allowing key NHS online services and allowing the exchange of information across local and national NHS systems.

StEIS
National Strategic Executive Information database which captures serious incidents reported by NHS organisations.

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
An infection that occurs after surgery in the part of the body where the surgery was performed.

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.

T

Treatment Escalation Plan (TEP)
A communication tool that provides the opportunity for patients, doctors and nurses to come to an agreement on the overall plan of care. It gives guidelines on what treatments the patient would like to receive should their condition get worse

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.