East Sussex Healthcare NHS Trust

Quality Account 2021/2022

Part 1 – Introduction

Statement of Quality from the Chief Executive

I am delighted to introduce the Quality Account 2021/22 for East Sussex Healthcare NHS Trust (ESHT).

This report summarises the Trust's quality achievements during 2021/22 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 2022/23.

Challenges have persisted across the NHS over the past year and ESHT has remained focused on improving the quality of care we provide to the patients under our care. We have achieved this while delivering care in exceptional circumstances; increased sickness absence, additional capacity open across our two hospital sites and significant resource challenges across the health and care sector more widely. All of these elements have together meant that 21/22 was a year unlike any other. 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.

The Trust introduced innovative ways of working during the pandemic in order to continue to provide patient care and some of these will continue, for example, virtual clinics for outpatient services. These enabled many patients to receive outpatient appointments without the risks and anxieties associated with travel and attendance at hospital, particularly when Covid rates were high in the local communities.

The Trust has made progress towards the priorities we set in the 2021/22 Quality Account despite Covid-related disruption to our planned Quality Improvement initiatives. In recent months this important work has now been re-established and we are seeking to strengthen this through a stronger focus on transformation during 22/23.

Over the past year we have worked collaboratively with system partners on services for patients who present to the Trust with significant mental health challenges alongside their physical ill health and this work is continuing.

More than ever, our Trust values continue to be the foundation of all that we do. During the pandemic the Trust invested in the wellbeing of its staff with support being available to them via the Occupational Health and Wellbeing Teams.

Whilst acknowledging the challenges that Covid 19 has brought 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 2021/22 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

About the Trust

East Sussex Healthcare NHS Trust provides 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.

We are one of the largest organisations in East Sussex with an annual income of £534 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.

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 General Practice (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.

In the past year…

- Our Emergency Departments were used over 150,000 times, an increase of almost 30% on last year. 78.8% of people using our EDs were seen, treated and either discharged or admitted, within four hours
- 2,939 babies were born in our hospitals
- There were almost 50,000 elective admissions, 90% of these were day cases
- Over 24,000 cancer referrals were made to us, between April 2021 and February 2022

- There were over 420,000 outpatient appointments, over 285,000 of these were consultant-led

- Over 290,00 X-ray and scans were carried out

- Our switchboard answered almost 1.2 million calls during the year

- 80 members of staff were presented with awards for 25 years' service with a remarkable 66 colleagues marking 40 years' service

- Over the last few years, the Trust and other health and care organisations across Sussex have worked together as the Sussex Health and Care Partnership (SHCP) to make sure the experience of local people using services is more joined-up and better suited to their individual needs. SHCP brings together 13 organisations (NHS and local authorities) as an integrated care system (ICS).

Our Strategy

In 2021 we published our ambitious strategic plan which sets the overall direction for our services; enabling our residents to access the best care in the most appropriate place – at home, in the community or when they need to come into hospital.

With our Board, staff and partners we developed our five-year forward strategy "Better Care Together for East Sussex" that we believe is best for our residents and consistent with the Sussex-wide priorities. Our plan is built on four strategic aims:

Improving the health of our communities
We will prioritise health outcomes for the people we serve. Given our demographics, this means an emphasis on older people's services and a focus into those areas of our county where we know deprivation and poorer access to care is greatest. COVID-19 has shown us that by using virtual and digital technologies we can help our patients using different approaches. Working smarter will be at the heart of how we develop our services to benefit our patients and service users.

Collaborating to deliver better care
We already work alongside health and care partners, and this will become more important over the coming five years. Truly patient-focused services think about organisational interests last, not first. Our duty to collaborate will mean that when we plan our future, we will do this with more partners and patients involved in that process. We have built strong links with other providers and local authorities through our clinical work. In areas like primary care, we know that we can build further with colleagues in General Practice to provide better care.

Empowering our people
We want to make the Trust a great place to work. This means strengthening our care and support

for staff and ensuring we identify and develop our best and brightest. We know that if our people like working here that will show in the care we provide and the stories that patients and staff tell about us. We want staff to be proud to work here.

Ensuring Innovative and sustainable care
We recognise that “doing more of the same” is not going to be enough. COVID-19 showed us that we can be better when we are bolder. We want to design future-focused ways of working and caring for our patients that we can take with us into the new, improved hospitals that we are planning for on the Eastbourne and Hastings sites as part of our Building for our Future programme.

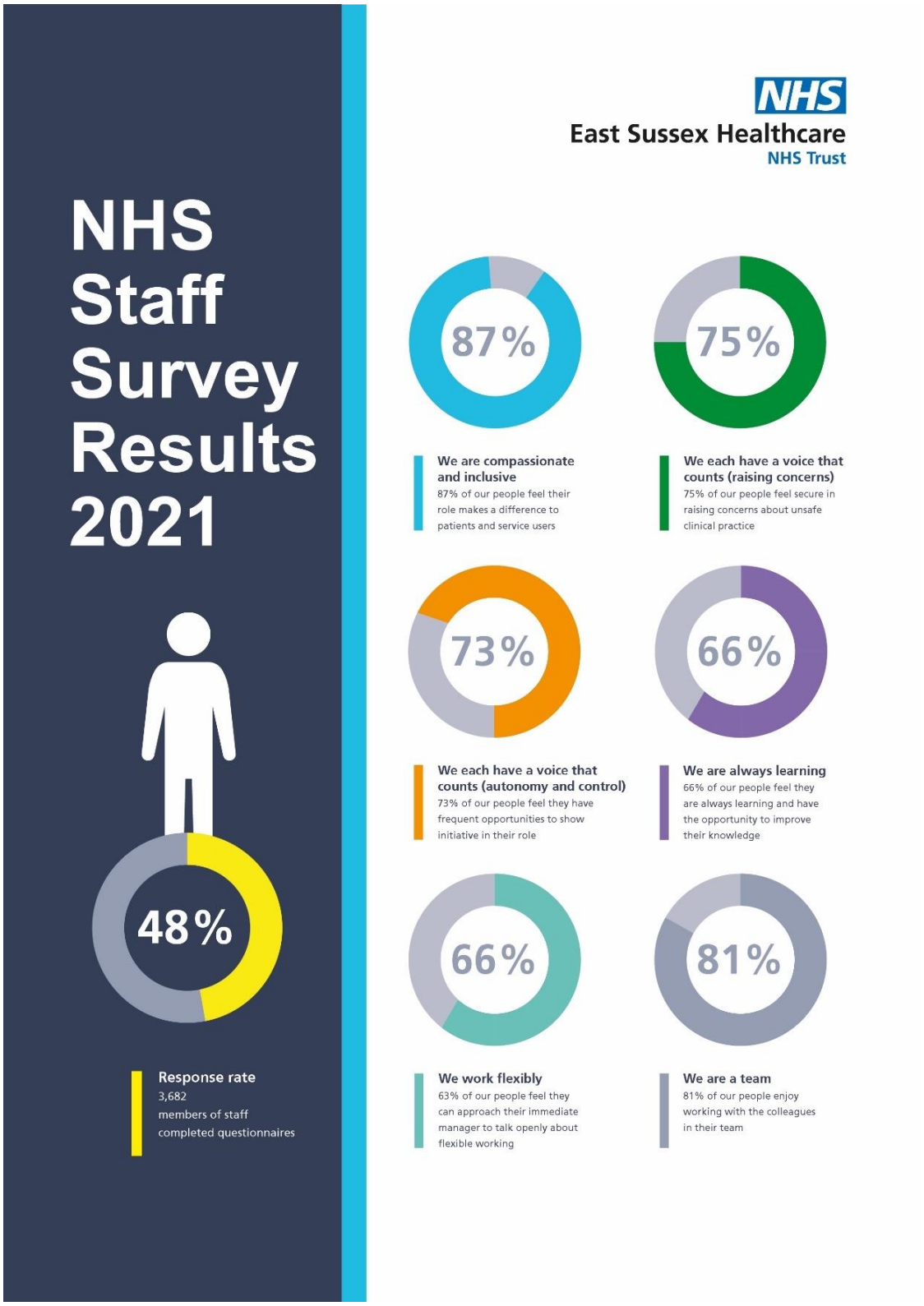
What the Trust will look like in 2026
The kind of Trust we want to see in five years is one where our performance is one of the best. Where we are:

- Providing excellent, high-quality care for patients, with national recognition for at least one service area (frailty)
- Recognised as a great place to be for the quality of care we provide and the support we offer for our people
- Prioritising our approach to green/sustainability issues
- Developing new clinical roles and ways of working that are collaborative and innovative that reach across organisational boundaries
- A digital-first way of working across our services
- A financially sustainable organisation within a viable Sussex system

We have also developed supporting strategies across the core areas that we know will enable us to deliver. Our supporting strategies – again developed with staff – cover:

- **Clinical:** Setting out the priorities for our services to enable us to serve patients the best we can
- **Digital:** Ensuring digital support for teams at the heart of improvements in care for patients
- **People:** Supporting our teams and workplace culture, making the Trust a great place to work
- **Estates:** Making the best use of our buildings for all our people and being environmentally aware

To be successful we will also need to work even more closely with our partners, in local government, in the NHS and within our voluntary and community sector.



We discuss the headlines from our Staff Survey results this year on p.46 of this report. Seeing these in the context of the Covid challenge shows that ESHT has performed well compared with our peers. This takes nothing away from the ongoing difficult operating environment, but it is a testament to our people and our developing workplace culture.

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 2022/23

Our Quality Strategy outlines the improvements required to achieve the Trust's ambition to be 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.

Table 1: Priorities for improvement in 2022/23

Quality Domain	Priorities for improvement 2022/23
Patient Safety	1. Safe Staffing
Clinical Effectiveness	2. Ensure all patient nutrition and hydration needs are met
Patient Experience	3. Learning from complaints

1. Safe Staffing

Why this has been chosen as priority
The aim of safer staffing is to be above 90% fill rate in all in-patient areas.

What we are going to do moving into 2022/23
Participate in national initiatives led by the Chief Nurse for England, Ruth May and encourage innovation locally through system working and collaboration with key partners. These include:

- International Nurse recruitment
- 'New to Care' recruitment of HCAs without formal caring experience whom we will train to an agreed standard of competence
- Identification and participation at recruitment fayres
- Participation in 'Kickstart'
- Work with local colleges to encourage T level and apprenticeship students into healthcare

- Encourage an increase of student nurse placement through initiative such as Collaborative Learning in Practice (CLiP)
- Inclusivity monitoring to allow alignment with trust plans under Core20PLUS5

What will success look like?

ESHT is committed to supporting the Kick Start programme and is working with the Sussex Health and Care Partnership, the local Job Centre and their coaches to support opportunities for work in a range of band 2 roles supporting clinical teams and the wider workforce at ESHT.
The Kickstart Scheme makes up part of the Government's 'Plan for Jobs' skills and employment programmes , which also include Apprenticeships, T Levels and Traineeships. T Levels are qualifications for students aged 16 to 19 who have finished GCSEs. They are a 2-year qualification and the equivalent to studying 3 A levels. There is a free government scheme to create industry placements so this would be helpful as a pipeline for recruitment.

The Kickstart Scheme offers six-month jobs for young people aged 16 to 24 years old who are currently claiming Universal Credit and are at risk of long-term unemployment. This provides an opportunity for a young person to work, and be paid, through Government funding. This offers a fantastic opportunity for young people into the world of work, and for the Trust to develop them with transferable skills that are aimed at increasing their chances of sustained employment. ESHT has a support training programme running alongside the working role, that the young people are undertaking as preparation for them for a career and other employment opportunities in the Trust.

- >10% improvement in rota gaps
- >10% improvement in e-roster compliance
- >95% Registered Nursing Associates completing their training
- >2% improvement in vacancies in nursing
- 2% improvement in annual leave compliance (i.e., spread evenly)

How we will monitor progress

- Board Reports
- People Organisation Development Board (POD)
- Safer Staffing meeting for Nursing
- Divisional Monthly Performance Review meetings Integrated Performance Review (IPRMs)
- Insight tracking through daily, weekly, and monthly reports:
- Nursing Roster Performance
- Staffing Gaps Profile
- Workforce KPI's
- Cross-site Staffing Meeting (Daily)

2. Ensure all patient nutrition and hydration needs are met

Why this has been chosen as priority

Malnutrition can occur for many reasons including access to food, ability to cook, poverty or more often in the context of NHS work, as a result of medical conditions for patients who have difficulties swallowing food, are unable to use cutlery/feed themselves because of a condition such as a stroke or neurological condition and rapid weight loss caused by an illness such as cancer. Malnutrition has a significant impact on an individual's ability to recover from illness or injury that has resulted in an inpatient stay, reduces their ability to fully engage in rehabilitation and can result in deconditioning whilst an inpatient due to unplanned weight loss.

The British association for parenteral and enteral nutrition (BAPEN) evidence that:

- Malnutrition is a serious condition which detrimentally affects the function of all body tissues, predisposing to disease, as well as increasing complications after an injury, and delaying recovery from an illness. It also makes day to day activities more difficult to complete, and increases the likelihood of dependency, especially in the elderly.
- Malnourished adults account for about 30% of hospital admissions, with increased visits to

hospital prolonged length of hospital stay.

- Overall, the cost of treating a persistently malnourished patient is over three times more than treating a non- malnourished patient.
- Evidence clearly shows that if nutritional needs are ignored health outcomes are worse and meta-analyses of trials suggest that provision of increased nutrition to malnourished patients reduces complications such as infections and wound breakdown by 70% and mortality by 40%.

Staff monitor malnutrition risk in the hospital via the malnutrition universal screening tool (MUST). This helps identify patients who are at risk of malnutrition or who are malnourished. Although there has been some improvement in the last MUST audit results, the Trust is not achieving the desired compliance in standards that describe how frequently the MUST should be used and the action plan required if a patient is at risk of malnutrition. It is also known from incident investigations that staff are not always assessing and referring patients with swallowing difficulties and then following specialist care plans consistently.

What we are going to do moving into 2022/23

This priority would involve a multi-disciplinary working group and project improvement plan to improve MUST audit compliance with sustainable change; a list of recommendations with an improvement plan to help close the gap on any areas identified as well as surveying patients' perceptions and views. Referral to appropriate services for those with non-medical causes of malnutrition, such as poverty or need for social/benefits support). Staff will also, repeat a Patient-Led Assessments of the Care Environment (PLACE) Lite audit and develop an action plan prior to the reintroduction of the formal PLACE audits, and will review information, Trust incidents & complaints data related to nutrition that will support the project and provide some measurable objectives

What will success look like?

- Benchmarking current practice: audit patients recognised as requiring assistance with a meal/at risk of malnutrition or with swallowing difficulties and if they have been supported with the red tray system (a visual flag system for wards to know who is at risk) to understand the gap in use, if any. Development of subsequent action plan to address any gaps
- Benchmarking current practice: audit swallow screening risk assessment tool to understand if being utilised across the wards and to determine if there is a gap in use, if any. Development of subsequent action plan to address any gaps.
- Improve to a minimum 90% patients having their MUST score recorded on admission.
- Improve to greater than 66% patients having their MUST score repeated 1 week after admission.
- Improve to greater than >66% patients who are identified as having a MUST score of 1 or more with an active ward lead treatment plan in place (food first nutrition support).
- To aim for one reporting area for MUST Score - aiming for this to be combined into to the electronic patient notes.
- Ensure every ward has access to adapted equipment for eating and drinking.
- Increasing vegan, vegetarian and high calorie high protein (specifically for patients identified at risk or who have malnutrition) options on the menu above current number of choices.
- Increasing the choice of texture modified for those with swallowing difficulties (pureed meals, soft and bite sized), above current number of choices. Could be focused on intermediate care before roll-out to rest of Trust.
- Re-assess progress since the pandemic, to develop an improvement plan to close other unidentified gaps in training.
- Launch of BAPEN nutrition e-learning in the Trust with 20% Compliance across staff groups within first year
- Continued role out of Eating and Drinking Competency Framework (EDCF) training across the Trust aiming for a minimum of 20% compliance across staff groups in 2022/23.
- Reduction in safety incidents scoring severity 3 or above (high risk of harm taking place) related to swallowing.

- Completed training needs analysis for a minimum of ward staff including housekeepers, HCA and nurses (ideally for all staff involved in patient care)..

How we will monitor progress

- Via the Nutrition and Hydration steering group against the above targets
- By utilising audits and learning & development data
- Completed action plans
- Project initiation documents
- Action plans with learning & development
- Complaints, PALs, and incident reports

3. Learning from complaints

Why this has been chosen as priority

Improving the experience of each individual patient is at the centre of the NHS Constitution.

One of the standards in the new NHS Complaints Standards, is to promote a just and learning culture - to use complaints as an opportunity to develop and improve services and to learn from complaints.

This priority has been chosen as trends and themes reported locally and as part of national CQC surveys are similar year on year. Whilst small changes have been made to address these trends and themes, a better understanding of the subjects is required.

What we are going to do moving into 2022/23

To investigate the top three primary complaint subject codes and have a better understanding of the reasons behind the complaints being raised.

Top 3 Primary Complaint Subjects - Rolling 12 Month Totals (Jan 2020- Jan 2021):

- Standard of Care = 233
- Communication = 72
- Patient Pathway = 54

This will involve reviewing current categories on Datix and consider revising them to provide a better understanding of what the trends and themes are providing managers with more intelligent information to make changes/ improvements.

Work to identify possible areas/ opportunities for improvement using QI methodology.

What will success look like?

The Patient Experience Team and Clinical areas will have insightful data representing trends and themes of complaints and will make changes/ improvements to address these.

A change in the top three complaint primary subject codes or a notable reduction.

How we will monitor progress

The progress of this will be reported within the Patient Experience report which is presented bimonthly at the Patient Safety and Quality Group and bi-monthly at the Quality and Safety Committee.

Service areas which are working with this Quality Account Priority will also be able to report through their IPRM

Part 2.2 – Statements of Assurance from the Board of Directors

Services provided and income

During 2021/22 ESHT provided and/or sub-contracted 77 NHS services.

ESHT has reviewed all the data available to them on the quality of care in all 77 of these NHS services.

The income generated by the NHS services reviewed in 2021/22 represents 100% of the total income generated from the provision of NHS services by ESHT 2021/22

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 reducing the burden on the NHS, national audit participation was paused throughout periods of 2021/22 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, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) perinatal surveillance and Intensive Care National Audit & Research Centre (ICNARC) (adult intensive care) which were required to continue. ESHT has continued to successfully submit data to these studies over the past year. Additionally, many studies had their start date significantly delayed.

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 partly 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. This is hoped to be the case from April 2022 onwards.

The national clinical audits and national confidential enquiries that ESHT was eligible to participate in during 2021/22 are detailed below.

National Audit and National Confidential Enquiries Programme

During 2021/22, 50 national clinical audits and 2 national confidential enquiries covered relevant health services that ESHT provides.

During that period, ESHT participated in 96% 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 2021/22 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 largely unavailable for 2021/22 due to the national pause on the mandatory clinical audit programme throughout much of the year.

The Trust also participated in 13 additional (non-mandated) national studies in 2021/22, which can be found in Appendix 4.

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)

NCEPOD issued one report in 2021/22:

- Dysphagia in Parkinson's Disease: Hard to Swallow
  Published in August 2021.

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

Maternal deaths to be reported are *all deaths* of pregnant women and women up to one year following the end of the pregnancy (regardless of the place and circumstances of the death).

Perinatal Deaths are reported by nominated staff in each hospital via the MBRRACE-UK system.

The Women and Children's division continues to report:

- **Late fetal losses** – the baby is delivered between 22 weeks+0 days and 23 weeks+6 days of gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Stillbirths** – the baby is delivered from 24 weeks+0 days gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth

Terminations of pregnancy – Any late fetal loss, stillbirth or neonatal death resulting from a termination of pregnancy should be notified.

Note: Births showing no signs of life (stillbirths and late fetal losses) – All births delivered from 22 weeks+0 days gestation showing no signs of life must be reported to MBRRACE-UK, irrespective of when the death occurred. This is to ensure complete data collection in line with the World Health Organisation (WHO) guidelines and to allow international comparisons. Please ensure that both the date of delivery and the date of confirmation of death are reported

Note: PMRT reviews – These criteria are not the same as the babies the Perinatal Mortality Review Tool supports review of. Details can be found in the latest version of the document "Guidance for using the PMRT" found in the PMRT section of the website, or the surveillance "User guide" found in the Perinatal surveillance section of the website.

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 2021/22 include:

Study	Cases
Antithrombin/Protein C Deficiency	**0**
Amniotic Fluid Embolism	**0**
Fontan and Pregnancy	**0**
New Therapies for Influenza	**0**
Pregnancy following Bone Marrow Transplant	**0**
COVID-19 Positive	**140**
Re-exploration after CS	**0**
Previous cardiomyopathy	**1**

National Clinical Audit Reports in 2020/21

The reports of 42 national clinical audits were reviewed by the Trust in 2021/22. 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.

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

National Potential Donor Audit (PDA)

Date of publication: September 2021 (reporting on April 2020 – March 2021 data)

Rationale

As part of a series of measures designed to improve organ donation rates in the United Kingdom, a potential donor audit was established by UK Transplant. The audit identifies the number of patients who could be solid organ donors and will establish the obstacles to donation, with national recommendations made to improve the rate of transplant.

The objectives were:

To determine the potential number of solid organ donors in the UK and provide information about the hospital practices surrounding donation.

Key Results

During the report period, there were 7 families who consented to donation at East Sussex Healthcare NHS Trust. This resulted in 4 proceeding solid organ donors and lead to 7 patients receiving transplants. Of the 3 patients whose family kindly agreed to donation but in whom donation did not proceed, 2 were subsequently found to have a contraindication during the screening process and 1 deteriorated and died prior to donation.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2020 - 31 March 2021

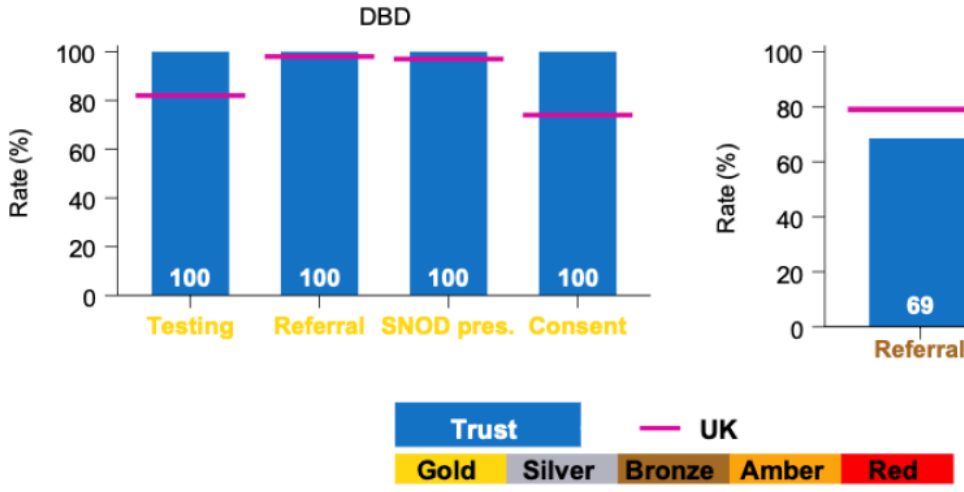


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2020 - 31 March 2021

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	4	1810	54	6027	58	7551
Referred to Organ Donation Service	4	1777	37	4770	41	6282
Referral rate %	G *100%*	*98%*	B *69%*	*79%*	A *71%*	*83%*
Neurological death tested	4	1490				
Testing rate %	G *100%*	*82%*				
Eligible donors[2]	4	1353	17	2860	21	4207
Family approached	4	1210	3	1042	7	2248
Family approached and SNOD present	4	1168	3	925	7	2089
% of approaches where SNOD present	G *100%*	*97%*	G *100%*	*89%*	G *100%*	*93%*
Consent ascertained	4	891	3	665	7	1553
Consent rate %	G *100%*	*74%*	G *100%*	*64%*	G *100%*	*69%*
Actual donors (PDA data)	2	777	2	404	4	1180
% of consented donors that became actual donors	*50%*	*87%*	*67%*	*61%*	*57%*	*76%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Referrals & Missed Opportunities:
Goal*: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135 and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors.*

ESHT Results: Of 4 potential Donation after Brainstem Death (DBD) donors, all patients were referred to the Specialist Nurse for Organ Donation (SN-OD). Of these patients all 4 families consented to donation. Of 54 potential Donation after Circulatory Death (DCD) donors, 37 patients were referred to the SN-OD, 34 patients had contraindications to donation and 3 families were approached and consented to donation.

ESHT has been rated as below average for referrals. However, of the patients not referred for consideration of donation, *all* had a medical contraindication to donation and therefore their families would not have been approached even if referred as donation would not have been clinically possible for these patients. The main reason for medical contraindication was a positive COVID-19 result (88% of cases). Additionally, the majority of "missed" referrals occurred during both COVID-19 surge peaks which represented a time of significant increased clinical workload for the entire critical care team.

This year has seen a significant drop in the DCD referral rate for the reasons outlined above. Alongside the ongoing consideration of Specialist nurse referral and End of Life Care in the daily ICU safety huddle, the organ donation team have also worked with the critical care teams to increase awareness amongst new and redeployed staff by the inclusion of an update in the ICU newsletter – so far included twice since December.

Neurological Testing:
Standard: *Neurological death tests are performed wherever possible.*

ESHT Results: Of 4 potential patients with suspected neurological death and potential for Donation after Brainstem Death, all patients underwent neurological testing. This is a local goal of the South East Organ donation collaborative and **ESHT has been rated as exceptional when compared to UK performance.**

Specialist Nurse for Organ Donation presence:
Standard: *A SNOD should be present during the formal family approach as per NICE CG135 and NHSBT Best Practice Guidance.*

ESHT Results: East Sussex Healthcare Trust had 100% SN-OD presence during formal family approaches to discuss donation following both Neurological death and for donation after circulatory death. **When compared to UK performance this means that ESHT was rated as exceptional.**

Consent:
ESHT Results: **The consent rate for families agreeing to organ donation at ESHT this year was 100% - rated as exceptional when compared to UK performance.**

Across the majority of domains there has been improvement in performance when compared to the previous year activity and in a number of domains ESHT is now rated as exceptional when compared to UK performance. The exception to this is referrals for consideration of donation after circulatory death where the rate has dropped significantly due to the covid-19 pandemic.

Local Action Plan to aid improvement

SMART Action Point	Timescale	Comments, Updates and available evidence	STATUS
Referral of patients prior to withdrawal of treatment (donation after circulatory death) - Increase staff awareness by including a section in the ICU staff newsletter	December 21	Complete this appears in the newsletter on a regular basis.	**COMPLETE**
Referral of patients prior to withdrawal of treatment (donation after circulatory death) - Ensure this is included in the morning ICU safety huddle	December 21	There was already a question in the morning ICU safety huddle regarding end-of-life care but now special attention is paid to it.	**COMPLETE**

Epilepsy 12

Date of publication: July 2021 (reporting on December 2019 – November 2020 data)

Rationale

Epilepsy is the most common significant long-term neurological condition of childhood and affects an estimated 112,000 children and young people in the UK. Epilepsy12 seeks to help improve the standard of care for children and young people with epilepsies. To do this, the audit collects and processes patient data. This information is used by the audit to highlight areas where services are doing well, and also identify areas in which they need to improve.

The objectives were:

- Continue to measure and improve care and outcomes for children and young people with epilepsies
- Include all children and young people with a new onset of epilepsy
- Enable continuous patient ascertainment
- Use a pragmatic and concise dataset
- Incorporate NICE Quality Standards alongside metrics about mental health, education and transition to adult services
- Provide services with local real-time patient- and service-level reporting

Results:

KEY

Trust
South East Thames Paediatric Epilepsy Group
England and Wales

Specialist Paediatrician

Standard *– The diagnosis of epilepsy in children should be established by a specialist paediatrician with training and expertise in epilepsy.*

ESHT result: **100%**

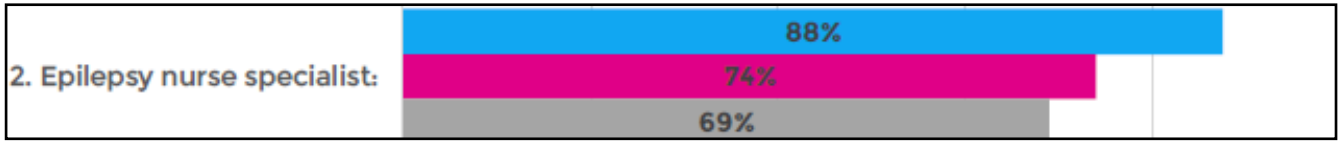
The percentage of children with epilepsy, with input by a 'Consultant Paediatrician with expertise in epilepsies' by 1 year:

Epilepsy Specialist Nurse

Standard *– Epilepsy specialist nurses should be an integral part of the network of care of individuals with epilepsy.*

ESHT result: **88%**

The percentage of children with epilepsy, referred for input by an epilepsy specialist nurse by 1 year:



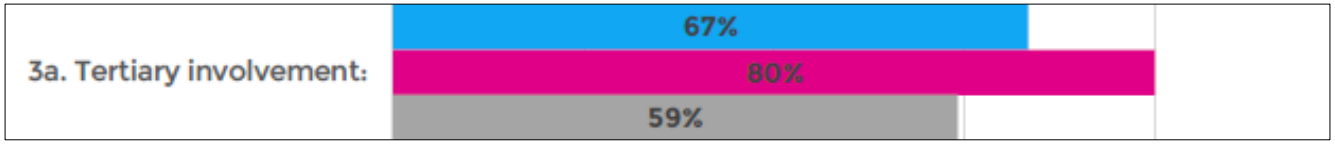
Tertiary Involvement

Standard *– Referral should be considered when 1 or more of the following criteria are present:*

- The epilepsy is not controlled with medication within 2 years of onset.
- Management is unsuccessful after 2 drugs.
- The child is under 2 years of age.
- The child or young person experiences, or is at risk of, unacceptable side effects from medication.
- There is a unilateral structural lesion.
- There is psychological or psychiatric comorbidity.
- There is diagnostic doubt as to the nature of the seizures or the seizure syndrome.

ESHT result: **67%**

The percentage of children meeting defined criteria for paediatric neurology referral, with input of tertiary care by 1 year:

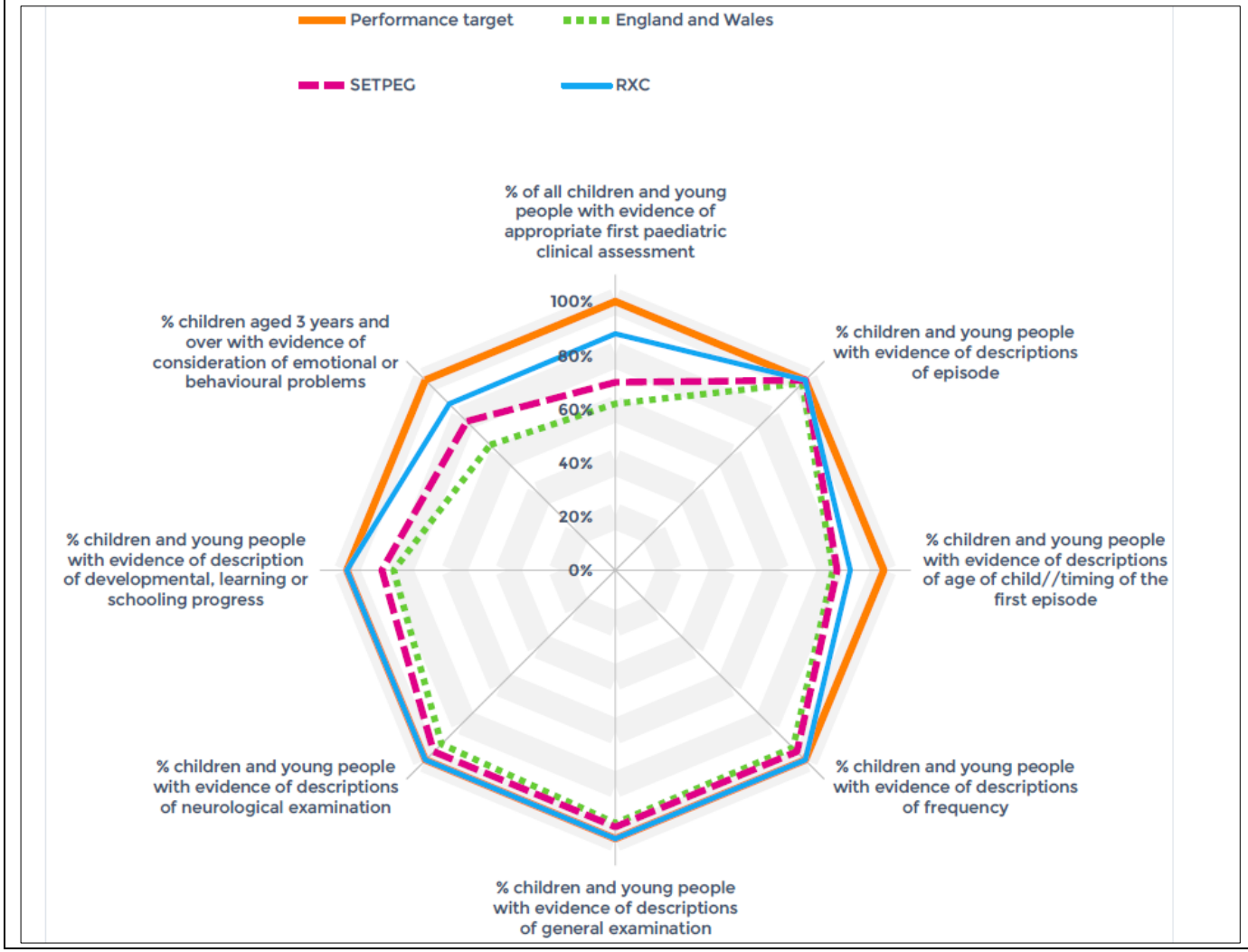


Appropriate first paediatric assessment

Standard *– In an individual presenting with an attack, a physical examination should be carried out.*

ESHT result: **88%**

The percentage of children, with evidence of appropriate first paediatric physical assessment:



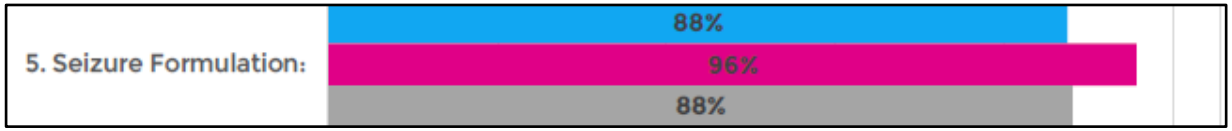
Radar Plot showing appropriate first paediatric assessment performance indicator measures by ESHT (RXC), Network and England / Wales

Seizure Formation

Standard *– Epileptic seizures and epilepsy syndromes in individuals should be classified using a multi-axial diagnostic scheme.*

ESHT result: **88%**

The percentage of children with epilepsy, with seizure classification by 1 year.

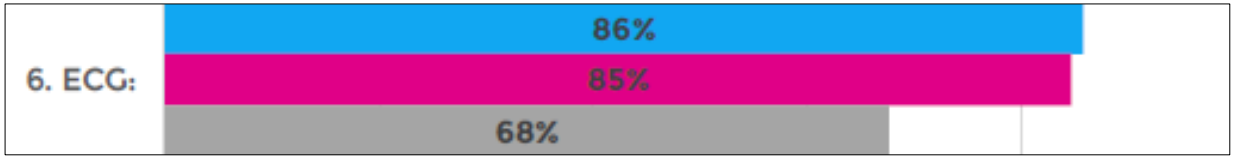


ECG

Standard *– In children, a 12-lead ECG should be considered in cases of diagnosic uncertainty.*

ESHT result: **86%**

The percentage of children with convulsive seizures, with an ECG by 1 year.



Brain MRI

Standard *– MRI should be the imaging investigation of choice in individuals with epilepsy.*

ESHT result: **50%**

The percentage of children with defined indications for an MRI, who had MRI or CT by 1 year.

Accuracy of Diagnosis

Standard *– AED therapy should only be started once the diagnosis of epilepsy is confirmed, except in exceptional circumstances.*

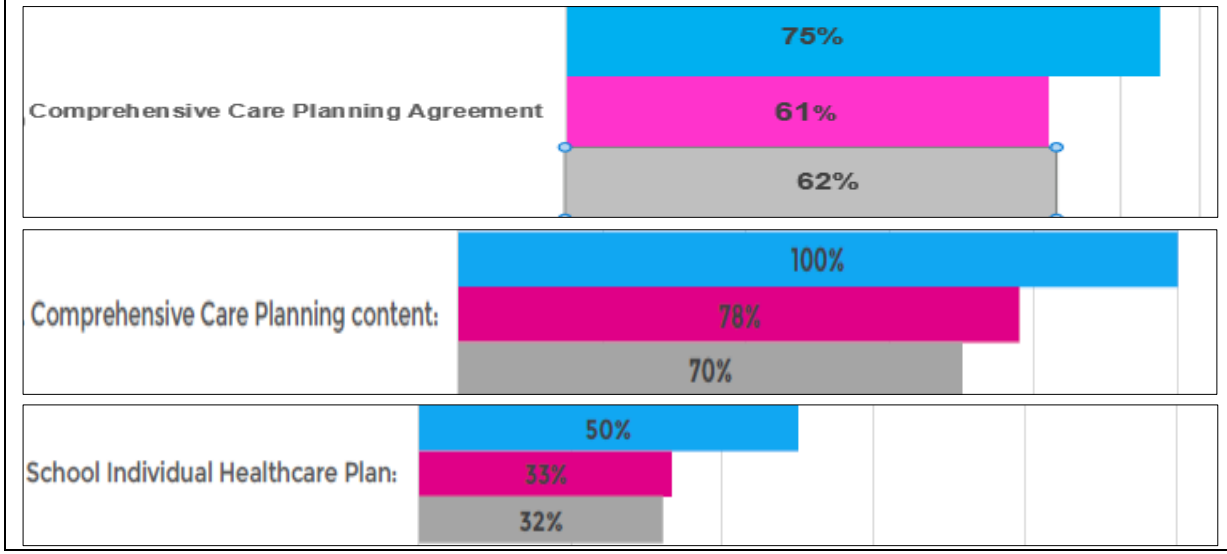
ESHT result: **100%**

The percentage of children diagnosed with epilepsy, who still had that diagnosis at one year.

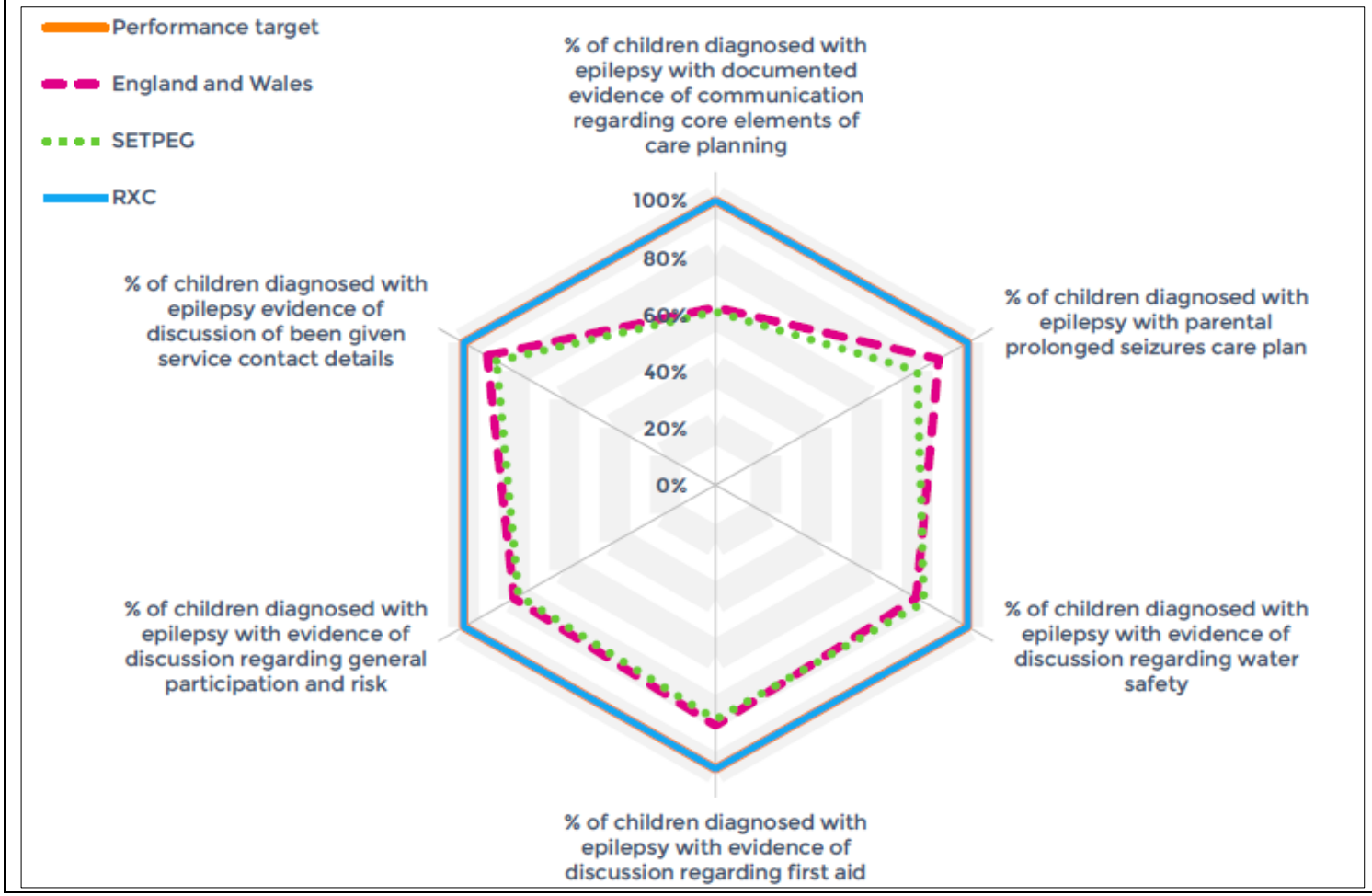
Care Planning

Standard *– All children, young people and adults with epilepsy should have a comprehensive care plan that is agreed between the person, family and/or carers where appropriate, and primary care and secondary care providers. This should include lifestyle issues as well as medical issues.*

ESHT results: **75% / 100% / 50%**



Radar plot showing comprehensive care planning content performance indicator measures by ESHT (RXC), Network and England / Wales



NICE recommends that children and young people with epilepsy have an agreed and comprehensive care plan (Quality statement 4).
100% (8/8) children and young people diagnosed with epilepsy in East Sussex Healthcare NHS Trust had documented evidence of communication regarding relevant core elements of care planning .

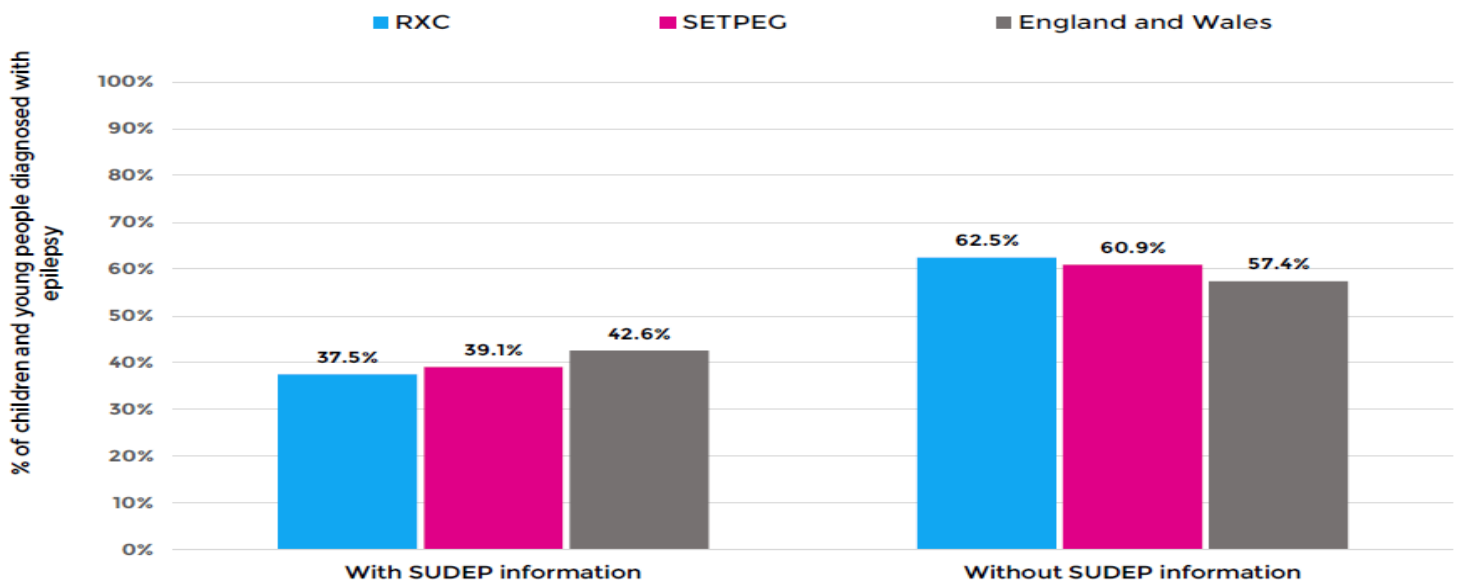
NICE recommends that children and young people with a history of prolonged or repeated seizures have an agreed written emergency care plan (Quality statement 6).
100% (2/2) children and young people diagnosed with epilepsy in East Sussex Healthcare NHS Trust and on rescue medication had a parental prolonged seizure care plan.

Sudden unexpected death in epilepsy (SUDEP)

Standard *– Children, young people with epilepsy and their families and / or carers should be given and have access to sources of information about SUDEP.*

ESHT result: **37.5%**

Figure 12: Percentage of CYP diagnosed with Epilepsy with/without evidence of SUDEP information by HB/T, Network and England and Wales combined.



Key National Recommendations

1. Health Board and Trust managers should ensure that:
• All children and young people with epilepsy are provided with psychosocial support and signposting to help them manage their condition and their related worries or anxieties, and
• All children and young people with epilepsy have ongoing screening for mental health problems using a validated tool as part of their routine epilepsy care. Where there are concerns about mental health, children and young people are referred to an appropriate mental health service via an agreed pathway. There should be timely access to diagnosis and treatment.

2. All Health Board and Trust managers and epilepsy clinical teams should implement standardised approaches to epilepsy care planning content provision to ensure that essential elements of care are always provided for all children and young people with epilepsy and these are reviewed on an ongoing basis. Health Board and Trust managers, epilepsy clinical teams, school head teachers, and school nurses should agree processes to facilitate appropriate, up-to-date health care planning within education and two-way information sharing.

3. Epilepsy services should be supported by their Trust or Health Board's management and the commissioning organisations to:
• Develop a defined epilepsy team approach to service provision and service improvement,
• Allocate time within job plans to support team functions including dedicated time for audit participation and related quality improvement actions.

4. All Health Board and Trust managers should employ sufficient Epilepsy Specialist Nurses and consultant paediatricians "with expertise" in epilepsy to ensure all children and young people with epilepsy can reliably receive responsive, individualised, specialist input into care for epilepsy and related concerns, for example, psychological and developmental issues. All Health Board and Trust managers and hospital and community commissioners should ensure that adult and paediatric epilepsy teams are resourced to allow, and have time allocated in job plans, for joint transition-related clinical appointments and quality improvement work.

Local Action Plan to aid improvement

SMART Action Point	Timescale	Comments, Updates and available evidence	STATUS
Share in departmental meeting the Strength and Difficulties Questionnaire tool and discuss how it can be used in clinic. Use of tool will highlight if a referral to CAMHS needs to be made, the standardised way of referral to CAMHs will then be completed. The tool will support the referral.	January 2023	After 6 months of using the questionniare the department has decided to evaluate its effectiveness. Timescale amended to reflect this.	**Not yet due**

Discuss the effectiveness of using the Strengths and Difficulties Questionnaire to support a referral to CAMHS with the team and remind to attach with the referral.	January 2023	After 6 months of using the questionniare the department has decided to evaluate its effectiveness. Timescale amended to reflect this.	**Not yet due**
Change template of seizure management plan in conjunction with regional group as a standardised approach.	August 2021	Template has been amended, saved and is in use.	**COMPLETE**
Analyse the data from referral to EEG date to see what the trends are with waiting times.	September 2021	Waiting time information has been analysed and reviewed. This analysis will take place with every new cohort to enable the department to act on trends as required.	**ONGOING**
Share findings with team. Refer to the tertiary centre as per NICE guidelines.	September 2021	Our part of the process is to refer to the tertiary centre as per NICE guidelines which are being implemented. Patients are then seen in the regional epilepsy clinic and surgery referrals are made through there.	**COMPLETE**

Local Clinical Audit Reports in 2021/22

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

The reports of 70 local clinical audits were reviewed by the Trust in 2021/22. 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.

Two 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.

Management of Children with Neutropenic Sepsis: Implementing NICE Guidelines (Re-audit)

Audit Number: 5056
Completion date: September 2021

Rationale

Neutropenic sepsis is a life-threatening complication of anti-cancer treatment affecting all ages because of the immunosuppression affecting the body's response to infection. However, with timely intervention and proper management, many lives could be saved, and deaths avoided.

In 2012, NICE published guidance on 'Neutropenic sepsis: prevention and management in people with cancer' and its implementation in the East Sussex NHS Trust was first audited in 2013-2016 due to the mortality risk associated and the need for timely, thorough interventions to save lives. A re-audit has not been conducted since 2016 to monitor any progress in the interval period, essential for ongoing development.

Aims and Objectives

The areas of particular focus were:

- Appropriate investigations for clinical assessment
- Correct antibiotic use
- Diagnosis based upon outlined criteria
- Early and frequent clinical reviews
- The use of a risk stratification tool to assess for complications
- Has our level of compliance confirmed?

Audit Standards and Key Results

Name of guideline	Clinical Standard	Exceptions	Result
NICE Neutropenic sepsis: prevention and management in people with cancer, Clinical guideline [CG151]	100% had risk assessment conducted within 24 hours for septic complications.	None	**0%**
	100% of patient received bloods including FBC, U&Es, LFTs, CRP, lactate and blood cultures.	None	**90%**
	100% patients <5 years old had a documented urinalysis.	7 patients >5	**33%**
	100% patients for diagnosis had a Neutrophil count <0.5 x10^9/L and either: • Temperature >38 • Clinical signs or symptoms suggestive of sepsis	None	**90%**
	100% of patients who require IV antibiotics, commenced on beta-lactam monotherapy with piperacillin with tazobactam (or suitable alternative if contraindicated)	None	**10% Beta-lactam monotherapy with Piperacillin.** **70% IV Tazocin and Gentamicin.** **20% alternative regime.**
	Appropriate duration of antibiotics documented for 100% of patients	None	**70%**
	Review within the 1st 24 hours by a competent professional in anti-cancer treatment	None	**100%**

Identified risks or concerns

Of the 10 patient admissions included, on one occasion a patient was diagnosed with 'febrile neutropenia' without meeting the NICE (2012) criteria for diagnosis, with a neutrophil count of 0.62. NICE does explain that if one suspect's neutropenic sepsis, the healthcare professional should commence treatment and not await the blood results. However, this neutrophil count exceeds the cut-off in the definition. Interestingly the Paediatric Haematology and Oncology: Supportive Care Protocols have the same diagnostic criteria (neutrophil count <0.5 x 10^9/L and either temperature >38 or clinical signs or symptoms suggestive of sepsis) but state that only signs and symptoms suggestive of a systemic infection necessitate intravenous antibiotics, rather than a numerical value of temperature and/or neutrophil count *(Great Ormond Street Hospital, The Royal Marden and University College London, 2020).*

Conversely, the lack of a validated risk stratification tool used to assess the patient's risk of complications was one of the most stand out features of this audit, similar to the previous audit. The purpose of the tool is to categorise patients into high and low risk of complications, which can then be used in combination with other biopsychosocial factors, to guide antibiotic therapy and discharge planning. The tool suggested in NICE (2012) is the modified Alexander Rule for Children and Young People (aged under 18). Without such tools being used, there could be a risk of prolonged admission due to extended intravenous antibiotic and subsequent risks associated with increased hospital stays. Conversely, if antibiotics are stopped or switched to oral too hastily, there could be more readmissions and greater morbidity and mortality.

Another point of note is regarding the paperwork and documentation. Data was collected from 2 main online systems – Esearcher and Evolve, with the former system for blood results and culture results and the latter system for uploading historic paper notes. However, when searching for paperwork on Evolve, it took longer than expected to find the data due to scattered arrangement of patient notes, with some paperwork missing altogether. For example, one patient had to be excluded as their drug chart was not uploaded onto the system.

Moreover, the most common way in which lactate levels are checked is via a blood gas, the results of which are given on a small, loose sheet of paper. It is therefore highly possible that the low percentage of lactate results could also be attributed to lost paperwork of loose sheets, rather than a true reflection of the percentage of lactate levels tested for admissions during this time.

Good practice identified

Appropriate antibiotic use is one of the key aspects of care in the management of patients with neutropenic sepsis and for this patient cohort, the most commonly used regime was Tazocin and Gentamicin. This does also coincide with NICE (2012) guidance as although it states to offer 'beta-lactam monotherapy with piperacillin wiith tazobactam' if intravenous antibiotics is necessitated and not to give aminoglycosides, it does state 'unless patient-specific or local microbiological indications. Therefore, both the 'Tazocin Monotherapy' and 'Tazocin and Gentamicin' patient admission cohorts could technically be clasified as adhering to NICE guidelines, which would total 80%.

Another strength identified was the fact that 100% of patients had clinical reviews, undertaken within 24 hours, in order to assess any complications, as per NICE guidelines. Moreover, it is important to note that the majority of the reviews were undertaken by a consultant. One could assume that this seniority assessment early on in a patient's admission could help aid decision-making, including regarding antibiotic choices, and outline plans to assist junior staff for different scenarios for that patient.

Recommendations

Firstly, health care professionals should be educated on validated scoring systems for complications of neutropenic sepsis and the rationale for their use, such as the Modified Alexander Rule for Children and Younge People <18 Years Old, suggested by NICE (2012). Furthermore, a proforma or checklist could be introduced for health practitioners who are managing patients who are presenting with probable neutropenic sepsis to ensure steps are not missed and a management plan is provided, which coincides with guidelines.

With the change from written notes to a paperless system still underway, it is essential to avoid the loss of information before being scanned. Therefore, with important elements of information recorded on small pieces of paper such as results from a blood gas, they should be preserved and written in the notes. This is important for both relaying to colleagues at the time of admission and for retrospective purposes, including audits.

A further re-audit should also be conducted to monitor further progress following changes implemented and continue to appreciate the ongoing strengths of the Trust. In addition, with the evidenced increase in-patient admissions during the COVID pandemic, a further audit should be diarised to continue to monitor the incidence of neutropenic sepsis for epidemiological purposes. With both of the above audits, this could be done over a longer time period to yield a great population size and thus greater statistical power.

Based upon this audit, one can identify many strengths in the Trusts practice including the frequent reviews, choice of antibiotics and investigations conducted. However, improvements are still to be made with the implementation of a risk stratification tool for complications to aid antibiotic decisions and discharge planning and with documentation.

SMART Action Point	Action by deadline	Comments, Updates and available evidence	STATUS
Educate healthcare professionals on the use of a validated risk stratification system to assess for complications. Introduce a proforma / checklist, in compliance with NICE (2012) guidelines for healthcare professionals to use when assessing patients presenting with probable neutropenic sepsis. - Present findings to division.	**Dec 2021**	23/03/2022 Presented to Clinical Audit meeting, circulated to the Junior teaching programme	**COMPLETE**
Educate healthcare professionals on the use of a validated risk stratification system to assess for complications. - Share validated risk stratification system as per NICE guidance.	**Dec 2021**	23/03/2022 Presented to Clinical Audit meeting, circulated to the Junior teaching programme	**COMPLETE**
Introduce a proforma / checklist, in compliance with NICE (2012) guidelines for healthcare professionals to use when assessing patients presenting with probable neutropenic sepsis. - Discuss in MDT proforma or checklist implementation.	**Dec 2021**	07/06/2022 Consultant emailed the Chair, co-chair and Paediatric Oncology Shared Care Unit guideline consultant for advice and clarification regarding whether or not the department should be following the	**OVERDUE**

		Royal Marsden Network's guidance or the NICE Gudiance (the Network's guidance is more frequently updated).	
Introduce a proforma / checklist, in compliance with NICE (2012) guidelines for healthcare professionals to use when assessing patients presenting with probable neutropenic sepsis. - Produce proforma / checklist and implement in practice.	**March 2022**	07/06/2022 Consultant emailed the Chair, co-chair and Paediatric Oncology Shared Care Unit guideline consultant for advice and clarification regarding whether or not the department should be following the Royal Marsden Network's guidance or the NICE Gudiance (the Network's guidance is more frequently updated).	**OVERDUE**
Continue to re-audit the management of children with neutropenic sepsis to monitor for ongoing successes and improvements. • Reaudit	**Sept 2023**	Not yet due	

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.

On 28/1/2020 Department of Health (DoH) requested activation of the Urgent Public Health (UPH) response in relation to Wuhan nCoV 2019, and asked Trusts to open an UPH study (ISARIC - CPMS 14152) as a matter of urgency. We continue to recruit to the following studies: Recovery Trial, GenOMICC and undertake follow up data on CCP ISARIC.

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. We have now initiated our Restart Program and have commenced opening and recruitment to the NIHR Portfolio and Commercial Trials. The department is now focusing on increasing Commercial trial activity whilst restarting core NIHR Portfolio studies as per table 1.

Project Short Title	Disease Area	Project Site Status	Project Site Date Open	Project Site Planned Closing Date	Principal Investigator
Clinical Characterization Protocol for Severe Emerging Infection ISARIC	Infection	Follow Up	11/02/2020	28/04/2022	Carruth, Vikki
RECOVERY – a randomised controlled trial with many treatment arms that changed often and rapidly during the pandemic	Infection	Open	03.05.2021	TBC	Kankam, Osei
GenOMICC – Patients in ICU with Covid	Critical Care	Open	15/05/2020	28/02/2030	Highgate, Dr J
Stampede – treatments for metastatic prostate cancer	Oncology	Open			Manetta, Dr C
Add Aspirin – Aspirin vs Placebo to prevent cancer recurrence	Oncology	Open	25.04.2016	01.04.2026	Soultati, Dr A
RAPPER - RADIOGENOMICS: ASSESSMENT OF POLYMORPHISMS FOR PREDICTING THE EFFECTS OF RADIOTHERAPY	Oncology	Open	21.08.2014	TBC	Manetta, Dr C
SEAGEN Echelon - A Randomized, Double-blind, Placebo-Controlled, Active-Comparator, Multicentre, Phase 3 Study of Brentuximab Vedotin or Placebo in Combination with Lenalidomide and Rituximab in Subjects with Relapsed or Refractory Diffuse Large B-cell Lymphoma (DLBCL)	Haematology	Open	23.12.2021	03.07.2023	Cowley, Dr A
MIDI – AI Deep Learning for Identification of Abnormalities on Head MRI	Radiology	Open	13.08.2021	20.11.2023	Sallomi, Dr D
Myeloma XIV Fitness - Frailty-adjusted therapy in Transplant Non-Eligible patients with newly diagnose Multiple Myeloma	Haematology	Open	16.03.2022	16.03.2022	Cowley, Dr A
PIQP- Anesthetic Care Pathway Study	Surgery & Anesthetics	Open	17.06.2020	31.10.2023	Murray, Dr, K
ROSSINI 2- Skin Prep for Major Abdominal Surgery	Surgery & Anesthetics	Open	07.09.2020	30.08.2023	El-Dhuwaib, Mr
ADDRESS 2 – Newly diagnosed diabetic and sibling study	Endocrinology	Open	26.06.2020	01.07.2023	Dashora, Dr U
ORION 4 Injectable Monoclonal Antibodies in pts With CHD	Cardiology	Open	13.11.2022	31.07.2026	Dickinson, Dr K
ACCURE-UK2 – RCT Appendectomy on the clinical course of Ulcerative Colitis	Gastroenterology	Open	17.11.2021	30.06.2022	Shaw, Mr S
Cerebral V1 derivation and narrow validation of a clinical decision rule - paramedics to triage older adu with traumatic brain injury	Emergency Care	Open	20.12.2021	01.05.2022	N/A
Flo-ELA Fluid balance in emergency laparotomy	Surgery & Anesthetics	Open	26.06.2020	01.07.2023	Lowe, Dr A
SHED- subarachnoid hemorrhage in the Emergency Dept.	Emergency Care	Open	02.12.2021	30.04.2023	Asokan, Dr A
SIGNET- Statins for improving organ outcome in transplantation	Critical Care	Open	01.02.2022	31.03.2026	Bahlool, Dr S
SENIOR RITA BHF The BHF older patients with non-ST Segment elevation myocardial infarction Randomized Interventional Treatment Trial	Cardiology	Open	01.04.2022	30.06.2024	Kalyar, Dr I
TriMaximize- A multicenter, prospective, non-interventional trial monitoring therapy pathways of asthma patients treated with an extra fine ICS/LABA/LAMA single-inhaler triple therapy in a rea world sett...	Respiratory	Open	11.04.2022	06.12.2023	Kankam, Dr O
UK MS Register	Neurology	Open	25.06.2020	31.07.2022	Sinclair, J

White 11 FRUITI World Hip Trauma Evaluation – FRUITI: Fix or Replace Undisplaced Intracapsular fractures Trial of Interventions	Orthopedics	Open	05.11.2021	30.04.2029	Keith-Butler, Mr O
TIPS Targeting Immune Pathways	Gastroenterology	Open	24.08.2021	15.07.2023	Tidbury, J

The number of patients receiving relevant health services provided or sub-contracted by ESHT in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 1675 participants. This is a decrease from 2020/21 where 2048 patients were recruited to participate into primarily COVID-19 Public Health England (PHE) research studies.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN scheme did not take place in 2021/22 due to the COVID pandemic.

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.
We were last formally inspected by the Care Quality Commission in November and December 2019 and the report was published in February 2020 where the overall rating for the Trust was 'good' with some areas identified as 'outstanding'. A total of 34 'should do' actions were identified to improve on service quality and although the pandemic impacted on progress these have all now been addressed.
Throughout this year the CQC have continued to adapt 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. We have taken part in two monitoring meetings, one in May to discuss our maternity services and a further one in August to look at our surgical services. No significant issues were identified. We also continue to have quarterly engagement meetings with the CQC to discuss any current issues that may be impacting on the delivery and quality of our services.
Throughout 2021-22 the CQC have found no breaches that justified regulatory action, no requirement notices were 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 2022/23 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, Badgernet
- Be a pro-active part of the EPR Project currently in process
- 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

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

- 99.9% for admitted patient care
- 100% for outpatient care
- 98.6% 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
- 99.6% 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. The deadline for the DSPT submission covering the 2021/22 is due at the end of June 2022 and therefore has not yet been made. ESHT are therefore still covered by the 2020/21 toolkit whilst continuing to work on the 2021/22 submission.

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 97.97%

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
99.5%	96.8 %	97.3%	96.3%	0

East Sussex Health Trust (ESHT) achieved an overall accuracy percentage of 97.97% highlighting 2.03% 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 specialties
- Encourage coders to pay more attention during the data extraction stage.
- 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 2021 and December 2021 2,040 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 2021 to December 2021)

Reporting period	Number of deaths
Q4 2020/21: January 2021 to March 2021	739
Q1 2021/22: April 2021 to June 2021	378
Q2 2021/22: July 2021 to September 2021	424
Q3 2021/22: October 2021 to December 2021	499
Total: January 2021 to December 2021	**2040**

Number of case record reviews or investigations
By 12/05/2022, 2,039 case record reviews and 170 investigations had been carried out in relation to the 2,040 deaths. In 170 cases, a death was subject to both a case record review and an investigation.

Number of case record reviews or investigations per quarter (January 2021 to December 2021)

Reporting period	Number of case record reviews or investigations
Q4 2020/21: January 2021 to March 2021	739
Q1 2021/22: April 2021 to June 2021	378
Q2 2021/22: July 2021 to September 2021	423
Q3 2021/22: October 2021 to December 2021	499

Two deaths, representing 0.098% of the patient deaths between January 2021 and December 2021, 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 2021 to December 2021)

Reporting period	Number of patient deaths considered likely to be avoidable	Percentage of the patient deaths considered likely to be avoidable
Q4 2020/21: January 2021 to March 2021	1	0.135%
Q1 2021/22: April 2021 to June 2021	0	0%
Q2 2021/22: July 2021 to September 2021	1	0.236%
Q3 2021/22: October 2021 to December 2021	0	0%

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:

Of the 2 cases identified, both were reviewed by SJR methodology, at the specialty M&M Meeting and at the Trust quarterly review meeting. One was included in the Trust's wider investigation concerning inpatient covid acquisitions.

1. This was investigated with an Amber review. The predominant learning from this incident was the need to transfuse urgently in cases of major haemorrhage, even before the site of bleeding is known, and where other pathology is suspected as well.

2. This was a hospital-acquired covid infection. The infection occurred during an intense wave of Covid, causing severe pressure on beds, with a very high positive inpatient population, impossible to completely isolate from other patents. This case was included in the Trust wide thematic review of deaths during the first and second waves of the Covid pandemic, which is still ongoing with anticipated completion in June.

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:

- As result of the learning from the first case, a trauma training update, incorporating clinical scenarios, has been provided to the relevant ED (Emergency Department) staff. Update training has also been provided for the major haemorrhage pathway. The of the amber investigation was discussed at the Weekly Patient Safety Summit, and the learning distributed to other Divisions.

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

The enhanced trauma and major haemorrhage training will improve the effectiveness and timeliness of interventions in cases of severe bleeding, but also the response to trauma admissions and major haemorrhage episodes both in the gateway areas and when instances happen in the inpatient areas.

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

34 case record reviews and 26 investigations were completed after 12/05/2021 which related to deaths in the previous reporting period (January 2020 to December 2020).

No deaths in the previous reporting period, which were reviewed or investigated after 12/05/2021, 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 2020 to December 2020) judged more likely than not to have been due to problems in the care provided to the patient, remains the same.
There were three deaths representing 0.165% of the patient deaths between January 2020 and December 2020 judged more likely than not, to have been due to problems in the care provided to the patient.

Seven Day Hospital Services

The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall, there are ten clinical standards for 7DS, of which four clinical standards were made priorities for delivery by NHS England (NHSE) and NHS Improvement (NHSI). Improvement in delivery against the four priority 7DS clinical standards was identified as an improvement priority from 2018/19 onwards. The Trust was able to demonstrate that it had reached compliance on all 4 core standards in April 2020.

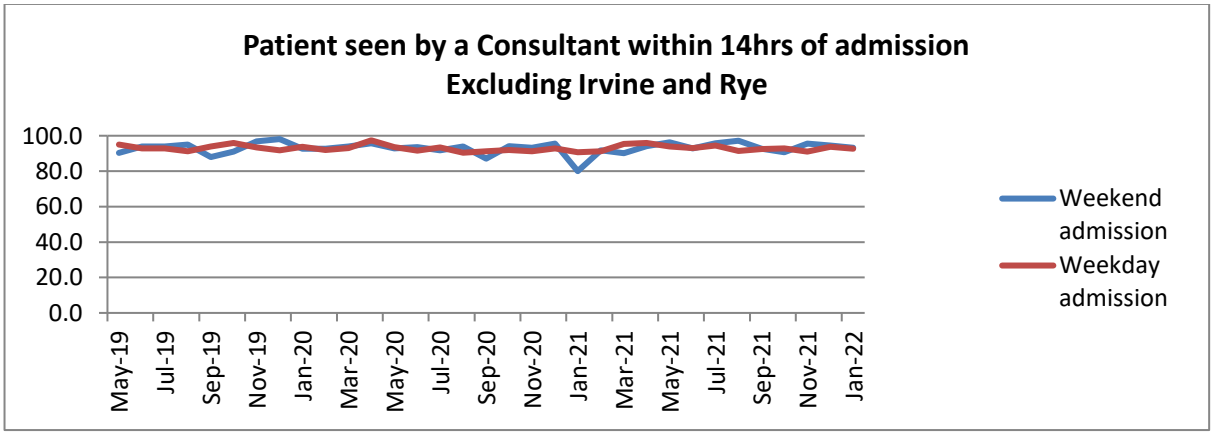
Trust aims

- To ensure that the Trust can continue to meet the 4 priority standards
- Nervecentre (live bed state system) to be used across the Trust to maintain the record of board round decisions
- The review needs of individual patients are determined, agreed, documented and reassessed regularly at ward rounds or the daily board round.

Core Standards

Standard 2 – time to first consultant review

- Since November 2018, we have monitored the rate of review within 14-hour standard, by ward, on a monthly basis as part of the “Excellence in Care” programme. This samples between 400-460 inpatients each month. Apart from a slight dip in weekend performance in September, overall compliance with Standard 2 has remained above 90% over the last year, despite the difficulties of dealing with the successive waves of Covid and the number of additional beds open to maintain patient flow. Weekday 93.2% and weekend 92.6%



Standard 5– Access to consultant-directed diagnostics

- The 24/7 endoscopy rota, which originally went live in 2019, has been challenged by ongoing consultant staff vacancies over the last year. It is fully operational from Friday to Sunday but out of hours provision is less robust from Monday to Thursday. As further consultant staff are recruited, we hope to be able to re-extend provision.

Standard 6– Access to consultant-directed interventions

- Other than the endoscopy rota, access remains unchanged.

Standard 8 – Ongoing consultant-directed review

- In 2020, just prior to the first wave of Covid, cross site audit of the wards cross-site audit of inpatients confirmed overall compliance, though a small number of specialties were challenged.
- During the first and second wave Covid escalation, daily reviews were undertaken by consultants. Since the covid escalation arrangements were reversed and the majority of wards moved back to normal working patterns, documentation of delegated consultant review has become less clear and has remained a challenge. Daily consultant led board rounds discuss all patients, and which patients require more intensive review, though documentation of this is variable.
- Review lists for patients that require daily review, by what grade of staff, over the weekend are generated for the on call and Hospital at Night teams.

Nervecentre roll-out

- **Nervecentre** has been now been rolled out to all the inpatient wards. This has, as hoped, become a fundamental tool supporting clinical review and patient flow, as well as providing ready access to patient observations, real time reminders of what tasks need to be undertaken, a wide variety patient alerts, escalation advice and the detailed supporting information for the daily board rounds. In particular, it supports the early recognition and escalation of deteriorating patients, enabling prompt intervention.

Review of individual patients' needs

- **Daily Board Rounds** incorporate the individual patient information and plans are recorded and updated on Nervecentre, in addition to the written notes made in the inpatient patient noted folder.

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

There are over 800 Freedom to Speak Up Guardians in nearly 500 organisations, including the NHS and independent sector organisations, clinical commissioning groups, hospices, professional bodies, regulators and elsewhere. The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's 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.

Two Freedom to Speak Up Guardians are substantively employed at ESHT to support staff to raise concerns when they feel that they are unable to in other ways, and to promote a healthy speaking up culture. Freedom to speak up is part of the NHS Standard Contract and the CQC well-led inspection.

From April 2021 to April 2022, 230 cases were brought to the ESHT Guardians. Nurses and healthcare assistants were the professional groups with the highest contact rates, followed by administrative and clerical staff. The common issues raised to the ESHT Guardians have been broadly in line with those cited across organisations nationally.

Whilst concerns raised in 2020 were largely related to Personal Protective Equipment (PPE), risk assessments and redeployment, these themes became less prominent in 2021 and there was an increase in issues related to poor conduct – certainly heightened by staff anxiety and fatigue. As the pandemic continued through waves, concerns regarding self-isolation, management of caring responsibilities and working with family self-isolating and the ensuing childcare disruptions became more frequent. The FTSUG's also received a significant number of calls in relation to the mandated vaccinations for staff in the community attending care homes and Nursing homes. These concerns were fed through to Human Resources (HR) and Staff Engagement and the FTSUG's supported the mandated Covid Vaccination Group.

A number of workers perceived inconsistencies in the way that working from home and leave requests were applied across the divisions. The Guardians endeavour to work closely with HR business partners to seek assurance and resolution in these instances. Bereavement, loss and the fears of our international staff for the wellbeing of their relatives abroad compounded an already fatigued workforce and a worsening of behaviours with an increasing number of incidents of micro-aggression between staff were recorded. The Guardians meet regularly with divisions and HR business partners to review the Datix incidents citing staff on staff aggression to ensure timely and robust responses. The Guardians are also part of the Trust's bullying and harassment subgroup.

For the first time in 2021, the NHS staff survey included a question which asks respondents if they feel safe to speak up about anything that concerns them in their organisation, with 66% nationally 'agreeing' or 'strongly agreeing' with this statement. Within ESHT, our score for this question was 66.9%. Since the start of 2020, over 84% of workers who gave feedback to Guardians nationally said that they would speak up again. In ESHT, the percentage was higher with 97% of respondents saying that they would speak up again.

The Freedom to Speak Up index survey is a metric widely used to measure the speaking up culture of an organisation. The results of the index are based upon questions extracted from the staff survey. The Freedom to Speak Up (FTSU) Index is one of the indicators that can help to build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns, and if they agree they would be treated fairly if involved in an error, near miss or incident. The latest survey showed that ESHT achieved an index score of 80%; this has remained consistent for the last 2 years. The Guardian's office suggests that a score above 70% is indicative of a healthy speak up culture.

Regular liaison between ESHT Guardians and HR business partners, OD and staff engagement, occupational health, chaplaincy teams and pastoral fellows facilitate the sharing of soft intelligence regarding staff wellbeing, patterns and trends. This provides valuable insight to help the identify areas which may benefit from targeted support. Walkabouts also enable the Guardians to informally drop-in to acute and community areas to speak directly with staff and to promote the speak up culture.

Given the national increase in appointment of Guardians, this affords an opportunity to network locally and nationally across all sectors, sharing examples of practice and looking at comparable data. ESHT Guardians have attended online national, regional and pan-sector meetings, and participated in case reviews and webinars delivered by the national guardian office. During Speak Up Month in October, all

ESHT workers were invited to access a series of weekly lunchtime, online webinars related to the topic of speaking up.
Wherever possible, the Guardians promote local and timely resolution, enabling staff to safely and professionally articulate their concerns, providing scaffolding to enable challenging, respectful conversations to take place. We recognise that persistent poor conduct negatively impacts upon

individual and team wellbeing and functioning. Our aim is to give consistent support, intervention and advice as well as signposting to mediation and/or wellbeing services as needed.

Staff Health and Wellbeing

We have continued to support the physical and emotional wellbeing of all our colleagues. Our menu of support has adapted to the needs of our workforce over the pandemic, and we have continued to focus on the things our people are telling us, make the biggest difference.
Our work with supporting teams and individuals with evidence based psychological support continues to be offered and accessed by 37 of our teams. When Covid-19 Vaccination as a Condition of Deployment was introduced in December we swiftly developed, in collaboration with our HR colleagues, a wide range of resources to support and enable staff to make an informed decision.

We have to provided snacks and refreshments to those critical teams such as Intensive Therapy Unit (ITU) and Emergency Departments as well as supporting the escalation wards and redeployed staff groups. The feedback has been that these small gestures have the biggest impact and make staff feel valued. We recognise the ongoing challenges faced by our emergency department colleagues with increased activity and an increase in incidents involving violence and aggression from the public, therefore those provisions will remain in place beyond March 2022. We now have 20 fully trained Traumatic Risk Management practitioners (TRiM). Another cohort of 10 are completing their training at the moment with ongoing dates to be agreed. 38 incidents have been referred for TRiM, with an increase over the past few weeks due to staff awareness. 76 staff accepted the TRiM intervention and have undergone the initial TRiM session following a potentially trauma event either in a group or 1:1 session. 51 attended for a 1 month follow up and 16 staff for a 3 month follow up (most staff feel they do not need a 3 month follow up as the intervention has already provided sufficient support)

We trained 135 staff in the Mental Health First Aid qualification and a further 145 are planned for 2022/23. This will support the Wellbeing Conversations.

We have provided 105 health checks in conjunction with One You Sussex for our Over 55 years workforce, helping those people to make informed decisions about choosing a healthier lifestyle and making positive changes. The support linked to menopause continues with café style drop ins / online support and further communication regarding the support available. With our workforce made up of 819 women aged 47-51 and 2,184 over the age of 51, this support and advice is paramount and linked to our recruitment and older workforce work. Our focus also remains on men's health particularly mental and physical wellbeing. We have made bids for external funding to look at programmes of support and plan to work with specific groups and disciplines.

We have used external funding from the League of Friends to support 130 teams to enhance their break / rest areas.

We opened a new nursery building in January 2022 at the Conquest site. In February 2022 Ofsted inspected for the first time since 2017. The nursery maintained its "Good" judgement with only two recommendations. The inspector stated in their feedback "it is very clear that the organisation and the nursery staff have put wellbeing at the heart of what they do. The financial support for parents back in 2020 and the ongoing wellbeing check in's with families, who we recognise as NHS staff and who

would have been at the forefront of the pandemic is wonderful to see and would have supported their wellbeing"

We have continued to support managers and teams involved in bereavement of colleagues and also expanded our support package with new guidance to include a new process and support and acknowledgment for any bereavement and the effect it can have.

We have now formed a robust subgroup linked to the main violence and aggression steering group which will focus on colleague-on-colleague harassment and bullying incidents. The focus will be to engage and work together with staff to develop solutions and make improvements, contributing to a transformational change in culture.

We have secured external funding to pay for this wellbeing initiative. Project Wingman is a charity founded in March 2020 in direct response to the Covid 19 and came together to explore how grounded airline crew from all airlines could support NHS staff. They offer their time, knowledge, and skills to serve and support NHS staff, providing vital well-being and mental health support. They were on site at the EDGH from August 9th until 20th August and dates are arranged for visits to the Conquest site for 2022. Any staff member can visit the bus between the hours of 10am – 4pm Monday to Friday and experience a 'first class' break, which includes being served refreshments by an airline steward or even the captain! We also have plans for a similar initiative for the community site at Bexhill and are awaiting dates.

The Trust Board and directors really value the work all colleagues do, and a 'buddy' scheme has been introduced where board member's visit wards and departments to meet colleagues to understand more about what their roles involve.

Carers week provided support and advice for staff who have caring responsibilities. Carers passport launched and staff continued to encourage staff to complete.

Schwartz Rounds sessions have continued throughout pandemic with session via Microsoft teams – 387 attended sessions

Compassion without burnout sessions taken place provided to enable staff to recognise the causes and signs of burnout and to proactively to explore ways in which work-related burnout can be minimised while delivering compassionate care and provides a safe space for reflection.

Staff Survey

Our response rate was 48% compared with the national average of 44.7%
The National picture shows a decline in staff who work for the NHS feeling valued.
The Trust results compared to other similar organisations are good. In the whole survey we had 41 questions that scored significantly better than other comparable organisations. 56 questions where we were similar.

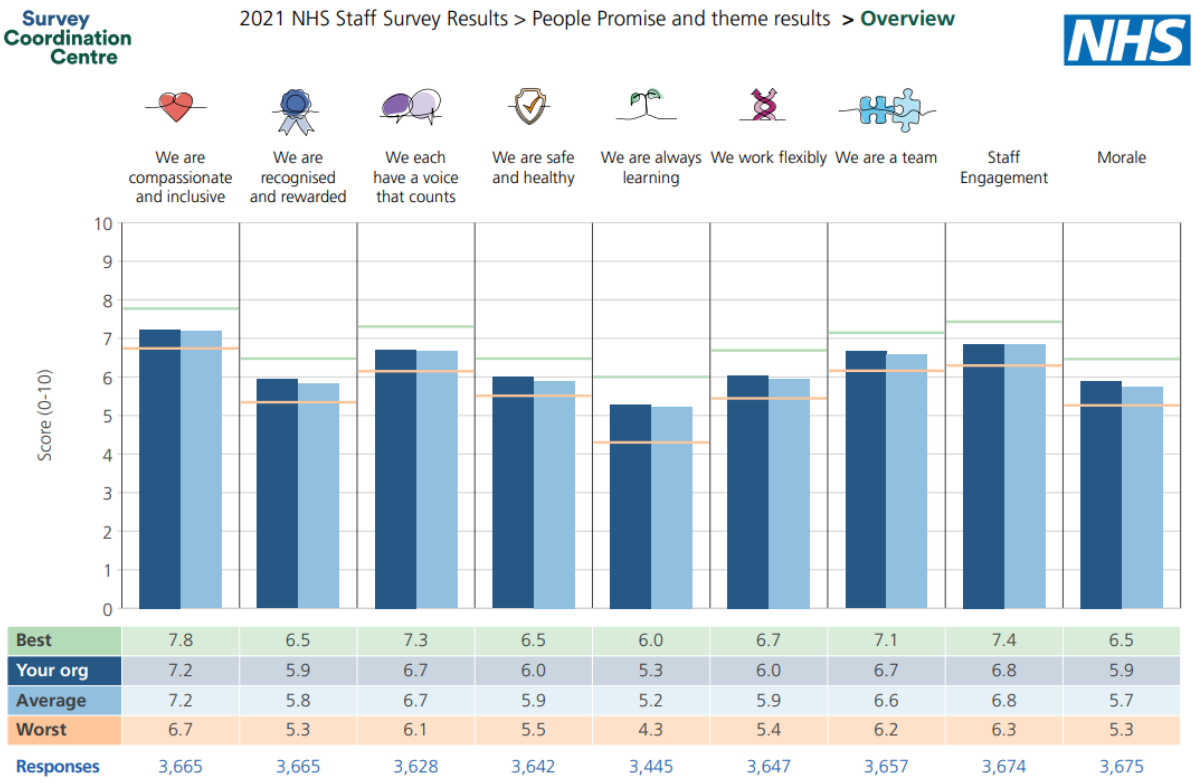
Positive messages:

- **'We are compassionate and inclusive'** 87% of our people feel their role makes a difference to patients/service users

- **'We each have a voice that counts'**
- 75% feel secure in raising concerns about unsafe clinical practice but acknowledge that there has been a decline in the number of people who feel unable to raise general concerns
- 73% of our people feel they have frequent opportunities to show initiative in their role

- **'We are always learning'** We are proud that 66% of our people feel they are always learning and have the opportunity to improve their knowledge and skills
- **'We work flexibly'** 66.3% feel they can approach their immediate manager to talk openly about flexible working
- **'We are a team'** 81.3% of our people enjoy working with the colleagues in their team
- **'We are safe and healthy'** We are delighted that we scored significantly higher than the sector relating to our staff experience of burnout.

There is acknowledgement of an increase in the numbers of our staff reporting poor behaviours across the Trust. Our focus on equality, diversity and inclusion continues and we continue to champion our values and behaviours that underpin those values.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.2	5.9	6.7	6.0	5.3	6.0	6.7	6.8	5.9
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,665	3,665	3,628	3,642	3,445	3,647	3,657	3,674	3,675

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 and be involved in effective change.
- Using People Pulse results (which were introduced in late 2021) as a source of intelligence to inform and signpost to areas for improvement in staff working life, wellbeing, conditions and work environment.
- Embedding the elements of NHS People Promise and delivering on the objectives laid out in the plan to support and our workforce
- Following the onset of the pandemic in March 2020 and during 2021, the Organisation Development (OD) team responded positively and flexibly to the significantly changed workplace conditions by: canvassing key leaders across the Trust on how we might best engage and support them in fulfilling and developing into their leadership and management roles throughout this time. Considering all we heard, we took the difficult decision to pause a number of leadership programmes on offer (Leading Service/Leading

Excellence and our High Potential Programme); we provided a new range of bespoke and general leadership and personal development activities; and adapted existing programmes to be delivered in a virtual learning environment. Following this a catalogue of programmes and supportive activities has subsequently emerged; primarily designed internally and delivered to Trust colleagues with some extending beyond our organisation to support both our local and wider health and social care system across Sussex

The Organisational Development and Staff Engagement and Wellbeing Teamwork with the Human Resources Business Partners / Occupational Health/ Divisional and Service leads to increased awareness and develop capability for continuous improvement across the Trust

Part 3 - Review of Quality Indicators and our Priorities for Improvement in 2021/22

Part 3.1 – Our Priorities for Improvement in 2021/22

The Trust identified three quality improvement priorities for 2021/22 to contribute towards the delivery of our Quality and Safety Strategy.

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 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

Patient Safety Improvements 2021/22

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 measurable 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?

This was undertaken by undertaking a review of the last 5 years for the Trust gap analysis in line with the impending National Patient safety Strategy. The key 5 areas have been highlighted in the gap analysis and in our action plan for 2022/23. The changes to the Serious Incident Framework (SIF) to the new Patient Safety Investigation Reporting Framework (PSRIF), changes to Strategic Executive Information System, (StEIS) and NRLS to Learning from Patient Safety Event (LfPSE) and thematic reporting.

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 and supported and monitored by the Patient Safety Team.

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 because 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 area was ‘overtaken’ with the development of Learning from Patient Safety Events (LfPSE) and the impending changes of the reporting incidents database

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. The Trust has agreed to changes to the Trust incident reporting database to i-cloud module so that the Trust will be compliant with the National changes to StEIS, National Reporting and Learning System (NRLS) and LfPSE live platform.

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 remained a key measure for infection prevention and control during 2021/22.

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 United Kingdom Health Security Agency (UKHSA).

Individual patient documentation dedicated IPC assessment page.

Nervecentre has been significantly developed to include infection control advice about all infections and to show COVID-19 status. Smart lists show detail on COVID-19 positive/suspected/exposed/recovered patients. This provides live information on patients with COVID-19 in our hospitals to support both IPC and 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. The IPC has updated documentation as guidance has changed during the year.

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.

There has been increased emphasis on the hierarchy of controls, reducing exposure to COVID and putting in place controls to minimize transmission including improving ventilation, use of hepa-filters for improved air quality, Perspex screening for social distancing.

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. Over 4,500 staff are fit tested to at least one FFP3 mask and additional powered respiratory hoods have been procured for use when staff require this level of respiratory protection and either choose not to or cannot wear a fit tested mask.

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 and update training offered to clinical teams throughout the year.

IPC has maintained very close working with the operational and incident management teams to inform operational decisions. Working collaboratively with IPC colleagues in acute, CCG and local authority as well as care home providers.

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 CQC National Inpatient Survey, our own internal complaints and inpatient questionnaires highlighted a number of areas where improvements could be made to discharge processes, including communication and information provided to patients about the discharge process.

Last year as part of a Quality Account priority, a Multidisciplinary Discharge Improvement Group (MDDIG) 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

Our aims

- 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.
- Analysis data to identify areas of focus (work streams were identified as- communication, process, medication and training and education).
- Key projects under the four work streams 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.

How have we done?

Communication

This work is down into external stakeholders regarding Transfer of Care (pathway one, two and three patients) and to patients about their discharge from hospital (pathway zero patients).

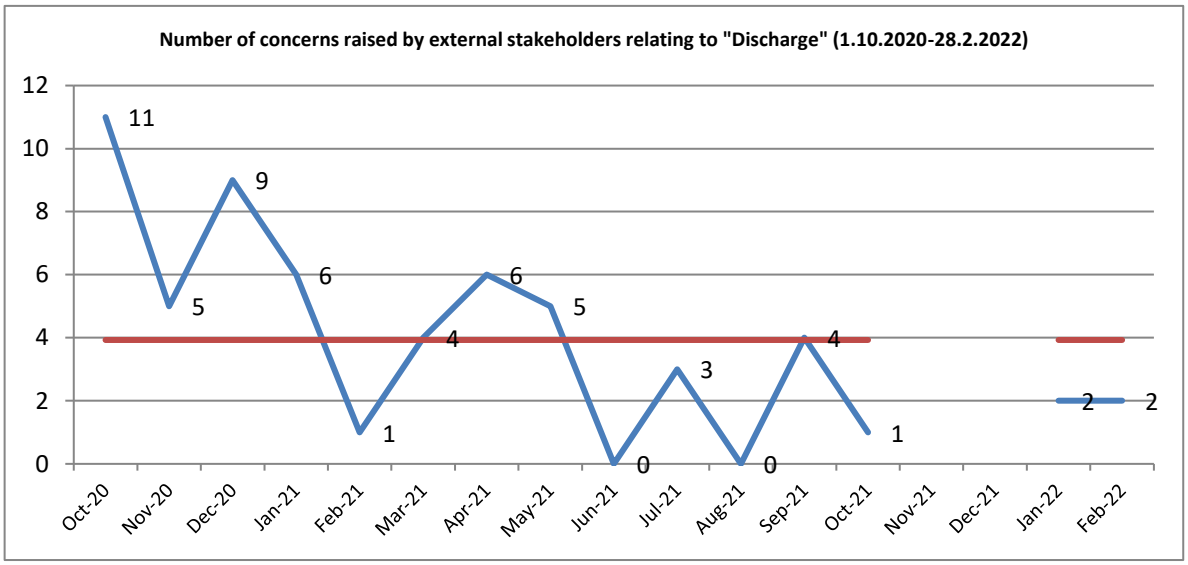
It was fed back to ESHT from external stakeholders that the verbal handover of a patient was not always accurate or included information required for ongoing care. A Head of Nursing has co-developed (with the multidisciplinary team and external stakeholders), piloted, and launched a Transfer of Care document which is completed by the Nurse who is discharging the patient.

CQC National Inpatient Surveys and local Friends and Family Survey results demonstrated that patients are not always sure who to contact if their condition deteriorates or what their

follow up arrangements are. A personalised patient discharge letter was developed and piloted on a surgical ward where they have high numbers of pathway zero patients. Whilst the feedback was positive from both the Nurses and Patients a concern from the Nurses was the time it took them to complete the form. It has been decided that this pilot will be extended to another ward to complete a time and motion study and to assess against the benefits.

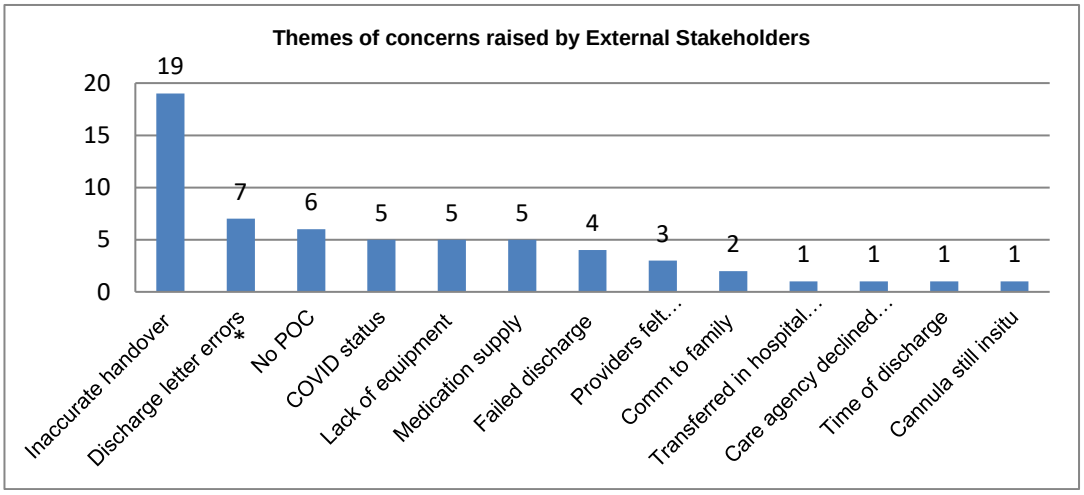
Discharge Summary provided to GP's was reviewed by the Deputy Medical Director and meets the required standards. The vision is to develop a Multidisciplinary discharge summary this has been incorporated into the digital scoping work with Electric Patient Record Team.

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 work streams to drive improvement. Quarterly reports were presented to MDDIG and Patient Safety and Quality Group which demonstrate less concerns being sent into ESHT over the last 6 months.



Due to a change in management within Adult Social Care (ASC) the process was amended to reflect the change in their processes. ASC encouraged care providers and patients to raise concerns directly to Patient Advice and Liaison. This has now become the business as usual route for raising concerns.

The table below shows the themes of concerns raised (some concerns raised had multiple themes):



*POC= Package of Care

It is hoped that with the development of the Transfer of Care document should reduce the number of concerns raised regarding the following themes:

- Inaccurate handover.
- COVID status.
- Lack of equipment
- Medication supply.

This document was launched on the 25th February 2022; at the time of writing this there has not been enough time to see a decline in this theme.

The discharge checklist is now available on Nervecentre and is due to be rolled out across the inpatient's areas by the end of April 2021. It is hoped this will address the following themes:

- Ensuring the families are communicated with regarding discharge arrangements.
- Clothing worn when patients are transferred.
- Cannulas removed prior to discharge.
- Medication supply.

Discharge Process

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 (rolled out on the 25th February 2022);
- 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 Division 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. The future of the Discharge Hubs is currently being considered as part of the 2023 plans.

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.

Medication

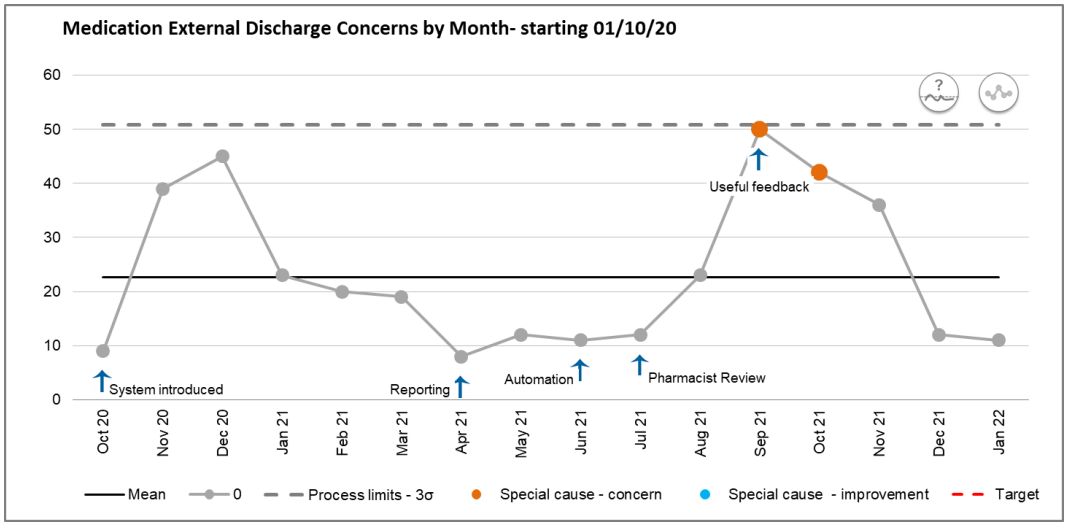
Analysis of data was completed to identify where improvements were needed to be made specifically relating to medication on discharge.

There is a medicines helpline, which is an established mechanism for patients to contact the Trust with queries about medicines provided at discharge. This was temporarily extended to healthcare professionals to collate data about discharge concerns. Analysis of the calls received and a deep dive into reported medication incidents showed the following key issues:

- incorrect 3-point checks, which should be undertaken on discharge
- incorrect discharge summary information about medicine changes
- prescribing incidents through discharge summary transcribing

Achievements to facilitate these improvements were:

- 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.
- The roll-out of a single point of contact for obtaining support for discharge and supply from pharmacy on both acute hospital sites.
- A new business continuity plan for acute clinical pharmacy services that optimises medicines reconciliation and supply around clustered arrangements
- Development and use of Nervecentre to improve medicines reconciliation rates and highlight discrepancies for resolution prior to discharge.
- Development and roll-out of Nervecentre workflows and metrics to direct proactive pharmacy support to Transfer of Care including discharges.
- Development of a new medicine's reconciliation process within electronic Prescribing and Medicines Administration (ePMA) that captures all changes made on admission and during a patients stay.
- Testing and deployment of the new process as part of the ePMA project.
- Review and renewal of doctor's induction materials for medicines history taking / reconciliation, discharge processes and the ICE discharge system.
- A new 'business as usual' process for lead pharmacists to review and liaise with primary care colleagues around external discharge concerns.
- Piloting, during COVID-19, the testing of remote pre-admission medicines reconciliation for elective surgical patients.
- A scoping exercise into secondary care discharge and primary care repatriation for frailty patients.
- A two-week pilot and feasibility study into 12 hour pharmacy services to Emergency Departments and acute medical units in November 2020.
- Scoping support required for the Emergency Department / Ward interface around medicines reconciliation from pharmacy.



External discharge concerns involving medication reported via the internet portal: After initial excitement about giving feedback numbers declined. An automated feedback loop allowing immediate response, investigation and implementation of improvements is the expected cause of the increase in reported concerns seen in September 2021 and the subsequent decline.

3 Point Check – Quality Improvement Project

The 3 Point Check is the final process and opportunity to ensure that patients have the correct medication and information on discharge from hospital. It involves systematically checking that all 3 of the following correlates prior to discharge:

1. The Prescription Chart/ medications that the patient has been receiving whilst in hospital
2. The medications listed on Discharge Summary to the GP
3. The medications and information provided to the patient

A review of incidents reported on Datix and feedback from our stakeholders identified that there was no recorded evidence of the 3-point check being undertaken prior to discharge. Therefore, a small working group was established to test if consistently applying the 3-point check in a standardised way on discharge would lead to a reduction in medication errors on discharge.

The test of change involved monitoring the discharge medications and information provided for patients discharged/transferred to our intermediate care units (Bexhill Irvine Unit and Rye Memorial Hospital).

A 4-week audit/data collection period was undertaken before and after the quality improvement interventions was applied, to determine if any improvement or reduction in medication errors could be achieved. The type and number of errors in the initial benchmark audit data were similar regardless of the origin or discharging ward location. The following wards were selected to test the change as they discharge patients most frequently to the intermediate care unit due to their specialty.

Egerton ward – Conquest (Orthopaedic)

East Dean ward – EDGH (Stroke unit – acute care)

Sovereign ward – EDGH (Stroke unit - step – down care)

Face to face training in systematically undertaking and documenting the 3 point check on discharge was delivered and cascaded to all registered nurses on these wards. After completion of the training the repeat audit was undertaken, and the findings analyzed and reported to the MDDIG.

Improvement was found in the reduction of errors for discharges for patients from the stoke unit but less so for the discharges from Egerton ward. The matrons from all 3 wards reported an increase in awareness of staff and identification of medication errors that otherwise would have been missed. It was recognised that recording the number and type of errors identified before and the intervention would have been helpful.

The project was hampered in its size and duration due to the Covid – 19 pandemic. Ideally the group would like to have had the opportunity to collect more information on a larger sample group. However, given the constraints the MDDIG agreed the recommendation of the working group that it was a reasonable assumption to make that if the 3 Point Check was applied in a systematic way across all wards there would be a reduction in medication errors on discharge of patients from hospital.

Recommendations for embedding the QI trust wide:

1. Training & Education Group to introduce routine training/education in how to undertake a 3 Point Check effectively for all registered nurses working on in patient wards. This would ideally be part of a suite of training related to discharge. Mode of delivery may need to be adapted for the trust wide delivery.
2. A review of the trust TTA (To Take Away) Policy, the 3-point check process and how

we provide information to patients once Electronic Prescribing & Medication Administration (EPMA) has been implemented across the organisation.

Training and Education

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 2021/22.
- In August 2020, all junior doctors were provided with a bespoke training session on the importance of discharge planning and the discharge summary, this is now business as usual training package.
- 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.

Further improvements identified

MDDIG has been made up of a wide range of the Multidisciplinary Team and external stakeholders. The successes of this group have been described in the text above and some of the work has been transferred to the operational teams and will now be led and transferred to business as usual.

MDDIG will hold its last meeting in March 2022 but ongoing improvement work addressing “Discharge” will continue to be progressed and be at the forefront of services.

Our work to improve “perfecting discharge” continues, and includes:

- Extending the personalised patient discharge letter to another ward to complete a time in motion study and to assess against the benefits.
- Continue to observe the theme “inaccurate handover” to ensure that the transfer of care document has improved the situation.
- Discharge Summary provided to GP’s was reviewed by the Deputy Medical Director and meets the required standards. The vision is to develop a Multidisciplinary discharge summary this has been incorporated into the digital scoping work with Electric Patient Record Team.
- Continue to develop the pathway for discharging Homeless patients.
- Discharge Check in Service, review as funding is due to cease end March 2022.
- IDT screening tool - initial review completed and rolled out as part of business as usual for therapies. Next step is to consider wider Multidisciplinary Team engagement with providing 'description of need' for patients requiring additional support on discharge.

Part 3.2 – 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 2021/22.

The percentage of patients aged 16 and over admitted in the year who were assessed for risk of VTE on admission to hospital 2021/22 ESHT achieved **91.36%** 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
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	17.0 *22.6

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 21/22 surveillance report had not been published.

Clostridioides difficile Infection (CDI) mandatory surveillance from 2021/22

The way that organisations are required to report CDI has significantly changed to include prior healthcare exposure. The CDI reporting algorithm from financial year 2020/21 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 69 cases against a limit of 58 for 2021//22.

Performance

Publication of the annual surveillance report have been delayed due to the COVID pandemic and the thresholds were released late in the Year.

A total of 69 cases were attributed to ESHT for 2020/21 which is higher than the threshold. This number does not take account of the increased number of beds and occupancy during the COVID pandemic. Much of the exceedance occurred in the first two quarters of the year and improvement followed.

Official data for 2021/22 has not yet been published due to the COVID pandemic. The PHE data capture system shows ESHT has a hospital onset healthcare associated (HOHA) rate of 17.0 for the financial year April 2021-March 2022. There is no ability to show a rate that includes prior healthcare exposure. The rate represents 52 C. difficile infections that are HOHA, there were also 17 community onset healthcare associated infections related to prior healthcare exposure within 28days of the result.

The reason for increased numbers of CDI is not fully understood but is believed that the COVID pandemic has had a negative impact. Post infection review has been undertaken on many of the hospital onset cases although this has been more difficult to achieve due to the additional workload of the COVID pandemic. All cases have been sent for ribotyping to assist with detecting outbreak and there is no evidence that the cases are a result of cross infection or outbreak.

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

The data from the National Reporting and Learning System (NRLS), NHS Improvement is only available up to the 31st March 2021.

*ESHT has robust data quality assurance process in place but is awaiting validation of the data for 2021 – 2022 by NHS Improvement and acknowledge that Covid-19 impacted on severe and death incidents.

Indicator NRLS Data	National Average	Best Performers	Worst Performers	ESHT 19/20	ESHT 20/21	ESHT* 21/22
	01/04/2020 31/03/2021	01/04/2020 31/03/2021	01/04/2020 -31/03/2021	01/04/2019 31/03/2020	01/04/2020 31/03/2021	01/04/2021 31/03/2022
Rate of patient safety incidents reported per 1,000 admissions	58.4 (12502 incidents reported	27.2 (3169 incidents reported)	118.87 (32917 incidents reported)	39.0 (9570 incidents reported)	46.4 (9012 incidents reported)	36.8 (10037 incidents reported)
% pf patient safety incidents that resulted in severe harm or death	Severe 0.3%	Severe 0.0%	Severe 1.0%	Severe 0.5%	Severe 0.2%	Severe 1.9%
	Death 0.2%	Death 0.0%	Death 1.8%	Death 0.3%	Death 0.3%	Death 1.9%

ESHT has the following systems and processes in place to improve the number and rate of incidents reported, which will have a positive impact on the quality-of-service delivery:

- The management of investigation of severe and serious incidents is centralised and is embedded in the Trust with an ongoing improvement in the quality of investigations.
- Serious incidents (SI) are all managed in accordance with national legislation timescales.
- Progress of Amber (up to moderate) and SIs (severe and catastrophic) are monitored by the Weekly Patient Safety Summit.
- Actions resulting from SIs and Amber investigations are monitored with updates on the number outstanding provided to the Patient Safety and Quality Group.

Clinical Effectiveness Quality Indicators

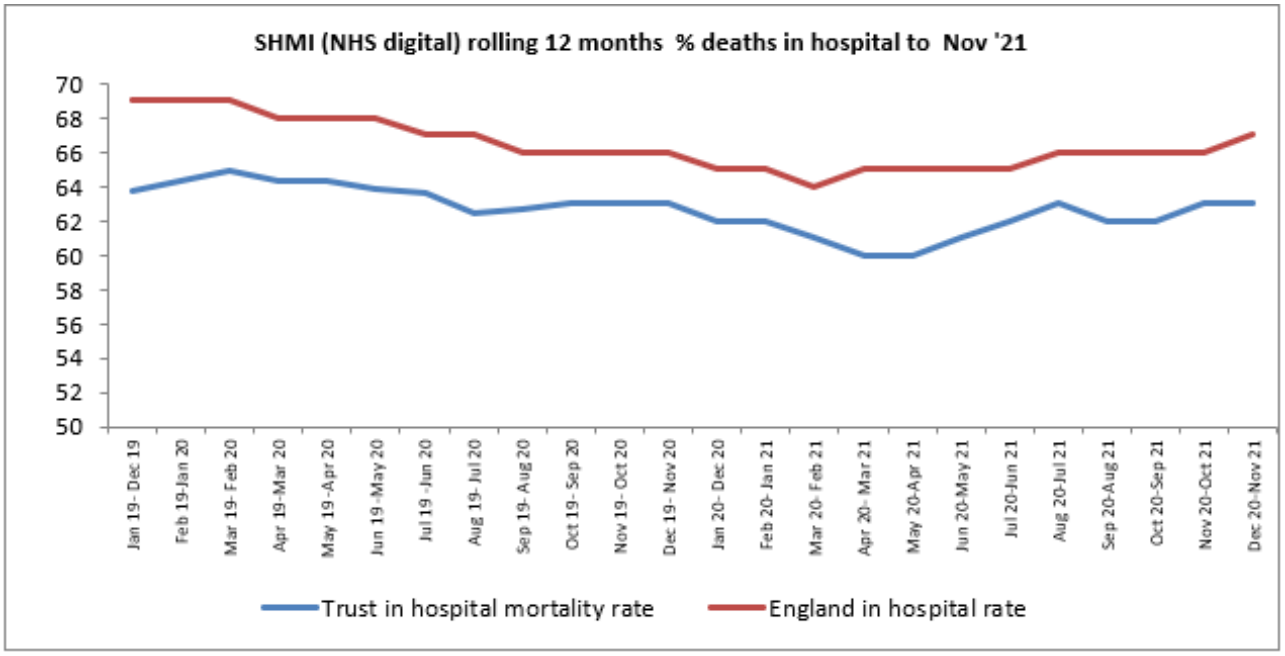
Summary Hospital-level Mortality Indicator (SHMI) Risk Adjusted Mortality Index (RAMI)

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.

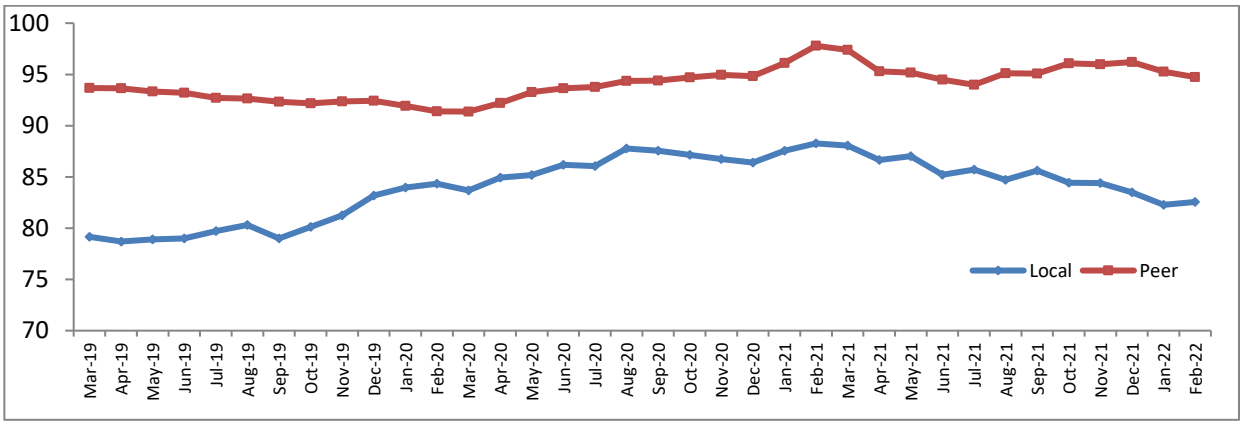
Indicator	ESHT Jan 15 – Dec 15	ESHT Jan 16 – Dec 16	ESHT Jan 17 - Dec 17	ESHT Jan 18 - Dec 18	ESHT Jan 19 - Dec 19	ESHT Jan 20 - Dec 20	ESHT Dec 20- Nov 21
SHMI value	1.14	1.09	1.04	0.97	0.97	0.96	0.96
Banding	1 (higher than expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (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	42

Source: NHS Digital

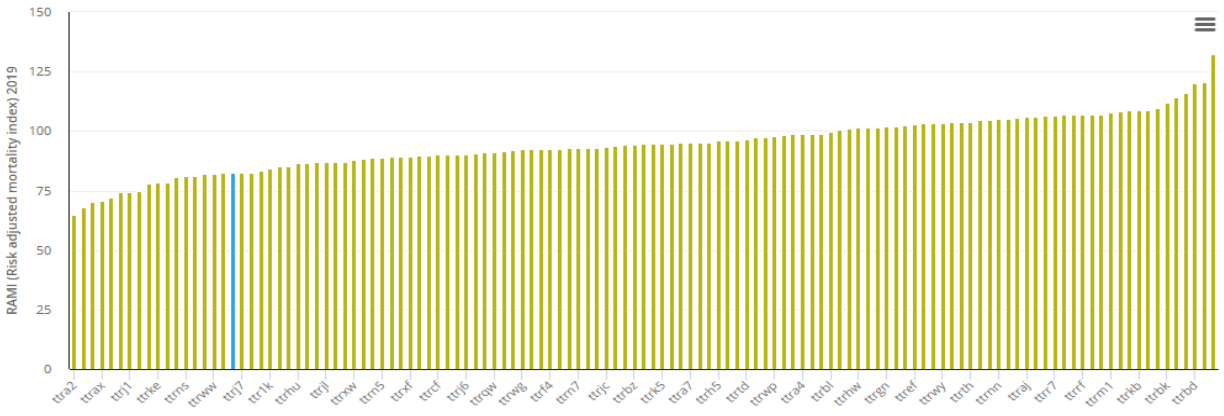


RAMI

Risk Adjusted Mortality Index (RAMI 19) rolling by month: March2019 – February 2022



RAMI v Peer: our position against other acute trusts Rank 17/124



ESHT has taken the following actions during 2021-22, 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.
- Increased the number of doctors resident at night.
- Improved provision of ambulatory emergency care (AEC), with units open on both sites, taking patients from Emergency Department and allowing more rapid senior input throughout the week.
- Maintained focus on the recognition and rapid treatment of Sepsis and Acute Kidney injury (AKI).
- Extensive infection control measures and streaming, especially during the pandemic.
- Provided timely senior decision making at ward level through multidisciplinary daily board rounds, led by the consultants.
- Improved handover for acute teams using Nervecentre for handover, task allocation, and patient tracking.
- Rolled out Nervecentre across the inpatient areas on both acute sites, 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.
- Introduced the Nervecentre Hospital at Night module, increasing the effectiveness and responsiveness of the Hospital at Night (H@N) team.
- Increased recognition of frailty, with specific documentation of this in the Integrated Patient Document (IPD). Rockwood frailty scoring is now standard in the gateway areas and incorporated in Nervecentre Documentation.
- Introduced Electronic Prescribing (EPMA) in a number of areas and is being rolled out across the hospital sites, along with an accompanying training programme. This increases the accuracy and safety of medication prescribing and administration.
- Overview of Trust mortality indicators is provided by the monthly Mortality Review Group, reporting to 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.
- The quality of mortality reviews is monitored monthly.
- More in depth reviews are carried out, using the Structured Judgement Review methodology (recommended by the Royal College of Physicians) in cases referred to the Coroner, and for deaths in patients with learning disability, to support the regional Learning Disability Mortality Review Programme (LeDeR) review system.
- A weekly Patient Safety Forum, chaired by the Medical Director and Chief Nurse, reviews incidents reported on the Datix clinical incident system, determining the level of investigation, to maximise the learning from these episodes.
- Learning from deaths and from clinical incidents is shared across Divisions, specialties, and wards.
- Wards hold regular safety huddles, promoting awareness of patient safety issues and disseminating learning.
- An additional quarterly review group reviews the case notes of all deaths graded by Morbidity and Mortality review as having poor quality of care, and deaths involving serious clinical incidents or complaints, to re-assess avoid ability and promote learning.
- The independent Medical Examiner system is now well established, providing 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.

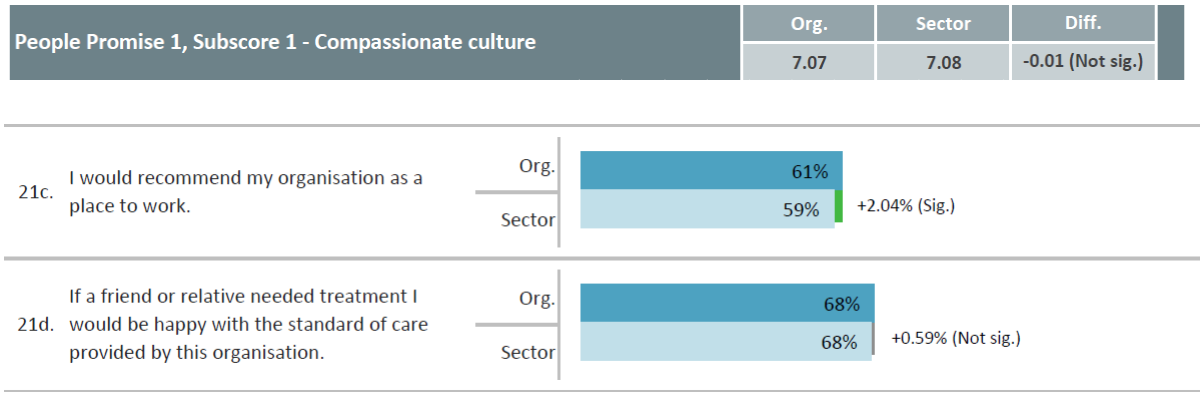
Patient Reported Outcome Measures /Scores (PROMS)

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.

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.



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 and be involved in effective change.
- Using People Pulse results (which were introduced in late 2021) as a source of intelligence to inform and signpost to areas for improvement in staff working life, wellbeing, conditions, and work environment.
- Embedding the elements of NHS People Promise and delivering on the objectives laid out in the plan to support and our workforce
- Established and embedded a Leadership Pathway which supports 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 Teamwork 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

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

Indicator	ESHT 2020
"Your care and treatment"	8.3

*CQC National Inpatient survey was published in October 2021.

The Adult Inpatient 2020 survey is significantly different to previous years' surveys with regards to methodology, sampling month and questionnaire content.
The questionnaire was amended significantly, with changes to both question wording and order. The 2020 results are therefore not comparable with previous years' data and trend data is not available.

Overall it is a reassuring report, although there is no comparable data to previous years as the questions have changed (wording and order of questions). Questions are now banded, and the following have been reported within the report:

Banding (better)

- ESHT results were much better than most trusts for 0 questions.
- ESHT results were better than most trusts for 1 question.
- ESHT results were somewhat better than most trusts for 5 questions.

Banding (worse)

- ESHT results were much worse than most trusts for 0 questions.
- ESHT results were worse than most trusts for 0 questions.
- ESHT results were somewhat worse than most trusts for 0 questions.

Banding (same)

- ESHT results were about the same as other trusts for 39 questions.

Overall, this survey demonstrates patients had a positive experience at ESHT, due to the amended questions we are not able to compare results with previous surveys but it is reassuring that no questions were banded as "much worse", "worse" or "somewhat worse".

An action plan has been created to help address areas where improvements can be made.

The Patient Experience team are looking to create a digital platform for completion of surveys and increase the number of volunteers available to seek the views of our patients/ carers/ relatives/ service users.

This report has been shared widely throughout the trust.

Annexes

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

Statement from Commissioners

Thank you for providing the CCGs with the opportunity to comment on the quality account for 2021/22. We appreciate the ongoing collaborative working, open communication with the Trust's clinicians throughout the COVID-19 pandemic and subsequent recovery period, whilst recognising that during these difficult and challenging times there has been strengthened collaborative working.

The CCG would like to congratulate the Trust for the ongoing positive work being undertaken to improve services for patients through quality improvement and to lead innovatively despite challenging conditions. Some highlights noted include:

- The Trust introduced innovative ways of working during the pandemic in order to continue to provide patient care and some of these will continue, for example, virtual clinics for outpatient services. This has enabled many patients to receive outpatient appointments without the risks and anxieties associated with travel and attendance at hospital, particularly when Covid rates were high in the local communities.
- The Trust has experienced significant staffing challenges during 2021/22 and, despite significant planning and all possible mitigations, there is no doubt of the impact working with a depleted workforce will have had. We acknowledge staff and volunteers who have gone above and beyond during this time, and who continue to ensure provision of care in this unprecedented situation.
- Despite these huge challenges the CCG note that the Trust has made progress towards the priorities set in the 2021/22 Quality Account. We also acknowledge that there was some disruption to the quality improvement work that had been planned but that over recent months this important work has been re-established.
- The CCG recognises that the Trust has worked collaboratively with system partners on services for patients who present to the Trust with significant mental health challenges alongside their physical ill health and we are aware that this work is continuing.
- The investment of the Trust in the wellbeing of its staff with support being available to them via the Occupational Health and Wellbeing Teams is commended.

The Trust has achieved many successes in 2021/22, most notably:

- Patient Safety & Clinical Effectiveness: Embedding Patient Safety.

Undertaking a gap analysis in line with the impending National Patient Safety Strategy, and an audit to review the completed Serious Incident Root Cause Analysis reports over a 12-month period to gain assurance that actions have been completed and learning embedded. It is positive that the Trust identified two staff members to be Patient Safety Specialists.

- Patient Safety & Clinical Effectiveness: Infection Control Excellence.

The ongoing focus the Trust has place in Infection prevention and control, including all patients being risk assessed including for the risk for COVID-19 at triage. The daily outbreak monitoring reporting during the second wave of the COVID-19 pandemic

- Patient Experience, Patient Safety & Clinical Effectiveness: Perfecting Discharge.

The Trust has made significant progress against this priority. There are continuous quality improvements including extending the personalised patient discharge letter, continuing to observe the theme “inaccurate handover” to ensure that the transfer of care documentation improves, developing a multidisciplinary discharge summary that is incorporated into the digital scoping work with Electric Patient Record Team and continuing to develop the pathway for discharging homeless patients.

The CCGs acknowledge the continued importance of priorities identified by the Trust and Commissioners would like to review the Trust progress against key priorities for 2022/23:

- Patient Safety & Clinical Effectiveness: Safe staffing
- Patient Safety & Clinical Effectiveness: Ensure all patient nutrition and hydration needs are met
- Patient Experience, Patient Safety & Clinical Effectiveness: Learning from complaints

The CCG looks forward to the continued collaborative working with the team at East Sussex Healthcare NHS Trust and wider system partners.

Yours sincerely

Allison Cannon

Chief Nursing Officer

On behalf of Sussex NHS Commissioners

Statement from Healthwatch East Sussex

Due to unforeseen circumstances Healthwatch were unable to provide a statement for East Sussex Healthcare NHS Trust.

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

East Sussex

Health Overview and

Scrutiny Committee

Statement from East Sussex Health Overview and Scrutiny Committee

Thank you for providing the East Sussex Health Overview and Scrutiny Committee (HOSC) with the opportunity to comment on your Trust's draft Quality Report 2021/22.

The HOSC recognises much of the Trust's efforts over the past year will have been focussed on maintaining its high standards of care whilst adhering to COVID-19 social distancing measures and dealing with the impact of the pandemic on staff sickness absence. The Committee, therefore, welcomes the success ESHT has achieved in 2021/22, despite the considerable pressures placed on it by COVID-19.

HOSC has invited ESHT to attend most of its meetings over the past year to look at various issues including proposals to reconfigure cardiology and ophthalmology services, hospital handover times, the response to COVID-19, and the healthcare system's winter plan. The Committee thanks those trust officers and clinicians who gave their time to attend.

As a committee, we took the decision that ESHT's proposals to reconfigure cardiology and ophthalmology both constituted a substantial variation to services requiring formal consultation under health legislation. This consultation has been carried out by two HOSC review boards whose findings and recommendations will be reported to the HOSC on 30th June ahead of the Trust and ICB's decision on both reconfigurations over the summer. The HOSC will then consider whether both decisions are in the best interest of the health service locally at its meeting on 21st September. HOSC members have found the Trust to be very engaged with this review process and have witnessed senior clinicians and senior management give up considerable amounts time to speak with the review boards and provide them with requests for evidence.

HOSC welcomes the work ESHT has undertaken with SECAmb to improve hospital handovers at your two main hospital sites in Eastbourne and Hastings, for example, the commitment to achieve 30-minute handover times and to eliminate all wait times of over 60 minutes. We plan to look at this issue again at our meeting in September.

Finally, HOSC also hopes to hear more about the plans for the considerable capital investment being made in the Trust's hospital sites as part of the Building for our Future when the time is right.

Quality Priorities

The Committee agrees with the trust's assessment that the 2021/22 year has been dominated by COVID-19 and we understand that the trust's depleted workforce will have had an impact on quality performance. Whilst progress has been made towards the Priorities for Improvement for 2021/22, we recognise the rationale that they were not fully realised due to the need to respond to the pandemic.

We note that this means there has been a mixed performance against the priority “Perfecting Discharge”, however, the introduction of the Transfer of Care document earlier this year to improve discharge of patients is a welcome step and the Committee would like to see the results of its introduction in due course.

Turning to the 2022/23 priorities, the choice to focus on safe staffing, hydration and nutrition and learning from complaints appear to suggest the Trust is keen to improve the patient experience at their hospital sites. We hope to see some of the outcomes mentioned, such as the 10% improvement in rota gaps; 2% improvement in vacancies in nursing and medical; every ward having access to adapted equipment for eating and drinking; and a notable reduction in the top 3 complaint subjects.

The Committee would expect the impact of COVID-19 to have declined sufficiently in the coming year for it to no longer be a major contributing factor to the Trust not completing its Priorities for Improvement in full.

Please contact Harvey Winder, Policy and Scrutiny Officer on 01273 481796 should you have any queries.

Councillor Colin Belsey

Chairman

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

30th June 2022

Steve Phoenix
Chairman

30th June 2022

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 2021/22.

Appendices

Appendix 1 – Integrated Performance Report

Safety	Target / Limit	Last month	This Month	Variation	Assurance
Patient Safety Incidents	M	909	1030	Common Cause	
Serious Incidents	M	2	1	Common Cause	
Never Events	M	1	1	Common Cause	
Falls per 1,000 bed days	5.5	5.5	6.3	Common Cause	Inconsistent
Pressure Ulcers, grade 3 to 4	0	2	3	Common Cause	Consistently Missed
MRSA Cases	0	1	0	Common Cause	Inconsistent
Cdiff cases	<5	6	6	Common Cause	Inconsistent
MSSA cases	M	2	0	Common Cause	
RAMI	94	84.4	83.5	Improvement	Consistently Hit
SHMI (NHS Digital monthly)	0.99	0.97	0.98	Common Cause	Consistently Hit
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	85%	85%	Concern	Consistently Missed
Nursing Fill Rate (Including Escalation)	100%	85%	85%	Common Cause	Consistently Missed

Patient Experience	Target / Limit	Last month	This Month	Variation	Assurance
Complaints received	M	33	45	Common Cause	
A&E FFT Score	M	90%	91%	Common Cause	
Inpatient FFT Score	M	99%	99%	Common Cause	
Maternity FFT Score	M	100%	95%	Common Cause	
Out of Hospital FFT Score	M	99%	98%	Common Cause	
Outpatient FFT Score	M	99%	100%	Common Cause	

Our Performance	Target / Limit	Last month	This Month	Variation	Assurance
A&E 4 hour target	>95%	72.8%	69.7%	Concern	Consistently Missed
A&E Non Admitted	M	80.4%	77.4%	Concern	
A&E > 12 hours from arrival to discharge	0	238	398	Concern	Consistently Missed
A&E waits over 12 hours from DTA	0	0	0	Common Cause	Consistently Hit
UTC 2 hour	>98%	69.9%	67.8%	Concern	Consistently Missed
Cancer 2ww	>93%	96.0%	97.8%	Common Cause	Consistently Hit
Cancer 62 Day	>85%	70.5%	77.4%	Common Cause	Consistently Missed
62 day Backlog	M	127	127	Common Cause	
104 day Backlog	M	28	29	Improvement	
RTT under 18 weeks	>92%	66.5%	66.6%	Concern	Consistently Missed
RTT 52 week wait	0	68	132	Common Cause	Consistently Missed
RTT Total Waiting List Size	36,833	38,442	40,044	Concern	Inconsistent
Overdue P2	M	231	227	Common Cause	
CHIC wait times < 13 weeks	>75%	84.8%	86.8%	Common Cause	Consistently Hit
Diagnostic <6 weeks	<1%	15.5%	14.6%	Improvement	Consistently Missed

Our People	Target / Limit	Last month	This Month	Variation	Assurance
Establishment (WTE)	M	7,840.3	7,840.1		
Vacancy Rate	<5%	8.0%	7.2%	Concern	Consistently Missed
Staff Turnover	<9.9%	11.1%	11.7%	Concern	Consistently Missed
Retention Rate	>92%	91.4%	91.6%	Concern	Inconsistent
Sickness - Absence % (rolling 12 mths)	<4.5%	5.4%	5.6%	Concern	Consistently Missed
Sickness - Average Days Lost per Fte	<16	19.5	20.5	Concern	Consistently Missed
Staff Appraisals	>85%	75.7%	74.0%	Common Cause	Consistently Missed
Statutory & Mandatory Training	>90%	88.5%	87.7%	Common Cause	Consistently Missed

Our Productivity	Target / Limit	Last month	This Month	Variation	Assurance
4 hour theatre sessions	M	429	487	Common Cause	
Average Cases per 4 hour session	M	2.4	2.4	Improvement	
Clinic run rate	M	80.1%	80.1%	Improvement	
Non Face to Face Outpatients	>25%	29.7%	27.8%	Concern	Consistently Hit
Elective Length of Stay	2.7	2.7	2.6	Common Cause	Inconsistent
Non Elective Length of Stay	3.6	4.3	4.7	Concern	Consistently Missed

There have been significant operational and workforce challenges over the past year as a result of the Covid pandemic and the increasing hospital activity levels.
Our performance, alongside other major providers nationally was impacted by these challenges.
We saw an increase in workforce sickness which meant a high volume of locum and agency staff had to be brought in to keep services provision at a safe level.
Coupled with this was our increased bed occupancy and higher acuity of patients which meant that the demand for workforce was even higher than normal. With the increased occupancy, this limited our ability to be able to stream patients efficiently from our emergency departments and this "exit block" had a direct impact on the delivery of our 4 hour standard.
Additionally, with the demand for acute beds, medicine patients were admitted to surgical and elective beds as outliers. Meaning some routine elective cases had to be postponed.
Medically ready for Discharge (MRD) patients have had their length of stay prolonged because of challenges with the adult social care market and the inability to discharge a patient to a community / rehab / onward care bed Despite the aforementioned, we managed to maintain safe and quality care throughout and remain in the top half of the country (and in some cases upper quartile) for many of our key performance metrics such as the 4 hour ED target, the 28 day cancer faster diagnosis standard, RTT standards – including long waits time and our diagnostic performance. And we have adapted and improved our services at pace, to meet the growing and changing demand. It should be noted that not all harns are avoidable depending on underlying conditions and patient choice.

Leadership and Culture

TRUST 2021/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend Line
Budgeted fte	7391.5	7392.0	7415.5	7535.7	7562.1	7581.2	7913.6	7980.0	7974.5	7846.5	7840.3	7840.1	
Total fte usage	7567.3	7319.3	7401.6	7413.1	7335.0	7458.4	7516.4	7556.5	7563.3	7525.9	7603.4	7719.4	
Variance	-175.8	72.7	13.9	122.6	227.1	122.8	397.2	423.5	411.3	320.6	236.9	120.7	
Substantive vacancies	321.2	331.9	387.5	496.6	434.2	452.7	691.6	714.1	748.2	665.9	604.2	541.1	
Fill rate	95.4%	95.3%	94.5%	93.1%	93.9%	93.7%	90.8%	90.6%	90.2%	91.2%	92.0%	92.8%	
Bank fte usage	706.2	567.5	643.9	655.0	571.3	637.2	622.2	656.4	644.9	635.3	658.9	676.8	
Agency fte usage	133.8	128.9	136.4	123.5	138.6	165.4	177.7	164.3	161.2	146.9	146.7	189.5	
Turnover rate	9.8%	9.9%	10.1%	10.1%	10.2%	10.1%	10.5%	10.4%	10.6%	11.1%	11.1%	11.7%	
Stability rate	92.4%	92.7%	92.7%	92.7%	92.3%	92.5%	92.5%	92.0%	92.0%	91.4%	91.4%	91.6%	
Annual sickness rate	4.7%	4.7%	4.8%	4.9%	5.0%	5.1%	5.2%	5.3%	5.3%	5.3%	5.4%	5.6%	
Monthly sickness rate	3.9%	4.4%	4.8%	5.3%	5.3%	5.5%	5.7%	5.4%	5.9%	7.0%	6.6%	7.2%	
Ave sick days per fte	17.1	17.2	17.4	17.8	18.2	18.6	19.1	19.4	19.4	19.2	19.5	20.5	
Appraisal rate	74.9%	73.8%	73.8%	73.0%	73.5%	73.2%	73.3%	73.8%	75.8%	76.6%	75.7%	74.0%	
Mandatory training compliance rate	89.6%	89.3%	89.4%	88.7%	89.9%	89.2%	89.1%	89.4%	89.0%	89.5%	88.5%	87.7%	

Budgeted establishment and fte usage have grown across 2021/22 reflecting service developments including H2 investments such as increased funding of emergency care pathway including Urgent Treatment Centres in Oct 21 and Integrated Community Services, including Urgent Community Response. Increase in budgeted establishment in Oct 21 resulted in an increase in vacancy rate/reduction in fill rate but this has been improving since start of 2022 with successful recruitment campaigns, including international recruitment of nurses and radiographers and “new to care” healthcare support workers.

The annual sickness rate has continued to rise as a result of the pandemic. The wave #3 Omicron variant, including a renewed upsurge in March 22 with the more infectious BA.2 variant, has led to higher than usual monthly sickness rates, particularly from Dec 21. This has led to increased demand for temporary workforce which bank & agency supply have been unable to completely meet. The consequent operational pressure has had knock on effects on the time available for appraisal and mandatory training, though levels have been fairly consistent. The continued pressure is having an effect on turnover, however, which has risen steadily across the year. There is some evidence that staff fatigue is a factor in this with a noticeable increase in leavers in the categories “voluntary resignation – work life balance” and “flexible retirement”.

Appendix 2 – National Clinical Audit and National Confidential Enquiries Programme

National clinical audits and national confidential enquiries we were eligible to participate in during 21/2022.

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 – Transition from child to adult health	**Y**	**Y**
NCEPOD - Epilepsy	**Y**	**Y**
National Clinical Audit	**ESHT Eligible**	**ESHT Participation**
National Comparative Audit of Blood Transfusion - 2021 Audit of Blood Transfusion against NICE Guidelines	**Y**	**Y**
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	**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**
Adult Critical Care Audit (Case mix programme - ICNARC)	**Y**	**Y**
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	**Y**	**Y**
Vertebral Fracture Sprint Audit	**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 – Bowel Cancer	**Y**	**Y**
National Gastrointestinal Cancer Audit Programme – Oesohago Gastric Cancer	**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**
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**	**N**
National COPD Audit Programme – Paediatric Asthma	**Y**	**Y**
Society for Acute Medicine's Benchmarking Audit (SAMBA)	**Y**	**Y**
National Outpatient Management of Pulmonary Embolisms Audit	**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**
BAUS – Management of the Lower Ureter in Nephroureterectomy Audit	**Y**	**Y**
BAUS – Renal Colic Audit	**Y**	**Y**
Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery	**Y**	**Y**
National Audit of Care at the End of Life (NACEL)	**Y**	**Y**
National Smoking Cessation Audit	**Y**	**Y**

Appendix 3 – Participation in Mandatory Clinical Audits

This information is unavailable for 2021/22 due to the national pause on the mandatory clinical audit programme throughout much of the pandemic.

Appendix 4 – Other Non-Mandated National / Regional studies

The Trust participated in 12 non-mandated national studies in 2021/22, as follows:

National Study	Specialty
MAMMA: Mastitis and mammary abscess management audit	Breast Surgery
NAP 7 - Perioperative Cardiac Arrest	Anaesthetics
British Spine Registry	Trauma & Orthopaedics
TORCH-UK - UK Multicentre audit looking at adherence to BASL/BSG guidance in the management of patient of patients with decompensated liver disease	Gastroenterology
BASHH national clinical audit 2021: HIV PEP pathways	Sexual Health
Post Colonoscopy Colorectal Cancer National Audit	Endoscopy
UK Registry of Endocrine and Thyroid Surgery	ENT
Sussex Rehabilitation Survey	Rehabilitation
A National Service Evaluation of paclitaxel pre-medication regimes for the prevention of hypersensitivity during a period of ranitidine shortage	Pharmacy
UK Foot and Ankle COVID-19 National Audit (UK-FALCON)	Trauma & Orthopaedics
The ABCD Nationwide COVID-19 Audit	Diabetes & Endocrinology
AMBROSE Study: 30-day morbidity and mortality of cholecystectomy for benign gall bladder disease: A TUGS Multinational Audit	General Surgery

Appendix 5 – Equality Impact Assessment

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Positive</td><td>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.</td></tr>
<tr><td>Equality Consideration

Highlight the protected characteristic impacted</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>Gender reassign ment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
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<tr><td>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</td><td>Positive</td><td>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.</td></tr>
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<tr><td>Equality Consideration
Highlight the protected characteristic impact</td><td></td><td>
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<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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</td></tr>
<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Positive</td><td>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.</td></tr>
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<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>
<tr><td>Equality Consideration

Highlight the protected characteristic impact</td><td></td><td>
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<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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</td></tr>
<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 experience at work around key Equality Diversity and Inclusion.

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

Our staff networks have now been re-branded into independent staff groups with elected Chairs and supported by a Trust Board sponsor. The new structure includes; celebrating difference, inspiring staff, help 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></tr>
<tr><td>Equality Consideration

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

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></tr>
</table>

<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>
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</td></tr>
<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>
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</td></tr>
<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.

B

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.

D

Data Quality
Ensuring that the data used by the organisation is accurate, timely and informative.

Data Security and Protection Toolkit (DSPT)
The Data Security and Protections Toolkit (DSPT) is an online performance tool developed by NHS Digital to support organisations to measure their performance against the National Data Guardian's data security standards.

Datix/DatixWeb
On 1st January 2013 ESHT introduced electronic incident reporting software known as DatixWeb. Incidents are reported directly onto the system by any employee of the organisation, about incidents or near misses occurring to patients, employees, contractors, members of the public. The data provided by DatixWeb assists the organisation to trend the types of incidents that occur, for learning lessons as to why they occur and to ensure that these risks are minimised or even eliminated by the action plans that we put in place. DatixWeb is also used to comply with national and local reporting requirements.

Department of Health (DOH)
The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

Deteriorating patient
A patient whose observations indicate that their condition is getting worse.

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

E

Excellence in Care (EIC)
Excellence in Care framework is to provide one source of robust data to enable clinical teams within the divisions to review, analyse and understand their performance against a range of metrics which align with national guidance and local policy. This will enable areas for improvement to be identified and the resource to monitor consistency in care delivery with a reduction in unwarranted variation

Electronic Prescribing and Medicines Administration (ePMA)
ePMA is a web-based system which will replace the traditional paper medication charts

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.

G

General Medical Council (GMC)
The General Medical Council (GMC) is an organisation which maintains the official record of medical practitioners. The GMC also regulates doctors, set standards, investigate complaints.

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.

H

Healthwatch
Healthwatch is the independent consumer champion created to gather and represent the views of the public on issues relating to health and social care. Healthwatch plays a role at both a national and local level, ensuring that the views of the public and people who use services are taken into account.

Hospital Episode Statistics
Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

Hospital Standardised Mortality Ratio (HSMR)
Hospital Standardised Mortality Ratio (HSMR) is an indicator of whether death rates are higher or lower than would be expected.

I

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

ICNARC
The Intensive Care National Audit and Research Centre.

K

Key Performance Indicators (KPIs)
Key Performance Indicators, also known as KPIs, help an organisation define and measure progress towards organisational goals. Once an organisation has analysed its mission, identified all its stakeholders, and defined its goals, it needs a way to measure progress towards those goals. Key Performance Indicators are those measurements. Performance measures such as length of stay, mortality rates, readmission rates and day case rates can be analysed.

L

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.

M

Methicillin Resistant Staphylococcus Aureus (MRSA)
MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections.

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.

O

Ofsted

Ofsted is the Office for Standards in Education, Children's Services and Skills. We inspect services providing education and skills for learners of all ages. We also inspect and regulate services that care for children and young people

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.

Perinatal Mortality Review Tool (PMRT)

A collaboration led by MBRRACE-UK has been appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'. The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

R

Research
Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health or both.

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.

Trauma Risk Management (TRiM)
TRiM is a means of supporting staff following a Potentially Traumatic Experience (PTE)

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.