East Sussex Healthcare
NHS Trust

Quality Account

2022/23

www.esht.nhs.uk
0300 131 4500
@ESHTNHS

Part 1 – Introduction

Statement of Quality from the Chief Executive

I am delighted to introduce the Quality Account 2022/23 for East Sussex Healthcare NHS Trust (ESHT).

This report summarises the Trust's quality achievements during 2022/23 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 2023/24.

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. This includes a new discharge lounge at Eastbourne District General Hospital and a new diagnostic facility for residents in Bexhill.

We are incredibly proud of all our staff and volunteers who often go above and beyond ensure we are to provide the best possible care in the ongoing challenges within the NHS. We have continued to offer support for individuals, teams and managers in many ways which is reflected in our staff survey results indicated we are a compassionate and inclusive organisation.

The Trust has made progress towards the priorities we set in the 2021/22 Quality Account Quality Improvement initiatives despite the increasing demand on services and the challenges presented by industrial action. For example, we have introduced adapted equipment for eating and drinking and an increase in the choice of texture modified food for patients with swallowing and eating difficulties in order to maintain optimal nutrition and hydration needs.

The Trust continues to work 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 with examples of our commitment to these values are demonstrated throughout this Quality Account.

Whilst acknowledging the challenges that the recovery of the NHS following 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 2022/23 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 £657 million and we are the only integrated provider of acute and community care in Sussex. Our extensive health services are provided by over 8,300 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. 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 Community Hospital we provide day surgery and outpatient care. We also provide rehabilitation services jointly with East Sussex County Council Adult Social Care.

In the community, we deliver services that focus on people with long term conditions living well outside hospital, through our Integrated Locality Teams working with district and Community Nursing teams. Community members of staff also provide care to patients in their homes and from a number of clinics, health centres and GP surgeries.

To provide many of these services we work in partnership with East Sussex County Council and other providers across Sussex, as part of a locally focused and integrated health and social care network. We aspire to provide locally based and accessible services that are outstanding and always improving and our values shape our everyday work. Working together we drive improvements to care, services and the experience of local people and members of staff.

Our 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

Hospital care in your own bed

From when it launched in December 2022 to the end of 2022/23, the trust's virtual wards have seen more than 300 patients, providing a range of hospital-grade services to patients in the comfort of their own home.

"It's about providing the care that a patient would ordinarily expect in a hospital bed, but at home," explains Sam Morley, Advanced Clinical Lead for Virtual Wards. "By monitoring of vitals like blood pressure, heart rate and oxygen levels remotely and administering IV antibiotics at home, we've made a real difference to the experience and comfort of a big cohort of patients."

Highly commended at Care at Home awards

The trust was highly commended in three of the categories at the South East Care at Home awards in June.

The Rehab, Restoration and Recovery forum were highly commended in recognition of their excellence and achievement in being an outstanding team for prevention and rehabilitation; the Rapid Access Clinic for muscular conditions were highly commended in recognition of their excellence and achievement in being an outstanding team for innovation and improvement; and the acute access virtual clinic for patients attending Emergency Department with musculoskeletal conditions were highly commended in recognition of their excellence and achievement in being an outstanding team for digital transformation.

Collaborating to deliver better care

Sussex Premier Health celebrates first anniversary

Sussex Premier Health celebrates its first anniversary of providing healthcare under the ownership of East Sussex Healthcare NHS Trust on 1 April 2023.

Sussex Premier Health, now a private division of the trust, offers private inpatient and outpatient services for a wide range of specialities, including orthopaedics, general surgery and ophthalmology. The division does not use NHS resources, and profits are reinvested back into the trust.

Ensuring Innovative and sustainable care

Over £27 million investment to improve energy efficiency at Eastbourne DGH

Funded by the Public Sector Decarbonisation Scheme, in Summer 2022 work began to install clean, efficient heat pumps and energy efficiency upgrades across the majority of the Eastbourne site. This will include insulation being added to the outside of the building, new fascia, new windows, new roofing, air source heat pumps and the addition of solar panels.

These improvements to the building will reduce the heating required and the upgraded heating system, powered by cleaner renewable energy, will reduce the use of fossil fuels, reducing our carbon footprint.

What the Trust will look like in 2026

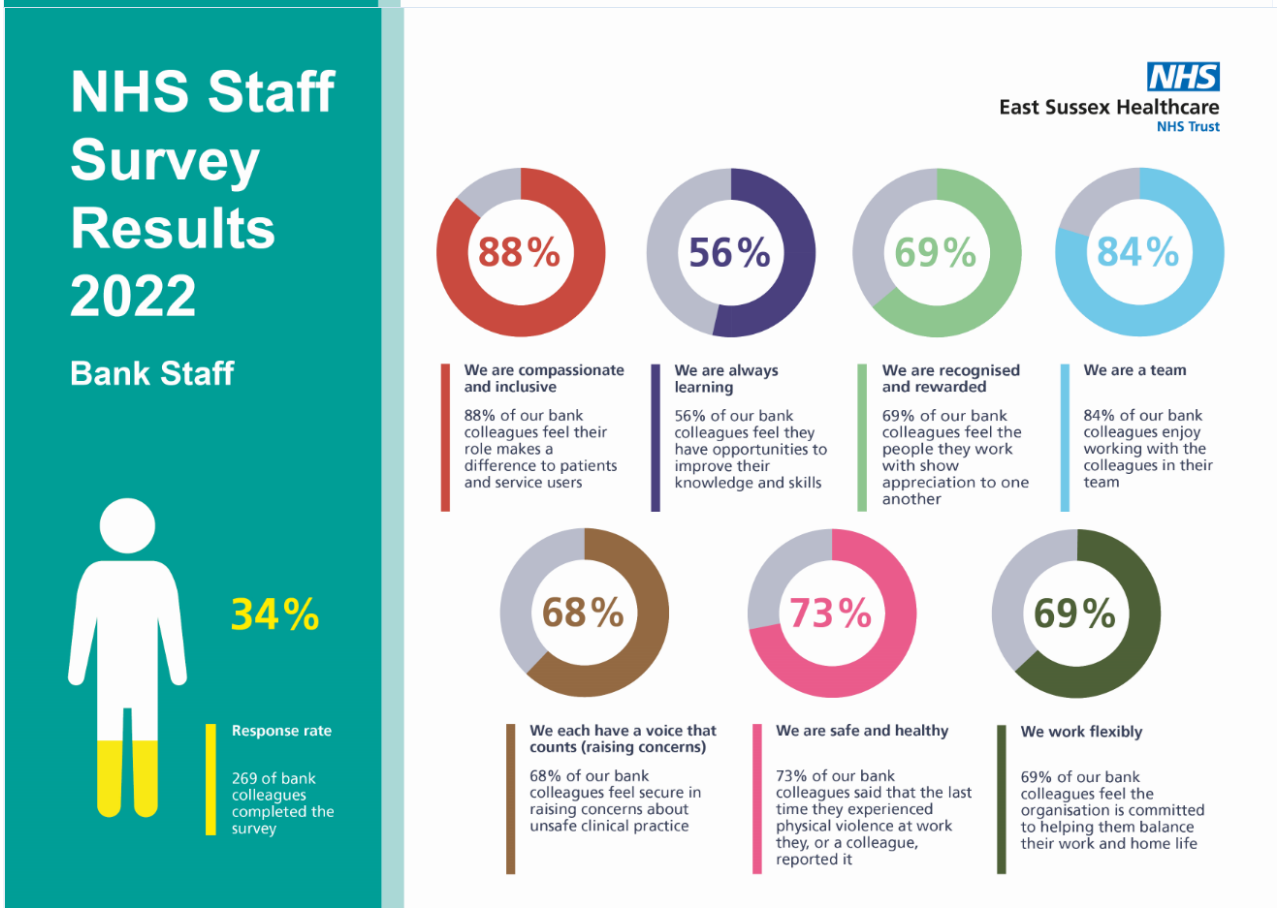
The kind of Trust we want to see in five years is one where our performance is one of the best. Where we are:

- 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.49 of this report. 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 those 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 2023/24

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 2023/24

Quality Domain	Priorities for improvement 2023/24
Patient Safety	1. Implementing the Patient Safety Incident Response Framework (PSIRF)
Clinical Effectiveness	2. Reducing insulin prescription and administration errors
Patient Experience	3. End of Life Care

1. Implementing the Patient Safety Incident Response Framework (PSIRF)

Why has this been chosen as a priority?

As part of the national Patient Safety Strategy that was introduced in 2019 (and updated in 2021), significant changes to the way in which patient safety incidents are responded to were outlined. One of the key changes included the implementation of PSIRF. PSIRF has multiple elements, and it is acknowledged nationally that it is likely to take time to implement so a range of them have been selected as priorities for 2023/2024.

What we will do in 2023/24

Working in conjunction with our Integrated Care Board (ICB) we will:

- Fully introduce After Action Reviews (AARs) following patient safety incidents as a means of identifying what happened, what should have happened, what the learning was for the organisation and an action plan describing how to mitigate risks of it happening again. AARs will also be able to identify learning from examples of good practice.
- Introduction of thematic reviews for the highest reported incident categories

- Development and introduction of Patient Safety Incident Investigations (these replace the previous Serious Incident investigations)
- Development of reporting templates to provide assurance regarding quality to the Trust Board and our ICB
- Review and improve how patients/their representatives are involved in the investigation of incidents involving them

What will success look like?

- After Action Reviews will be used throughout the Trust as a means of identifying learning from incidents and sharing this in a timely way
- Thematic reviews will be introduced in order to analyse themes from the highest reported incident categories
- Patient Safety Incident Investigations will supersede Serious Incident Investigations within the Trust, in line with national advice
- Reporting templates will be developed that provide assurance to the Trust Board and ICB colleagues regarding how the Trust is responding to patient safety incidents
- A process will be developed and implemented to ensure that patients/their representatives are routinely involved in investigations of incidents involving them/their loved ones

How will we measure success?

- The learning from AARs will be carefully recorded as will the identified learning. This will be shared across the Trust as appropriate in order to reduce the risk of patient safety incidents from reoccurring; it will also enable examples of good practice to be learned from and shared across the Trust
- The thematic review process will be embedded and there will be examples of thematic reviews that will provide analysis of the various themes identified; these will be shared across the Trust as appropriate
- The process for Patient Safety Incident Investigations will be established and embedded within the Trust and this will be reflected in Trust policy. Learning from these will be widely shared as appropriate
- Reporting templates will be used within the Trust and will be shared with ICB colleagues.
- The process for including patients/their representatives in the investigation of incidents involving them will be established and embedded in practice. Compliance with this can be recorded electronically and audited as required.

2. Reducing insulin prescription and administration errors

Why has this been chosen as a priority?

There are a consistently high number of insulin prescription and administration errors. This is both a medical and nursing responsibility (prescribing-medical and non-medical prescribers; administration- nursing). Medicine administration errors are the most frequent errors related to medications reported nationally and locally. Improvement in these areas present an opportunity to detect and prevent an error before adversely affecting a patient/individual.

The National Diabetes Inpatient Audit (NaDIA, 10-17) in their published report in 2017 revealed:

- 31.3% medication errors across England, with the Trust recording 24.3% at Conquest and 35.5% at EDGH.
- 19% prescription errors across England, with 8.1% at Conquest and 19.4% at EDGH.
- 18.5% management errors across England, with 21.6% at Conquest and 19.4% at EDGH.
- 18.6% insulin errors across England, with 13.5% at Conquest and 19.4% at EDGH.
- 7.1% incidences of severe hypoglycaemia across England, with 4.4% at Conquest and 4.96% at EDGH

And the NaDIA Harms (2021) audit reported:

- 1.4% of inpatients with diabetes required hypoglycaemic rescue in the last 7 days.
- 3.6% with Type 1 diabetes had developed diabetic ketoacidosis (DKA) during their hospital stay.

What are we going to do?

Explore in depth why this might be and propose (actions):

- Increase uptake of the essential to role safe use of insulin training and re-introduction of the competency assessment tool to be demonstrated three yearly to support revalidation for midwives and RNs, and one yearly for Community Support Workers (CSW).
- Encourage uptake of regular training for doctors joining the Trust to attend the regular training sessions provided by the Diabetes Team on safe use and prescription of insulin.
- Inclusion of the Datix reports on insulin errors and hypoglycaemia on the governance meetings.
- Active participation to the Medicines Safety meetings at ESHT (requested to be included on the membership)
- Inclusion of insulin treated patients and hypoglycaemia incidences on the huddles.
- Early referral to the diabetes team of patients requiring diabetes management review.
- Continued participation to the national awareness campaign on insulin safety and hypoglycaemia.

This project would explore by stakeholder engagement with nurses and doctors why these errors occur and test interventions to improve using quality improvement methodology.

There are a wide range of errors that can occur in the process of prescription and administration of insulin. These are reflective of the 6 R's that the diabetes team have been including as critical elements of the training they provide. These are:

- Wrong Time
- Wrong Patient
- Wrong Route
- Missed Dose
- Wrong Insulin
- Wrong insulin
- Wrong Device

The project would explore via a deep dive interrogation of the incidents and causes of these errors in the different settings (hospital and home for example) and test interventions within our control to reduce errors and risks to patients.

What will success look like?

- Reduction in incidents related to errors in the prescription of insulin (% to be determined)
- Reduction in incidents related to errors in the administration of medicines (% to be determined)
- Reduction in incidents reported by our stakeholders related to insulin.
- Reduction in harm to patients/individuals related to the prescription and administration of insulin (% to be determined)
- Reduction of incidents of hypoglycaemia related to errors in the prescription and administration of insulin (% to be determined)
- Nurses, midwives and CSWs trained and competent in the safe administration of insulin to most up to date standards of practice included shared learning from incidents
- Improved attendance from the medical teams on the safe use and prescription of insulin training
- Improved patient experience

How will we monitor progress?

- Reduction in harm and incidents reported monitored via Datix reports presented to Medicines Safety Group
- Patient survey results
- Evidence of training and competency assessment of nurses and midwives included in appraisals and will support 3 yearly revalidations of registration of nurses and midwives with the Nursing Midwifery Council (NMC) and 1 yearly for CSWs.

- Evidence of attendance by the medical teams on the training on safe use and prescription of insulin.
- Results of the deep dive into administration of medicines incidents presented for stakeholder engagement to Medicines Safety Group, Professional Advisory Group, Medicines Optimisation Group, and recommendation for improvement approved by the Patient Safety Group.

3. End of Life Care

Why this has been chosen as priority?

Open communication with patients approaching death can enable better, more personalised care focussing on what matters to them. In healthcare we need to enable clinicians to initiate and have honest conversations with people earlier in their end-of-life journey so they can make informed decisions about their own care and support. Open and honest discussions allow and enable people to develop personalised care and support plans that can be shared with others involved in their care, including those important to them to the extent that the person wishes.

The National Audit of Care at the End of Life (NACEL) focussed on the quality and outcomes of care experienced by dying patients and those closest to them during their last hospital admission throughout England and Wales. ESHT participated in this audit, which monitored progress against NICE Quality Standard 144, including recognising that a person is nearing the end of their life, person centred communication and assessment of their needs and the needs of those closest to them. The last two NACEL audits indicated that dying is either recognised very late or not recognised at all at ESHT and demonstrated that staff do not feel confident in initiating open and honest conversations about death and dying. The overarching themes of EoLC complaints relate not to care, but to poor communication about deteriorating conditions, uncertainty around recovery, dying and death; and often the wishes of patients and those closest to them are not listened to.

The Trust is continuing to focus on quality improvement work in end-of-life care.
The aim being to:

- Improve the quality of care for people at the end of life in acute hospitals.
- Improve communication about likely disease progression to allow realistic advance care planning discussions to occur
- Increase the opportunity to identify those patients who may benefit from early identification that they are entering their last year / days of life
- Ensure that the wishes of patients and those closest to them are taken into account, even if those wishes conflict with other local and national targets.
- Learn from complaints and incidents related to EoLC

What are we going to do?

- Improve the ReSPECT process, putting patients at the heart of decision making.
- Equip senior decision makers will tools that will help them to identify those patients likely to die in the next year and have open and honest conversations with them about their wishes e.g., SPICT, Rockwood Score.
- Openly discuss that a person is ‘sick enough to die’ and explore patient / family wishes in this situation, including preferred place of care and how much intervention they would want.
- Improve access to advance care planning across the organisation and ensure that any information is shared with all relevant service and people
- Participate in dying matters week
- Board awareness session
- Seek views on care from bereaved family members i.e. VOICEs survey
- Use learning and stories from complaints and plaudits in education and awareness sessions across the organisation

What will success look like?

- A culture where death and dying is openly discussed with patients / families
- An organization where all staff feel confident in talking about death and dying and in caring for dying people
- Patients at the heart of decision making and care planning
- Earlier recognition of dying to allow patient wishes to be explored and acted on
- More patients dying in their preferred place of care
- Increased numbers of patients expected to die will have an individualized care plan
- Fewer complaints related to patient / family experience around end-of-life care

How we will monitor progress?

Embed the process of improving and measuring the 5 priorities of care.
Data from the following sources to be triangulated to inform the improvement process:

- SPCT spot audits of dying patients
- EIC
- NACEL or other national audits
- Percentage of expected deaths with an individualised care plan
- Percentage of patients with a ReSPECT form completed
- Audit of the quality of ReSPECT forms
- Mortality database
- Bereavement survey
- Complaints and incidents

Part 2.2 – Other improvement priorities being taken forward for 2023/2024

Reconditioning our patients

Why has this been chosen as a priority?

When an older patient is admitted into hospital physiological, physical, and psychosocial changes commence within 24 hours of bed rest affecting their ability to undertake Activities of Daily Living (ADLs) like walking and making a cup of coffee. Deconditioning is "the loss of physical, psychological and functional capacity due to inactivity" Public Health England 2021(PHE) and is associated with the loss of muscle mass, increased risk of falls and reduced independence.

Evidence suggests:

- Hospitalised patients are 61 times more likely to develop disability in Activities of Daily Living than those not hospitalised
- 17% of older medical patients who were walking independently 2 weeks prior to admission needed help to walk on discharge
- 60% of patients placed on bed rest have no documented rationale for this decision
- 50% of patients experience functional decline between admission and discharge
- Deconditioning contributes to delayed discharge in more than 47% of older patients

There is a national reconditioning program which aims to prevent deconditioning by encouraging designated areas to come up with innovative ways to promote physical activity, functional and emotional well-being. It is hoped that these will reduce deconditioning and associated harms; improve hospital discharges and improve patient outcomes. Associated harms are difficult to capture in current incident data bases as many are invisible such as psychological harm, and functional deconditioning. We will design, trial and agree metrics to demonstrate the impact of initiatives.

What we are going to do?

ESHT (East Sussex Healthcare NHS Trust) (East Healthcare NHS Trust) will work alongside the national initiative led by the Emergency Care Improvement Support Team (ECIST) as part of #ReconditionTheNation. ESHT will undertake some focused work to support older frail people to recondition whilst they are in hospital.

This will include:

- Design / agree indicators which will track 1) this group of patients reconditioning progress which may include Rockwood score, hand grip, Abbreviated Mental Test score (AMTS), and 2) associated harms
- Provide information to eligible patients to raise awareness of how to prevent deconditioning
- Document when patients on the identified frailty wards are medically ready for discharge, undertake measurements to track reconditioning
- Where patients do not have mental capacity, who are waiting for a package of care to apply a DOLS (Deprivation of Liberty Safeguards)
- Each identified frailty wards to choose an improvement activity to improve patients conditioning e.g., Bay exercises, Sir Tom 10 metre walkway
- Each frailty ward to identify a frailty/ reconditioning champion who will receive extra training

What will success look like?

- 90% of eligible patients identified on frailty wards receive a leaflet such as nationally approved letter 'Sit up, Get Dressed and Keep Moving'
- At the end of the year an agreed set of metrics will be in place to enable accurate monitoring
- Lower rate of readmissions secondary to patients being able to undertake ADLS at home
- Cognitive function of designated group remains the same or improves
- Functional ability improves to enable reduction in package of care requirement or the need for long term care

How we will monitor progress?

- Patient Safety and Quality Group (PSQG)
- Frailty Steering Group
- Medicine Divisional Governance Meeting

Part 2.3 – Statements of Assurance from the Board of Directors

During 2022/23 ESHT provided and/or sub-contracted 84 NHS services.

ESHT has reviewed all the data available to them on the quality of care in all 84 of these NHS services.

The income generated by the NHS services reviewed in 2022/23 represents 100% of the total income generated from the provision of NHS services by ESHT 2022/23.

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.

The national clinical audits and national confidential enquiries that ESHT was eligible to participate in during 2022/23 are detailed below.

National Audit and National Confidential Enquiries Programme

During 2022/23, 55 national clinical audits and six 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 2022/23 can be found in Appendix 1.

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, *and for which data collection was completed during 2022/23*, are listed in Appendix 2, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The Trust also participated in six additional (non-mandated) national studies in 2022/23, which can be found in Appendix 3.

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)

NCEPOD issued three applicable reports in 2022/23:

- Epilepsy - Published December 2022.
- Remeasuring the Units – Published December 2022
- How data captured by NCEPOD supports the identification of healthcare inequalities – Published April 2022

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 & Children's Division contributes, where cases meet the criteria, to these studies.

<u>The studies undertaken during the period 2021/22 include:</u>

Study	Cases
Amniotic Fluid Embolism	0
Fontan and Pregnancy	0
New Therapies for Influenza	0
Pregnancy following Bone Marrow Transplant	0
Re-exploration after CS	0
Previous cardiomyopathy	0
Thrombotic microangiopathy associated Acute Kidney Injury	1
NEW: Biological agents in pregnancy	1
NEW: Severe Pyelonephritis in Pregnancy	1 (data not readily available for Q4; we are waiting for data to be re-sent)

National Clinical Audit Reports in 2022/23

The reports of 18 national clinical audits were reviewed by the Trust in 2022/23. 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.

Four 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/

Society for Acute Medicine Benchmarking Audit (SAMBA) 2022

The Society for Acute Medicine Benchmarking Audit (SAMBA) 2022 provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 23rd June 2022. At the time that SAMBA22 took place, urgent and emergency care services were already under increasing pressure. The number of patients waiting within the Emergency Department for over 12 hours for an inpatient bed has been rising, with all parts of the emergency, acute care and inpatient pathway needing to confront the increasingly complex challenge of maintaining the quality and of care provided.

Key findings

Overall message Performance against all key clinical quality indicators was lower than in SAMBA2021. Acute care services are facing ever increasing pressures – careful consideration of how clinical quality and efficient patient pathways can be maintained is needed. Emergency medicine remains the most common route of referrals, with many units seeing a high proportion of their patients within the Emergency Department.

Close working between specialties is needed to improve patient pathways.

Key to Trust results

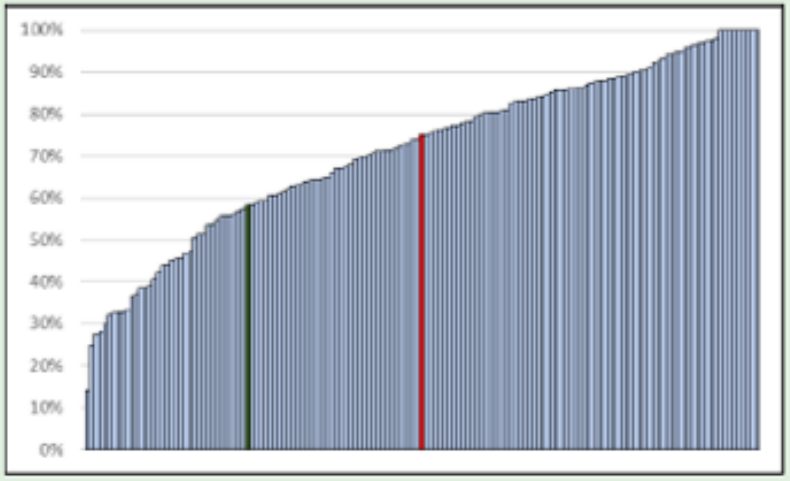
Trust site

National Average

SAMBA22 local report

Eastbourne District General Hospital

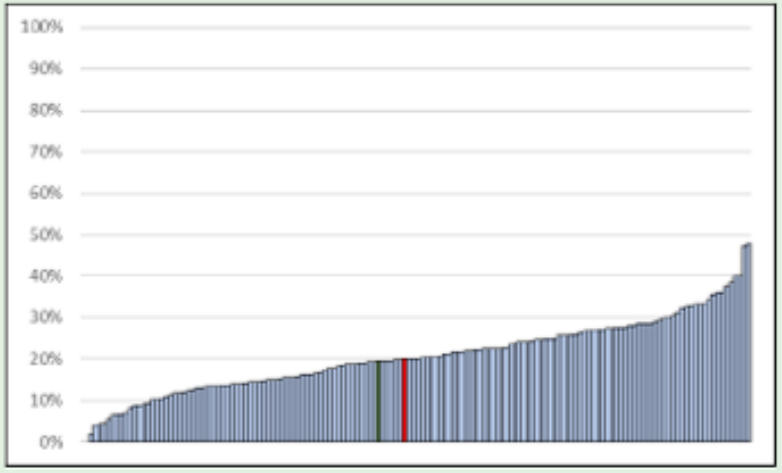
Early Warning Score



Percentage of unplanned admissions with Early Warning Score recorded within 30 minutes of hospital arrival.

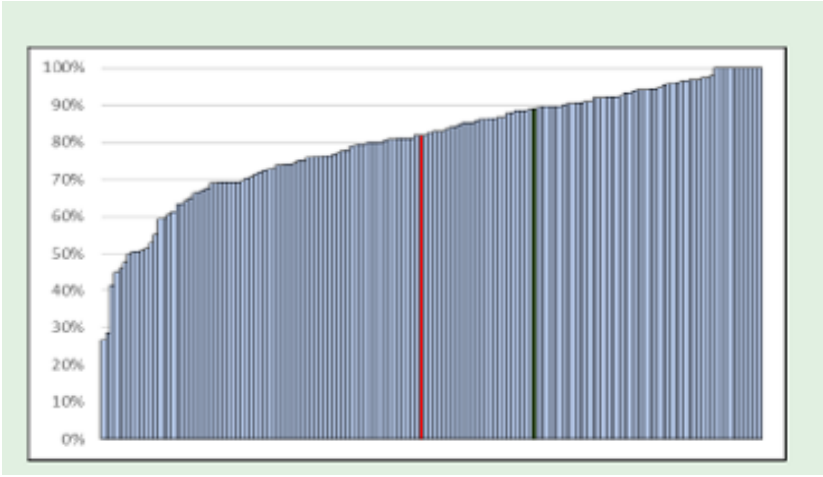
Median unit performance: 75%
EDGH: 58%

Percentage of unplanned adminssions who had been in hospital in the prior 30 days



Average: 20%
EDGH: 19%

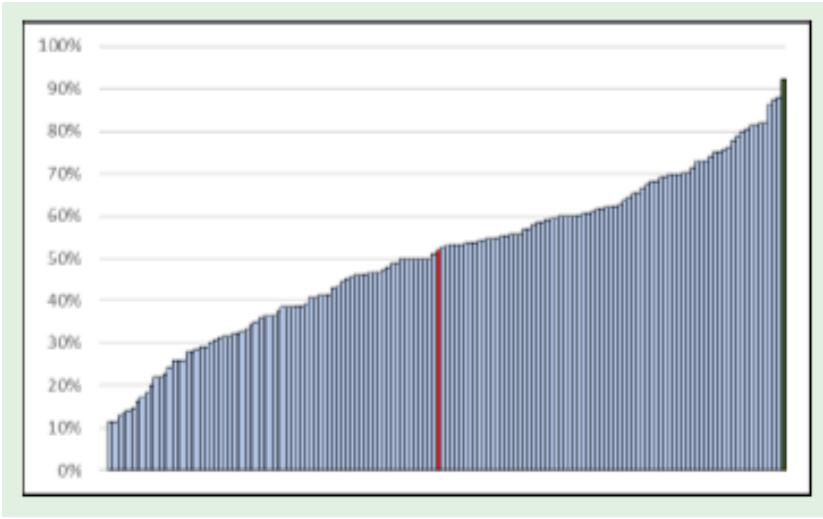
First Clinician Review



Percentage of unplanned admissions reviewed by a competent clinical decision maker within 4 hours of hospital arrival

Median unit performance: 82%
EDGH: 89%

Consultant Review



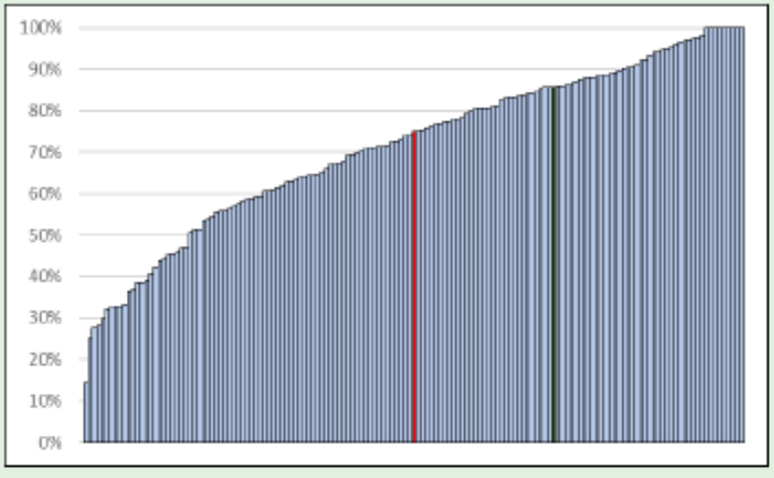
Percentage of unplanned admissions with consultant review (if required) within the target time

Median unit performance: 52%
EDGH: 92%

SAMBA22 local report

Conquest Hospital

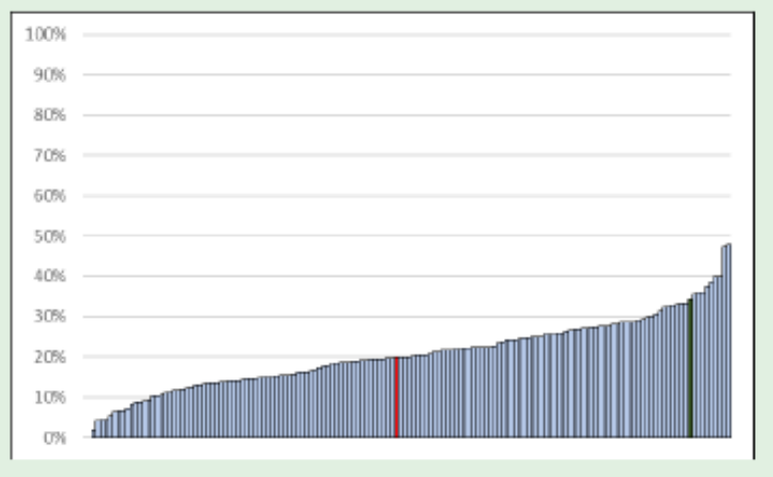
Early Warning Score



Percentage of unplanned admissions with Early Warning Score recorded within 30 minutes of hospital arrival.

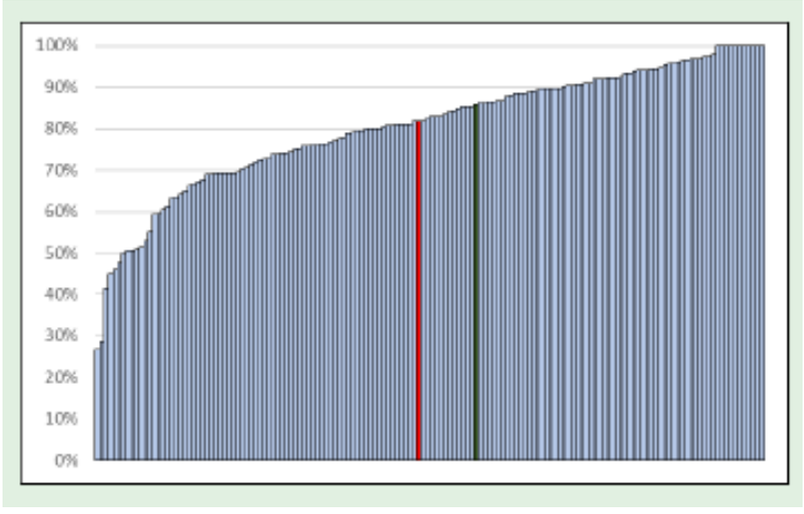
Median unit performance: 75%
CONQ: 68%

Percentage of unplanned adminssions who had been in hospital in the prior 30 days



Average: 20%
CONQ: 34%

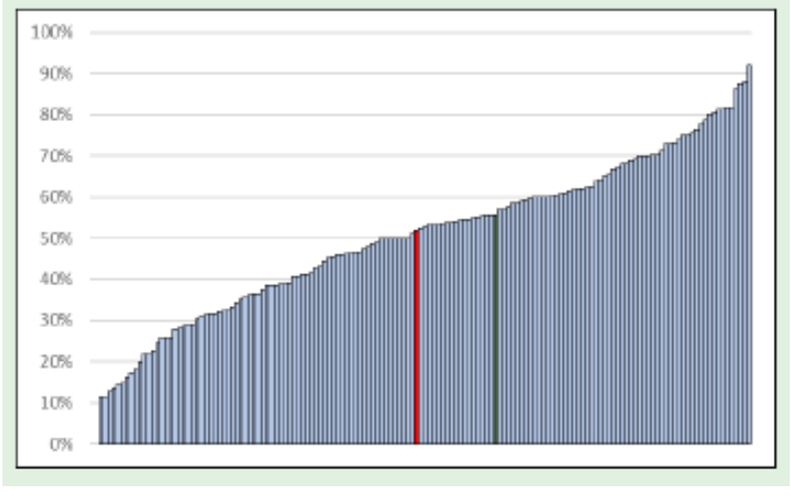
First Clinician Review



Percentage of unplanned admissions reviewed by a competent clinical decision maker within 4 hours of hospital arrival

Median unit performance: 82%
CONQ: 86%

Consultant Review



Percentage of unplanned admissions with consultant review (if required) within the target time

Median unit performance: 52%
CONQ: 56%

Trust SAMBA Audit Action Plan

Recommendation	SMART Action Point	Action by deadline	Comments / action status
All patients admitted to an AMU should have an early warning score (EWS) measured upon arrival	Communicate to nursing staff about the importance of NEWS to be measured and documented on arrival.	30th June 2023	**Completed**
All patients should be seen by a competent clinical decision maker within 4 hours of arrival on AMU, who will perform a full assessment and instigate an appropriate management plan	Share findings with Acute and ED via email, *as local results were above national average continue to deliver service as it is being delivered*	30th June 2023	**Completed**
All patients should be reviewed by the admitting consultant physician or an appropriate specialty consultant physician within 6 hours of admission to hospital or within 14 hours of admission to hospital.	Share findings with Acute and ED via email, *as local results were above national average continue to deliver service as it is being delivered*	30th June 2023	**Completed**
Outcomes shown for overall cohort and for the unit (14-day follow-up).	Share findings with Acute and ED via email, reminding the management of patients to discharge them when possible.	30th June 2023	**Completed**

Royal College of Physicians

National Audit of Inpatient Falls
A hip fracture is one of the most severe consequences of a fall. Evaluating the care given to inpatients who experience such fractures, will likely reflect the quality of fall prevention practice and post-fall management available to all inpatients. Not all falls are avoidable, and it is vital that patients are enabled to be active during their inpatient stay. However, it is equally important that all possible steps are taken to identify and address modifiable falls risk factors.

Key findings
While three-quarters of patients had a multi-factorial falls risk assessment (MFRA) documented, their quality varied. More than two-thirds of patients had assessment for delirium, continence, mobility and a medication review but it is concerning that less than half had a measurement of lying/standing blood pressure or vision assessment.

The audit has highlighted the potential for inequity in the experience of patients who fracture as an inpatient compared with those whose fracture occurs elsewhere. Inpatients who sustain a femoral fracture are less likely to have prompt surgery, get up the day after surgery and be free of delirium compared with those who sustain hip fracture outside of hospital. They are also twice as likely to die within 30 days. Organisations are urged to review their policies and procedures for managing inpatient fall-related injuries and ensure there are no barriers to providing timely and dignified care in line with hip fracture guidelines.

Trust Results

Multi-factorial risk assessment

Nationally, 76% of patients had a multi-factorial fall risk assessment (MFRA) performed in the hospital before they sustained the IFF. It was undertaken on average 3 days before the fall that caused the fracture. In 20% of cases, the patient had fallen in hospital before the fall that caused the fracture. Of the patients who had already fallen, 60% had a subsequent review of their MFRA after the previous fall.

In your organisation, 88% of patients had a MFRA performed in the hospital before they sustained the IFF. It was undertaken on average 3 day(s) before the fall that caused the fracture. In 38% cases, the patient had fallen in the hospital before the fall that caused the fracture. Of the patients who had already fallen, 67% had a subsequent review of their MFRA after the previous fall.

Analgesia after fracture

	Proportion nationally	Proportion in your trust/health board
Analgesia prescription recorded	78%	100%
Average time from fracture to analgesia	120 minutes	48 minutes

Components of MFRA

MFRA components documented	Proportion nationally	Proportion in your trust/health board
Vision assessment	44%	25 %
Lying / standing BP	35%	75 %
Medication review	69%	63 %
Mobility assessment	73%	13 %
Continence assessment	74%	100 %
Delirium assessment	73%	100 %

Compliance with care plans

Compliance with care plans	Proportion nationally	Proportion in your trust/health board
Mobility	71%	13 %
Continence	95%	100 %
Walking aid being used	58%	100 %
Delirium plan documented	73%	50 %

Post fall management

Compliance with NICE QS86	Proportion nationally	Proportion in your trust/health board
Check for injury before moving	71%	88 %
Check for injury and injury suspected	*47%*	*0 %*
Flat lifting equipment used	26%	0 %
Medical assessment within 30 mins	62%	88 %

Written information about falls prevention

	National	Your trust
Written information about fall prevention available	92%	Not readily available in any wards reviewed
Not available on any wards	17%	
In less than half the wards reviewed	21%	
More than half of wards reviewed	21%	
In all wards	41%	

Falls working groups

	National	Your trust
Multidisciplinary group that meets at least 4 times a year	87%	Yes
Quarterly incidence of falls routinely presented	99%	Yes
Information on falls rates expressed as per occupied bed days	86%	Yes
Quarterly data on falls rates and trends provided to directorates, wards and units	91%	Yes

Trust Inpatient Falls Audit Action Plan

Recommendation	SMART Action Point	Action by deadline	Comments / action status
Clinical leads should implement quality multi-factorial risk assessments (MFRAs) in all ward types, as inpatient falls can happen anywhere	○ Update the Trust Policy ○ To add the Multifactorial assessment on Nerve centre with electronic prompts for when assessments are due	17.05.2023	28.04.2023 Removed paper version of the MFRA, waiting for the new MFRA paper version then will launch onto nerve centre. May/June 2023 for this to be completed. 28.04.2023 Trust policy - couple elements left to complete.
Senior leaders and clinical teams should run at least one quality improvement (QI) project per year aimed at improving the quality of MFRA and to ensure care plans are followed	Arrange a meeting with the Frailty Team to discuss implementing a QIP	28.02.2023	28.04.2023 Proposal to be discussed.
Falls leads and clinical teams should use QI methods to improve performance against NICE QS86	Assess compliance against QS86 and CG161 6 months after implementation of the Multifactorial Assessment (MFA) on Nerve Centre	31.10.2023	The launch of the new MFA for Falls in Nerve centre will commence on 15th May 2023
Clinical teams should administer analgesia as soon as a provisional diagnosis of IFF is made, aiming for within 30 minutes of the fall	○ To include the recommendation in the Trust Policy. ○ Conduct a QIP to analyse the timeframe changes once the Trust Policy has been updated and shared.	30.04.2023 31.10.2023	28.04.2023 Trust policy - couple elements left to complete.
Falls leads and senior leaders should review NAIF reports and online real-time data for your trust in quarterly meetings of multidisciplinary team (MDT) falls working groups, so that these can be drivers for local QI projects	Share 2022 data at the next Falls Steering Group	15.03.2023	28.04.2023 The next falls steering group is 17th May – will prepare to feed back at that meeting
Senior leaders should include time for participation in NAIF and related QI activities in job specifications and plans for falls leads / practitioners / coordinators	To discuss with the Executives for the Trust for business planning recommendation	31.12.2023	

National Audit Quality Reviews
The Trust's Clinical Effectiveness Team regularly undertake Quality Reviews in order to assess compliance and implementation of best practice national recommendations across the Trust.

This process enables the Trust to continually improve service user outcomes and recovery processes by:

- Placing best practice guidance at the heart of clinical governance by providing mechanisms for reviewing and addressing non-adherence issues systematically and explicitly
- Contributing to continuing clinical education
- Ensuring compliance with Care Quality Commission (CQC) Fundamental Standards

Aims and objectives

- To assess and review the completeness of audit action plans, ensuring actions have been fully embedded in practice.
- To provide evidence of robust implementation and track continuous improvement in patient care.
- To flag up any areas of non-compliance or concern to the appropriate specialty / division for monitoring and further action as appropriate.
- To mitigate any identified risks to patient and staff safety, sharing lessons learnt across the Trust.

NELA
National Emergency Laparotomy Audit

National Emergency Laparotomy Audit (NELA) national year 8 data comparison to Trust data

NELA looks at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy and compares these against standards of care such as those detailed in recent NCEPOD reports, and the Department of Health/Royal College of Surgeons of England's "Higher Risk General Surgical Patient (2011)".

The National Emergency Laparotomy audit (NELA) has been active since 2013. Collection of NELA data allows continuous evaluation of performance against UK standards at hospital and at regional level. NELA modifies annual data collection to reflect changes in national standards and clinical practice whilst continuing to analyse care processes and outcomes. Much variation remains in these measures between different hospitals.

Standards against which NELA audits

1. Hospitals which admit patients as emergencies must have access to both conventional radiology and computerised tomography scanning 24 hours per day with immediate reporting.

2. An assessment of mortality risk should be made explicit to the patient and recorded clearly on the consent form and in the medical record.

3. Trusts and health boards should ensure theatre access matches need and ensure prioritisation of access is given to emergency surgical patients ahead of elective patients whenever necessary.

4. Each high-risk case should be reviewed before surgery by a consultant surgeon, consultant anaesthetist, and consultant intensivist.

5. Each high-risk case should have a consultant surgeon and consultant anaesthetist present in theatre during surgery.

6. All high-risk patients should be admitted to critical care after surgery.

7. Each patient aged 65+ and frail or 80+ should have multidisciplinary input that includes early involvement of geriatrician teams.

8. Frailty should be assessed using a validated scoring system in all patients aged over 65.

9. Timeliness of antibiotic administration.

10. Unplanned returns to theatre.

11. Unplanned critical care admissions.

12. Postoperative length of stay

Trust results VS National Results

Key Standard	Key Process Measure	National %	Trust %	Comments
An assessment of mortality risk should be made explicit to the patient and recorded clearly on the consent form and in the medical record	Proportion of patients in whom a risk assessment was documented preoperatively	**86.8**	**99.3**	
Trusts/health boards should ensure theatre access matches need and ensure prioritisation of access is given to emergency surgical patients ahead of elective patients whenever necessary	Proportion of patients arriving in theatre within a time recorded as appropriate for the urgency of surgery – this metric assesses the interval between decision to operate, and arrival in theatre	**71.8**	**96.7**	
Each high-risk patient should have a consultant surgeon, anaesthetist present in theatre during surgery	Proportion of patients with a preoperative risk of death ≥5% for whom BOTH consultant surgeon and consultant anaesthetist were present in theatre	**91.3**	**98.5**	
	Proportion of patients with a calculated preoperative risk of death ≥5% for whom a consultant surgeon was present in theatre	**96.4**	**98.5**	
	Proportion of patients with a preoperative risk of death ≥5% for whom a consultant anaesthetist was present in theatre	**94.1**	**100**	
All high-risk patients should be admitted to critical care postoperatively	Proportion of patients with a postoperative risk of death ≥5% who were directly admitted to critical care postoperatively	**79.1**	**76**	Trust - 55% of all patients received postoperative critical care. 76% of high-risk patients were admitted to critical care postoperatively. 24% went to the normal ward.
Each patient aged 65 or over and frail (Clinical Frailty Scale [CFS] ≥5) or 80 or over should have multidisciplinary input that includes early involvement of geriatrician team	Proportion of patients aged ≥65 years and frail or ≥80 years who were assessed by a member of the geriatrician led multidisciplinary team during any part of the perioperative pathway	**31.8**	**8**	
Frailty assessment in patients aged 65 and over	Assessment of frailty using a validated scoring system in all patients aged over 65	**86.5**	**97.6**	
Median [IQR] postoperative length of stay*		**10 days**	**10 days**	There was one LOS of 60 days plus that was removed for this calculation
Unplanned return to theatre (proportion)4*		**5.3**	**5**	
Unplanned admission to critical care		**3.1**	**1.3**	
In-hospital mortality rate		**9.2**	**11**	There was a total of 16 deaths in Year 8 (11%), 13 were high risk patients. All these patients spent time in critical care.

Frailty and Input by Consultant Geriatrician

Total number of Frailty patients	Number of patients over 80	Number of patients over 65 marked as frail	Number seen whilst inpatient by Consultant Geriatrician	
			Nationally	Trust
50 (33.3%)	28 (19%)	22 (15%)	31.8%	4 (8%)

Main Key Findings

- Radiology CT reporting – Many of the CT scans taken are sent off site for reporting. Although reporting is relatively quick, there are instances where Trust Consultants have had to add addendums.
- 92% of patients had a CT performed before procedure, of these 99% were reported.
- The number of frail patients seen by a Consultant Geriatrician whilst an inpatient needs to be improved.
- The number of patients going to Critical care when risk of death is greater than 10% is considerably lower than the national figure.
- NCEPOD Surgical Urgency Category patients with sepsis – Although the median for each of the categories was reached, there is considerable variance in the range of times.

Conclusions

Overall, the Trust results measured against the National results are similar.

Compared to the national figures those high risk > greater than 10% are not always sent to Critical care, this is a sharp contrast to national figures.

Discussion

A business plan is currently being drafted for a surgical frailty liaison consultant. If this is approved and appointed to, this should fulfil the need for input from a Consultant Geriatrician.

A future study could be conducted to review patients entered into the audit for Year 8 – looking specifically at the Radiology reports to establish the quality of reporting 'inhouse' compared to an outside agency.

The Royal College of Emergency Medicine

Royal College of Emergency Medicine Fractured Neck of Femur Audit review

66,313 patients a year (National Hip Fracture Database 2019 Annual Report) across England, Wales and Northern Ireland suffer a fractured neck of femur, the majority presenting via Emergency Department. Our focus should be on pain relief including nerve blocks and making the correct diagnosis through the use of MRI and CT scans where necessary.

The purpose of the audit is to identify current performance in Emergency Department's (ED's) against Royal College of Emergency Medicine (RCEM) clinical standards and show the results in comparison with other departments. The audit will enable individual hospitals to compare their current performance with results from previous audits.

Aims and objectives:

Nationally

- Identifying current performance in ED's against clinical standards
- Showing ED's their performance in comparison with performance nationally and in the ED's country in order to facilitate quality improvement.
- Empowering and encouraging ED's to run QI initiatives based on the data collected.

Locally

- Improve pain assessment at patient presentation.
- Improve provision of analgesia within 30 minutes for patients in moderate or severe pain
- Improve timeliness of x-ray
- Improve re-evaluation of pain and appropriate action within 30 minutes.

Standards / guidelines / evidence base:
The standards are set out as Fundamental (top priority for EDs to get right, no provider should provide any service that doesn't comply with) and Developmental (second priority to fundamental).

Key Trust Results

Clinical Standard	Nationally	Conquest	Eastbourne
Pain is immediately assessed upon presentation at hospital (within 15 minutes of arrival or triage, whichever is earlier) **Fundamental**	Within 15 minutes 48.62% Pain score not recorded 27.4%	Within 15 minutes **32.1%** Pain score not recorded 46.9%	Within 15 minutes **16.6%** Pain score not recorded 66.6%
Patients in moderate or severe pain (e.g., pain score 4 to 10) should receive appropriate analgesia within 30 minutes (or in accordance with local guidelines) unless there is a documented reason not to **Fundamental**	14.98%	**77.5%**	**Not entered**
Patients should have an x-ray at the earliest opportunity. **Developmental**	56.14%	**70.3%**	**17.8%**
Patients with severe or moderate pain should have documented evidence of re-evaluation and action within 30 minutes of receiving the first dose of analgesic. **Developmental**	3.43%	**8.5%**	**24.9%**

Recommendations:

- All Registrars / middle grade doctors at Conquest can perform fascia iliaca block.
- Time to pain assessment is linked to time to triage and needs to improve cross site.
- Documentation of pain scores - we are now using Nervcentre where pain scores need to be documented alongside the re-assessment of pain scores after analgesia.
- The EDGH doesn't see many fractured neck of femur patients, however any changes and training around fascia iliaca blocks must be cross site.
- A fracture neck of femur clinician / nursing lead is required.
- A short re-audit should be conducted once changes implemented.

Results have been shared with the Division and across the Trust, to promote improvement and learning a further Quality Improvement Project was undertaken to address the audit results and re-assess compliance to the standards. As a direct result of this project, a Fractured Neck of Femur pathway was developed and is available for all staff to access on the Trust's extranet site.

National Audit Successes

The Trauma Audit and Research Network (TARN) is the National Clinical Audit for traumatic injury and is the largest European Trauma Registry, holding data on > 800,000 injured patients including > 50,000 injured children.

Every year across England and Wales, 16,000 (approximately) people die after injury. It is the leading cause of death among children and young adults of 44 years and under. In addition, there are many thousands who are left severely disabled for life.

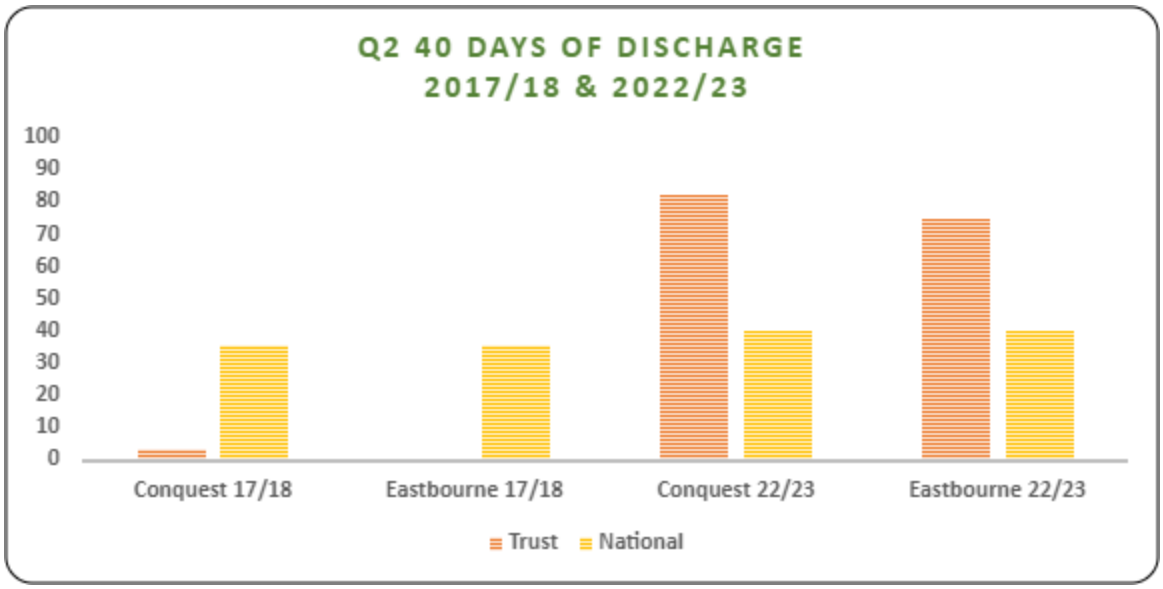
This national audit allows us to assess our performance in managing and treating our trauma patients, benchmarking on a local and national scale to identify improvements and optimise clinical outcomes.

One of the standards measured, is our ability to assess patients within 40 days of discharge, historically it has been a challenge to capture this data. Our dedicated TARN Facilitator has been working closely over the past five years with colleagues across the Trust to try and improve our performance.

Following an evaluation of our methodology, we now collect our audit data weekly (as opposed to monthly) which has enabled a more efficient data capture – ESHT is now capturing data above the national average.

The next step is to maintain our delivery of excellent data submission and ensure continued engagement across the Trauma Network.

Since 2017, the Trust has successfully improved our compliance to national standards, and our data quality, as evidenced in our quarterly dashboard reports. This data can now be used to analyse our clinical services and improve the quality of care for our patients.



Local Clinical Audit Reports in 2022/23

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 54 local clinical audits were reviewed by the Trust in 2022/23. 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.

One of these locally completed clinical audits is detailed below with the associated actions that the Trust intends to take (if required) to improve the quality of healthcare provided.

Audit Title:	Delirium Audit
Audit number:	5238
Division:	Medicine
Specialty / Service:	Frailty
Report Completion Date:	21st September 2022

Rationale

In August 2018, an audit was carried out to review the diagnosis of delirium within medical admissions at EDGH. This audit revealed that '0% of patients with indicators of delirium had a delirium assessment carried out using a validated delirium assessment tool.' A '4AT assessment' has since been introduced to the Integrated Patient Document (IPD) - The **4 'A's Test** (**4AT**) is a bedside medical scale used to help determine if a person has positive signs for delirium. The 4AT also includes cognitive test items, making it suitable also for use as a rapid test for cognitive impairment.

The '4AT assessment' use was audited 2020 and revealed this tool was often not carried out.

This audit was therefore carried out to see if there has been a change in practice with using the '4AT assessment' now that delirium teaching has been carried out.

Key findings

- 25% of acute admissions in those aged > 65 years had a 'delirium screen' filled in, an improvement from 22.5% seen in the previous Audit (carried out in EDGH 2020).
- Of those admitted to EDGH, 40% of patients demonstrated indicators of delirium (21 patients of a total 52 audited). 7 of these patients, i.e., 33% had a completed 4AT assessment on admission. We must note, however, that a further 2 patients with indicators of delirium on admission, were unable to undergo assessment due to a language barrier and a diminished level of consciousness.
- Patients with a completed 4AT assessment and score > 0, documentation was present in the clerking diagnosis / plan 29% of the time. This is less than seen in previous audits (reduced by 14%). Of those with the 4AT completed and a score > 0, documentation was present in the post-take ward round (PTWR) clerking plan/diagnosis 29% of the time. This is an improvement from previous audits, demonstrating an increase of 15%.
- Of those with the 4AT completed and a score >4, this was documented in the Junior Doctor clerking plan/diagnosis 40% of the time. This is less than seen in previous audit (reduced by 35%). Of those with the 4AT completed and a score >4 documented; this was present in the PTWR plan/diagnosis 40% of the time. This is less than seen in previous audit (reduced by 10%)

	2020	2022
Acute admissions with 4AT completed	22.5%	25%
When 4AT score greater than 0, this was acknowledged in the Junior Doctor clerking plan/diagnosis	43%	29%
When 4AT score greater than 0, this was acknowledged in the PTWR plan/diagnosis	14%	29%
When 4AT score was 4 or more, this was acknowledged in the Junior Doctor clerking plan/diagnosis	75%	40%
When 4AT score was 4 or more, this was acknowledged in the PTWR plan/diagnosis	50%	40%

	2022
Acute admissions with 4AT completed	33%
When 4AT score greater than 0, this was acknowledged in the Junior Doctor clerking plan/diagnosis	33%
When 4AT score greater than 0, this was acknowledged in the PTWR plan/diagnosis	0%
When 4AT score was 4 or more, this was acknowledged in the Junior Doctor clerking plan/diagnosis	50%
When 4AT score was 4 or more, this was acknowledged in the PTWR plan/diagnosis	0%

Good practice identified

- When the 4AT was done, it was clearly documented (facilitated by IPD).
- There was a slight improvement of number of 4AT assessments being carried out from 22.5% (2020) to 25% (2022).
- We also note an improvement in acknowledging an abnormal 4AT score in PTWR documentation. 14% (2020) to 29% (2022).

Identified risks or concerns

- The 4AT was poorly utilised. 75% of those 'at risk' of delirium as advised by NICE, were not screened using the available 4AT tool. 66% of patients with indicators of delirium were also not screened.
- Even if the 4AT was correctly filled, a positive result was not always recorded within the plan for the clerking doctors or within the PTWR documentation. This in fact, is worse than seen in previous audit cycles.

Conclusions

Although only 25% of at-risk patients (>65 years) were screened for delirium over the period that was audited, this was an improvement from the previous Audit (carried out in EDGH 2020). NICE advise we should be screening all those at risk of delirium with clinical indicators as a means of preventing and treating it urgently and systematically. Less than half of patients admitted with clinical indicators of delirium underwent appropriate assessment, far from the NICE recommendations.

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

Recommendations

- To continue to run training sessions for existing/new trainees (induction) on delirium assessment and management.
- Discuss the findings at the geriatric departmental meeting to explore ways to approach improving our delirium screening. This should be then re-audited when improvements are in place.
- As previously stated on 2018 Audit recommendations: "consider annual data collection/full time database of delirium assessment & management with monthly analysis and review (to be directed by elderly care Doctors and dementia nurse team)." (4)
- Present findings at grand round to educate a wider audience (due to take place July 2022)
- Consider Comms email alert to be sent out making doctors aware of results of audit
- Pilot new 'Delirium' clinical tool sticker to be used by Frailty Team, in Frailty Unit and Acute Medical Unit.

Action Plan

Recommendation	SMART Action Point	Action by deadline	Comments / action status*)*
To continue to run training sessions for existing / new trainees (induction) on delirium assessment and management.	Incorporate into departmental and foundation teaching sessions	September 2022	Complete – now imbedded into the teaching sessions
Discuss the findings at the geriatric departmental meeting in order to explore ways to approach improving our delirium screening.	Present the findings at the CG meeting for a discussion.	September 2022	Complete – pilot new delirium clinical tool sticker
Discuss findings at EDGH grand round to reach a wider audience	Present the findings at the grand round for a discussion	September 2022	Complete – discussed
Re-audit	Re-audit of the use of the 4AT tool once changes have been implemented.	September 2023	Lead Consultant to supervise/guide future re-audit in order to improve EDGH screening/diagnosis rate with regards to dementia.
Consider comms email alert to Trust Doctors to inform them of summary of audit findings	Disseminate the findings in the CEF newsletter for distribution	October 2022	Completed - Audited findings shared via email, meeting and via the CE report. Findings shared across the organisation via the November Clinical Effectiveness newsletter
Pilot new 'Delirium' clinical tool sticker to be used by Frailty Team, in Frailty Unit and Acute Medical Unit.	Action use of the delirium clinical tool sticker in Acute Frailty team and Frailty unit as well as AMU team	March 2023	The acute frailty team use the delirium stickers when reviewing patients in AMU, however the AMU team do not always use them. Additionally, they are used on the Frailty Wards. Furter work and insight required regarding usage and education of staff.

Participation in Clinical Research

The Trust acts as a participating site for national and international research studies, recruiting patients to take part in novel treatments. All research in the NHS is approved centrally by the Health Research Authority.

ESHT delivers research recruitment to approximately 35 National Institute of Health Research (NIHR) Portfolio studies. Although most Covid studies have closed to recruitment, ESHT continues to recruit retrospectively to the GenOMICC study. Since April 2022 the team has worked to ensure a wide portfolio of academic and commercial trials are available for our patient population to access as per table 1.

Project Short title	Disease area	Project site date open to recruitment	Project site Planned closing date	Principal Investigator
Add-Aspirin	Cancer	25/04/2016	01/04/2026	Soultati, Dr Aspasia
AFTER – Ankle Fracture Treatment: Enhancing Rehabilitation trial	Musculoskeletal	09/02/2023	14/06/2024	Rose, Mr Barry
Anti-Freaze-F	Musculoskeletal	20/09/2022	15/09/2023	Gallagher, Vincent
ACCURE	Surgery	17/11/2021	31/08/2022	Shaw, Mr Simon
Azithromycin Therapy for Chronic Lung Disease of Prematurity	Meds for Children	15/06/2021	30/06/2022	Kandasamy, Dr Mani
Brentuximab Vedotin Lenalidomide and Rituximab in DLBCL	Cancer	23/12/2021		Elzein, Dr Abier
Catheter ablation in symptomatic atrial fibrillation: a double blind randomised controlled trial	Cardiovascular	17/01/2020	31/12/2023	Veasey, Dr Rick
DRN 552 (Incident and high risk type 1 diabetes cohort – ADDRESS-2)	Diabetes	08/04/2013	31/07/2023	Dashora, Dr Umesh
Emergency Medical Services Streaming Enabled Evaluation In Trauma: The SEE-IT Trial	Emergency Medicine	24/06/2022	31/07/2023	De Freitas, Toni
Fluids Exclusively Enteral from Day 1 (FEED1)	Meds for Children		31/12/2024	Kandasamy, Dr Mani
Genetic and cellular analysis of malignant haematological samples	Haematology	04/08/2022	01/03/2037	Jones, John
GenOMICC	Critical Care	15/05/2020	28/02/2030	Corner, Dr Andrew
HD Grid	Cardiovascular	16/07/2021	15/05/2023	Veasey, Dr Rick
MIDI (MR Imaging abnormality Deep learning Identification)	Neurological	13/08/2021	31/03/2025	Sallomi, Dr David
MINDfulness And Response In Staff Engagers (NHS)-MINDARISE-V1.3	Mental Health	30/09/2022	28/09/2023	Tsawayo, Mr Tan
UK MS Register	Neurology	01/04/2019	31/07/2027	Kasti, Dr Marianne
Myeloma XIV (FiTNEss)	Cancer	16/03/2022		Sargant, Dr Nigel
ORION-4	Cardiovascular	01/12/2018	31/07/2026	Dickinson, Dr K
Perioperative Quality Improvement Programme: Patient Study	Anaesthesia, Perioperative Medicine and Pain Management	25/02/2019	31/10/2023	Murray, Kate
Positive Voices: National Survey of People with HIV	Infection	27/04/2022	31/03/2023	Jones, Mr Martin
RAPPER	Oncology	15/11/2010	31/10/2024	Manetta, Dr Caroline
Reduction Of Surgical Site Infection using several Novel Interventions	Surgery	05/02/2020	30/08/2023	El-Dhuwaib, Mr Yesar
SHED - Subarachnoid Haemorrhage in the Emergency Department	Emergency Medicine	06/12/2021	01/02/2023	Death, Kelly
Senior Rita	Cardiovascular	06/12/2016	31/03/2023	Kalyar, Dr Imtiaz
Statins for Improving Organ Outcome in Transplantation (SIGNET)	Critical Care	01/02/2022	31/03/2026	Bahlool, Dr Sinan
Stampede	Oncology	07/11/2008	31/03/2023	Manetta, Dr Caroline
Targeting Immune Pathways	Oral and Gastrointestinal	17/05/2019	31/12/2025	Tidbury, Mrs Judith
The impact of psychological stress on cancer burden and recurrence in ovarian cancer	Oncology	10/03/2023	10/03/2025	Lankester, Dr Kate
TIA Rapid Insights Study	Stroke	20/03/2023	17/04/2023	N/A
TriMaximize	Respiratory	11/04/2022	30/06/2024	Kankam, Dr Osei
WHiTE 11- FRUITI	Musculoskeletal	05/11/2021	30/04/2029	Keast-Butler, Mr Oliver
WHiTE 12 - DUALITY	Musculoskeletal	02/12/2022	30/07/2024	Buckle, Christopher

The number of patients receiving relevant health services provided or sub-contracted by ESHT in 2022/23 that were recruited to participate in clinical trials approved by a research ethics committee was 1400 participants.

Commissioning for Quality and Innovation (CQUIN)

The Trust agreed 5 CQUINs with our local CCG / Sussex ICS for 2022/2023.

We were able to monitor 4 of these – a range of operational pressures meant we were unable to track compliance with CCG5 '*Treatment of community acquired pneumonia in line with BTS care bundle'.*

The table below shows performance for the year:

Ref	Scheme	Target	Detail	reporting	Service	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CCG4:	Compliance with timed diagnostic pathways for cancer services	65%	65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones	Quarterly	Cancer	**68%**	**60%**	**65%**	**70%**
CCG1:	Flu vaccinations for frontline healthcare workers	90%	90% uptake of flu vaccinations by frontline staff with patient contact.	Monthly Sept - March	HR	**N/A**	**0%**	**53%**	**53%**
CCG3:	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	60%	60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 recorded.	Quarterly	ITU	**N/A**	**N/A**	**95%**	**86%**
CCG6:	Anaemia screening and treatment for all patients undergoing major elective surgery	60%	60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24.	Quarterly	Pre-op	**N/A**	**100%**	**100%**	**100%**

Statements from the Care Quality Commission

ESHT is registered with the Care Quality Commission (CQC) to carry out eight legally regulated activities from 17 registered locations with no conditions attached to the registration. Two new locations have been added this year, the Bexhill Community Diagnostic Centre, and new accommodation for the Community Paediatric Service.

In October 2022 our Maternity Services were formally inspected as part of the CQC's national maternity inspection programme. The report was published in January 2023 and the Trust was assessed as performing strongly on the Well Led domain, however the Safe domain was felt to require improvement. Four 'must do' recommendations were identified for the maternity services at the Conquest Hospital and two for the services at Eastbourne. An action plan has been developed and all actions are progressing positively.

The CQC continues to 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 quarterly engagement meetings with them to discuss any current issues that may be impacting on the delivery and quality of our services.

Throughout 2022-23 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 2023/24 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. A data quality Matrix has been established to assess data entry systems used within services and this will be used to addressing issues and identify a work plan to improve data quality in targeted areas, with the intention to raise the level of data quality across the trust over time.
- A focus group on training to support data quality has been established and this group will continue to work with key roles within the organisation to review data entry and ensure staff in roles such as administration, ward clerks, and secretaries all have a core baseline of education to enhance 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.
- A series of patient stories called 'Sonia's stories' have been produced to demonstrate the clinical impact of poor data entry on our service users and the awareness week on Data quality is being planned for the end of the year.
- A project lead role has been established through ICS funding to evaluate the recording of health inequalities in system within ESHT and SCFT. The objective of this role is to produce a work plan to improve recording of health inequalities and associated recommendations for training to improve health inequality data reporting from both organisations. This will improve reporting into the Sussex integrated data se, and therefore improve population health reporting across the ICS to improve care and reduce health in equality.

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
- 99.3% 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
- 99.4% 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 142 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 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 2022/23 period is due at the end of June 2023 and therefore has not yet been made. ESHT are therefore still covered by the 2021/22 toolkit whilst continuing to work on the 2022/23 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 95.77%

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

To ensure accuracy of clinical coding a number of internal audits are undertaken in addition to an external DSPT Audit conducted by a Clinical Classifications Service Registered Auditor.

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

Levels of attainment – percentage accuracy targets for Acute Trust

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

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

Primary Diagnosis Correct	Secondary Diagnosis Correct	Primary Procedure Correct	Secondary Procedure Correct	Unsafe to Audit
95.00%	93.24 %	96.71%	97.18%	0

East Sussex Health Trust (ESHT) achieved an overall accuracy percentage of 95.77% highlighting 4.23% 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 paying less attention and time pressures during data extraction.
- Some of the errors were due to inconsistencies in documentation and scanned record not available at the time of coding.
- Clinician awareness in coding terms and in recording co-morbidities is limited.

<u>ESHT will be taking the following actions to improve data quality:</u>

- Management will immediately feedback the audit findings and refresh coders on the National Coding Standards where the standards have not been followed.
- Encourage coders to pay more attention during the data extraction stage.
- Increase engagement and awareness with clinicians across all specialities.
- Liaise with management to improve the availably of scanned record in time for coding.

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 2022 and December 2022 2,032 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 2022 to December 2022)

Reporting period	Number of deaths
Q4 2021/22: January 2022 to March 2022	496
Q1 2022/23: April 2022 to June 2022	493
Q2 2022/23: July 2022 to September 2022	490
Q3 2022/23: October 2022 to December 2022	553
Total: January 2022 to December 2022	**2032**

Number of case record reviews or investigations
By 20/04/2023, 2,031 case record reviews and 85 investigations had been carried out in relation to the 2,032 deaths. In 85 cases, a death was subject to both a case record review and an investigation.

Number of case record reviews or investigations per quarter (January 2022 to December 2022)

Reporting period	Number of case record reviews or investigations
Q4 2021/22: January 2022 to March 2022	496
Q1 2022/23: April 2022 to June 2022	493
Q2 2022/23: July 2022 to September 2022	490
Q3 2022/23: October 2022 to December 2022	552

Two deaths, representing 0.098% of the patient deaths between January 2022 and December 2022, 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 2022 to December 2022)

Reporting period	Number of patient deaths considered likely to be avoidable	Percentage of the patient deaths considered likely to be avoidable
Q4 2021/22: January 2022 to March 2022	2	0.403%
Q1 2022/23: April 2022 to June 2022	0	0%
Q2 2022/23: July 2022 to September 2022	0	0%
Q3 2022/23: October 2022 to December 2022	0*	0%

*The Quarterly Mortality Review Audit for this period has not yet taken place, so this result may change.
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 at the Trust quarterly review meeting.

1. A patient with chest pain, thought initially to be due to an acute coronary syndrome, was subsequently diagnosed as an aortic dissection. Further detailed internal investigation of the entire clinical episode was undertaken. This revealed some communication issues concerning radiological findings and the suspicion of dissection.

2. In a patient with multiple organ co-morbidities and acute sepsis, there were delays in the recognition of the severity of a patient's condition and uncertainty about ceiling of care in a patient that was unlikely to survive resuscitation. Prompt response to changes in a patient's condition and good communication between admitting and ITU teams would have led to a clearer management plan. The importance of consultant-to-consultant communication, where there is uncertainty or disagreement about the best treatment approach was underlined. It is important that, if a care grading is changed, the specialty re-visits the care and the learning from it.

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:

1. As well as reflection by individuals, the clinical case has been, and continues to be, used as a teaching case to promote awareness amongst clinical staff to the possibility of aortic dissection as a cause of chest pain, to underline the importance of urgent appropriate investigation (chest X ray followed by CT) and of rapid transfer to a tertiary centre for intervention.

2. The case was discussed at MRAGDelays in recognition of condition and subsequent care. Avoid-ability rating changed to 2: strong evidence of avoid-ability. The importance of consultant discussion between teams, where there is uncertainty about treatment has been underlined. Training forward staff in responses to changes in a patient's physiological status is ongoing. The current clinical information systems support this.

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

The learning from the first patient has been used for education and should help in the prompt recognition and treatment of what is a rare but life-threatening condition.

Improved communication between medical teams and should help avoid patients transferring to ITU when this is not to their benefit, and the increased clarity from treatment plans agreed between acute specialties and ITU and improve our ability to support patients appropriately in wards.

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

The remaining 1 case record review and 4 investigations were completed after 12/05/2022 relating to deaths in the previous reporting period (January 2021 to December 2021).

No deaths in the previous reporting period, which were reviewed or investigated after 12/05/2022, 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 2021 to December 2021) judged more likely than not to have been due to problems in the care provided to the patient, remains the same.
There were two deaths representing 0.098% of the patient deaths between January 2021 and December 2021 judged more likely than not, to have been due to problems in the care provided to the patient.

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 Doctors in Training
- 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 improve working lives for 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 for each department
Oversight Group Meeting	Every 4 months (no longer happening)

Junior Doctors Forum	Quarterly
Junior Doctors Inductions	Three times a year
CEO Junior Doctors Forum	Every 4 months
Local Negotiating Committee	Monthly
GOSWH team meeting	Fortnightly

Each year the Trust is commissioned junior doctors from NHSE on training programmes in 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 by the GMC have been appointed to and are now helping to cover ward areas.

Staff who speak up

The National Guardian's Office and the role of the Freedom to Speak Up Guardian (FTSUg's) were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).which found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. There are over 900 guardians in NHS and independent sector organisations, national bodies and elsewhere.

The Trust has two Freedom to Speak Up Guardians who provide a service Monday- Friday. This provides an additional route to support workers to speak up. At ESHT staff are encouraged to raise and share concerns and speak up to line Managers Supervisors clinical leads.

The Freedom to Speak Up Guardian's work in partnership with all colleagues to ensure those who speak up are thanked, that the issues they raise are responded to, and to make sure that the person speaking up receives feedback on the actions taken. The FTSUg's work proactively to support the organisation to tackle barriers to speaking up. When things go wrong, we need to make sure that lessons are learnt, and things are improved. If we think something might go wrong, it's important that we all feel able to speak up to stop potential harm. Even when things are good, but could be even better, we should feel able to say something and be confident that our suggestion will be used as an opportunity for improvement.

The FTSUG's had 239 contacts from April 2022- March 2023 with Nursing and Midwifery staff reporting the most concerns in each quarter. Data demonstrates a whole range of staff at ESHT at all levels have accessed the Freedom to speak up Guardians including AHP staff, Administration and Secretarial staff, Medical and Dental staff, Estates and Ancillary staff. Agency staff and Volunteers have also accessed the service.

The key themes are in line with national trends and the Guardians report quarterly to the National Guardian office. Below are the report metrics required for ESHT for 2022-2023

SpeakUp - National Report Metrics

Fiscal Year	Fiscal Year Quarter	Detriment	Bullying	Patient Safety	Worker Safety	Attitude Behaviour	Total Issues Logged
2022/23	1	2	9	18	1	30	57
	2	3	11	9	2	22	62
	3	1	7	2	2	25	54
	4	0	4	10	6	23	66
	Total	6	31	39	11	100	239
Total	Total	6	31	39	11	100	239

The recent staff survey results at ESHT are in line with a decline across all NHS Trusts and Foundation Trusts in speaking up and assurance when staff speak up. The National Guardian Dr Jayne Chidgey-Clark has said nationally:

"It is disappointing that the staff survey results reflect a decrease in workers' confidence to speak up, and especially concerning that this includes about clinical matters. "No one should feel they cannot speak up to protect their patients or their colleagues. These survey results must be a wakeup call to leaders at all levels that Freedom to Speak Up is not just a 'nice to have' – it is essential for safe services."

At ESHT our data and partnership working has highlighted that staff at ESHT do speak up. When staff speak up, we continue to seek consistency and timely responses with feedback for staff to enable review support and learning and improvement. The FTSUG's present at Board and following discussions regarding feedback from staff who have shared concerns the Board have committed and supported the mandatory role out of training for all Managers and leads.

The National Guardian's Office, in association with Health Education England launched 3 modules.
The first module 'Speak Up' is Core Training for all workers including volunteers, students and those in training, regardless of their contract terms. Its aim is to help everyone working in health to understand what speaking up is, how to speak up and what to expect when they do. "Listen up" focuses on listening to concerns and understanding the barriers to speaking up. Managers should complete both *Speak Up* and *Listen Up* to ensure they understand what speaking up is and how they should respond when someone speaks up to them. "Follow up" Developed for senior leaders throughout healthcare – including executive and non-executive directors, lay members and governors – this module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to and action taken. All the Executive team at ESHT have completed this training.

Guardians regularly liaise with colleagues across the organisation to share insight into staff wellbeing, patterns and trends. This helps identify areas which may benefit from additional targeted support from the Trust. Walkabouts enable the Guardians to informally visit areas to speak directly with staff and to promote the speak up culture. Ongoing training student Nursing staff continues in partnership with Brighton University and both Guardians attend team meetings and divisional meetings to ensure speaking up is an agenda item and part of everyday business.

Wellbeing of our People

We continued to support the physical and emotional wellbeing of all our colleagues during the year and adapted the range of support that we offered during the pandemic to reflect the impact of ongoing pressures on our People. We've continued to focus on the things our people tell us make the biggest difference. Our work in supporting teams with evidence based psychological support, delivered by trauma therapists continues and has been accessed by a range of staff from teams working both within the acute and community areas, in clinical and support roles. Rapid access for individual staff members suffering from work related trauma continues to be available and has been very well received.
We now have 30 fully trained Traumatic Risk Management (TRiM) practitioners, with a further cohort of 6 who are completing their training. We have seen a significant increase in referrals for TRiM for individuals and teams, particularly since the start of 2023. An example of this, is that since 1st February 2023 to 22nd March 2023, our TRiM leads have reached out to 110 of our people. We have also trained 80 staff in the Mental Health First Aid qualification and a further 48 are planned to be trained during 2023/24 taking our total to 218. We have continued to support Wellbeing Conversations with colleagues in the Trust.
Within our in- house Occupational Health department we have supported:

- 2098 referrals of employees from their manager. This results in an appointment with an occupational health specialist who provides the manager with a report.
- The recruitment of 3468 candidates, offering health clearance and advice to both managers and newly recruited employees.
- In the moment advice through our duty nurse to 2665 colleagues

We have adapted our wellbeing menu of support during 22/23 with a focus on self-care. We have continued to offer support and information for individuals, teams, and managers on subjects our people are telling us are important to them such as menopause, men's health, and mindfulness. In conjunction with One You Sussex we have provided144 health checks for those colleagues aged between 40-74 and supported 38 of our international nursing colleagues with welcome, wellbeing checks and support.

Since April 2022 we have offered 8 Schwartz rounds and seen in the last quarter a return to face to face rounds.

Our main focus through 22/23 has been on Financial Wellbeing. We have partnered with the local foodbank and our wellbeing team have been able to issue vouchers directly to those in need. We have also been able to support via external wellbeing funding access to supermarket vouchers to support those with additional cost pressures. We have adapted our information and are able to sign post those struggling or in financial distress. We have also partnered with Barclays Bank who have given our people free access to webinars on managing money and budgets. We also arranged for their Barclays community bus to visit our acute and community sites, and these will continue throughout the coming year.

We have increased the number of visits from the wellbeing team to our community teams and provided 24 bespoke sessions from our menu of support in their venues and to teams. We also utilised external funding to provide our people who spend time in cars visiting patients with 'Spring into Wellbeing' packs. We have continued to thank and celebrate the achievements of our people with events throughout 2022/23. We celebrated the Jubilee with a delivery of scones cream and jam to all wards and all teams. In December, our executive team joined us in giving out refreshments and taking time to talk and thank all colleagues.

Staff Survey

NHS Staff Survey 2022

Our response rate was 43.4%% compared with the national average of 44.6%.
Like many trusts we saw a decline in the health and wellbeing of our people, including burnout, which is echoed nationally and is indicative of the challenges faced over the last three years.
The Trust results compared to other similar organisations are good.

Positive messages:

'We are compassionate and inclusive'
We are proud that 86% of our people feel their role makes a difference to patients/service users

'We are always learning'
71% of our people say their manager is interested in listening to them when describing challenges

'We are recognised and rewarded'
73% of us feel that our immediate manager values our work

'We each have a voice that counts (raising concerns)'
71% of our people feel secure in raising concerns about unsafe clinical practice and 90% of us feel trusted to do our job

'We work flexibly' 68% of us feel we can approach our immediate manager to talk openly about flexible working

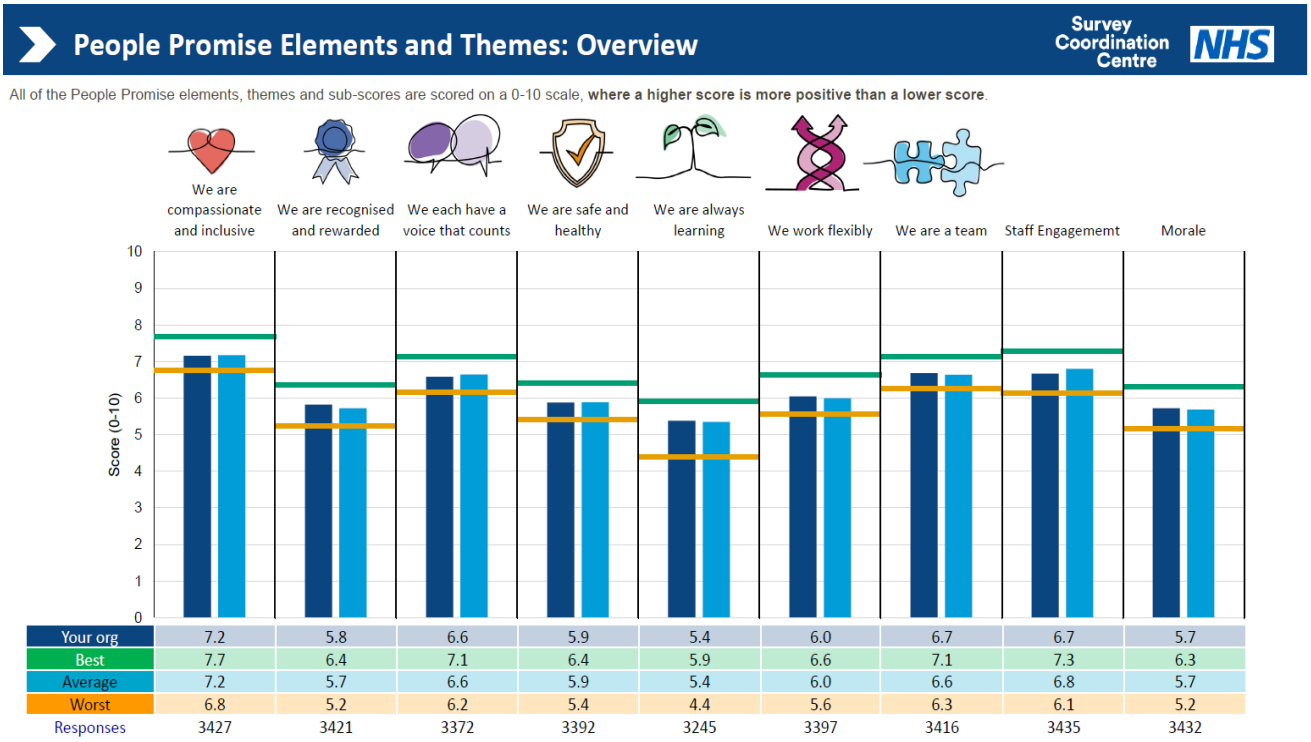
'We are a team'
74% of our people work in a team with a set of shared objectives

'We are safe and healthy'
73% of our people say that they, or a colleague, reported when they experienced physical violence or harassment and bullying at work

In 2022 there was an opportunity for our Bank colleagues to take part in the survey for the first time. This is important as it ensures all people working at the Trust can tell us about their experiences at work. Results have shown that 88% of our Bank colleagues feel that their role makes a difference to patients and service

users and 84% reported that they enjoy working with the colleagues in their team. Results have also highlighted that our Bank people are less likely to feel involved and more likely to experience discrimination and violence in the workplace.

There is acknowledgement of an increase in the numbers of our people reporting poor behaviours from patients and the public, witnessed across the NHS. Our focus on equality, diversity and inclusion is ongoing and we continue to champion our values and behaviours that underpin those values.



Our Trust is committed to improvements and therefore the quality of services by:

- Analysing the NHS staff survey results and using the information to identify key priorities for not only the whole organisation to focus on, but each of it's divisions. To deliver on these priorities each division is tasked to engage with its people, implement action plans enabling those involved to be in effective in change
- We have established engagement groups from a cross representation of staffing groups and disciplines to focus on key themes where we have seen a decline in a positive response to key questions.
- We have established multi-disciplinary groups to focus on workforce data.
- People Pulse- this has nationally undergone changes in 2022 and our intention is to use and show the results in an interactive and meaningful way.
- We have established a framework linked to the staff survey results for divisions and moving forward our intention is to measure and demonstrate action taken in the year.

Part 3 - Review of Quality Indicators and our Priorities for Improvement in 2022/23

Part 3.1 – Our Priorities for Improvement in 2022/23

The Trust identified three quality improvement priorities for 2022/23 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 2022/23

Quality Domain	Priorities for improvement 2022/2023
Patient Safety	1. Safe Staffing
Clinical Effectiveness	2. Ensure all patient nutrition and hydration needs are met
Patient Experience	3. Learning from complaints

Safe Staffing 2022/23

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.

Our Aims
We wanted to 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 included:

- 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

- To achieve:
  - >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 have we done?

Participation in Kickstart
At ESHT, we were excited to support the introduction of Community Assets with particular focus on the Kick Start programme aimed at 16yrs to 24yrs where the Integrated Care System have committed to recruiting 500 participants in total.

A community asset group is a local membership-led resource such as a sports club, youth group, societies, voluntary groups etc that can work in a community to deliver a range of outcomes e.g. education; health and well-being; advice, guidance or training. In Sussex there are circa 800k members identified as a potential source of recruitment for Health and Social careers.

The ongoing recruitment gap would be potentially addressed by introducing programme participants to a wider range of roles and opportunities within the health and social care sector, which they may not have previously considered.

Each placement had funding for 6 months for 25 hours a week. This was paid at a minimum wage dependent on age ranges from £3,003 to £6,064 which included pension, national insurance. There were also a £1,500 additional grant per participant to support set-up and admin.

On completion of the 6 months, the participant had the opportunity to apply for a vacant Trust position advertised in the usual way or seek alternative employment outside the Trust. There was no guarantee of a substantive position however the programme equipped the participant with a range of skills and experience through vocational, educational, and pastoral support. The Trust encouraged participants to look at apprenticeships and the New to Care opportunities to provide a robust, career pathway.

The department managers reviewed their service and identified areas for additional support. These were not positions that are current substantive vacancies but a newly designed placement opportunity. We had a library of job description examples, and we provided support and advice with next steps and timelines.

ESHT exceeded our target of 15 and placed 22 participants across the Trust. We have linked Project Search participants to Kickstart and are in the process of promoting the New to Care, apprenticeships, and graduate programme opportunities for those who are already looking to stay at ESHT and become part of our working community.

FILLED POSITIONS	EDGH	CQ
Ward Support	3	6
Social Media & Office Support	2	0
Emergency Department Support	1	1
Management Support Administrator	1	2
Housekeeping Support	2	1
Porter Support	1	0
PPE Management and Stockroom Project	0	1
Catering Support	0	0
Total per site	**10**	**12**
1 x Left the Trust		
Total at ESHT	**22**	

Following the completion of the Community Assets programme, 7 participants secured ongoing roles at ESHT, 3 secured roles with health and social care partners, 2 returned to further education stating they felt inspired by the programme. The remaining returned to the Universal Credit government support. The conversion rate for this government programme was 55% which includes the secured roles either for careers or for further education.

ESHT have been recognised by the ICS as a leader in the Kickstart and Community Assets Programme and will continue to build on the relationships and network made to strengthen our position in promoting health and social care roles across the system. Feedback from line managers and participants shows a high confidence in many of the Kickstart participants transitioning to a substantive post by the end of the programme in August 2022.

New connections have been made between Recruitment and the DWP to build a dedicated NHS profile within the 'Job Centres' and promote opportunities using our new attraction strategy. Further work is underway to explore and develop the other workforce pipelines with the Armed Forces Network as a priority.

Placement expansion

A further 3 placement areas have been developed in preassessment clinics (both sites), Trauma and Orthopaedic Outpatients Department and Bexhill Child Development Unit/Looked After Children as a pathway. Judy Beard Unit and Sexual Health Services on both sites are currently being developed into placement areas.

Further to the pilot of a placement capacity tool with Women, Children and Sexual Health Division to identify minimum and maximum placement capacity of each area based on hours/day of service and Electronic Staff Records data of Whole Time Equivalent registered staff, we have now completed the placement capacity tool with Diagnostics, Anaesthetics & Surgery Division. We are also reviewing data for the Medicine, Urgent Care and Community Health and Integrated Care Divisions.

Caveats have been added that placement capacity can be very fluid and dependent on a number of factors; staff levels, service redevelopment, other learners being supported at any one time, e.g. other professional and non-professional groups of learners, overseas nurses, new to care HCAs. This will further be impacted on by T level students - this is applicable across all professions and placement areas.

CLiP has had some limited success in areas that have used it. In the initial stages it requires a lot of support from the Integrated Education team and due to other workloads, this has been challenging. Following the recruitment of new team members, there is now more capacity to support.

We continue to work with local colleges, East Sussex College Group and Bexhill College, to offer observational placements to T level students. This consists of a three-week block placement in June of year one where the students have classrooms sessions and some clinical exposure to with a range of nursing, midwifery, and Allied Health Professions. In year two the student undertakes one half day per week in a range of nursing clinical areas from October – May (during term time).

We have also agreed to offer a three-week placement to RCN nursing Cadets in August 2023.

Safe Staffing indicators

Metric	Target	Benchmark	Jun	Sep	Dec	Mar
Rota Gaps	10% improvement	30.4%	37%	40%	41%	43%
Compliance (6 weeks sign off)	10% improvement	33%	43%	55%	44%	51%
Reg Nurse Associates Completed Training	Over 95%					
Vacancies in Nursing: Reg Nurses	2% Improvement	10.2%	7.3%	7.3%	8.9%	8.3%
Vacancies in Nursing: HCA's/Non-Reg	2% Improvement	22.6%	12.3%	19.3%	22.4%	19.9%
Annual Leave Compliance (spread evenly)	2% Improvement	28.0%	20.6%	25.8%	21.8%	29.4%
Reg Nurse Associates Completed Training	Over 95%		Feb 20 cohort		Sep 20 cohort	
			3 out of 4 (1 intermitted due to pregnancy)	3 out of 4 (1 delayed - illness)	100%	3 out of 4 (1 intermitted due to bereavement)
Reg Nurse Associates Ongoing Cohorts	Sep-21	Currently 8 started, no attrition				
	Feb-22	Currently 11 started, 1 attrition (left for St Michael's Hospice)				
	Sep-22	Currently 11 started, no attrition.				
	Feb-23	Currently 6 started, no attrition.				

Rota Gaps – There has been an incremental increase in rota gaps across the 4 quarters. This is likely to be due to an increased number of patients to care for in terms of escalation of bed numbers due to post-acute care of patients waiting to be discharged. Virtual wards have also increased staff need whilst waiting for recruitment processes to fill vacancy in the community setting.

Compliance - There has been an 11% increase on the benchmark of 33%. This shows improvement on compliance with a 6 week sign off of rosters.

Vacancies in nursing: Registered Nurses - There was a slight increase in Registered Nurses vacancy rate but is below the benchmark of 10.2%.

Vacancies in nursing: Health Care Assistant/Registered Nurses - There has been an 11% increase on the benchmark of 33%. This shows improvement on compliance with a 6 week sign off of rosters.

Annual Leave Compliance (spread evenly) – 25% for each quarter should be evenly spread. Q3, therefore shows less annual leave taken than is ideal and more in Q4. This is likely to be due to a number of factors such as seasonal respiratory infections and higher occupancy resulting in additional patients beign treated in escalation and super surge beds so staff less able to take annual leave.

Registered Nursing Associates (RNAs) Completed Training - Although the percentage of RNAs that have completed their training is only 50% for Q4, as the data shows the numbers of RNAs that we have trained is minimal.

2. Ensure all patient nutrition and hydration needs are met

Why was this chosen as a 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: Reference: The cost of malnutrition in England and potential cost savings from nutritional interventions, Public expenditure on health and social care (bapen.org.uk), 2015
- 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 a prolonged length of hospital stay.
- Overall, the cost of treating a persistently malnourished patient is two to three times more than treating a non- malnourished patient.
- The total public expenditure on malnutrition in health and social care was estimated to be £19.6 billion, with older adults accounting for 52% of the total, younger adults for 42%, and children for 6%. Institutionalisation of malnourished people (hospital inpatients and care home residents) accounted for up to £9.3 billion.
- 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%.

Fluid is important in the body and when levels start to reduce, negative health consequences are observed. Low levels of fluid (dehydration) in the body can lead to headaches, dizziness, lethargy, poor concentration and a dry mouth. In the long term, dehydration can lead to constipation and be associated with urinary tract infections, the formation of kidney stones and reduced skin integrity. Regular and adequate intakes of fluid can help to address these. Adults need to drink around 1.5–2 litres of fluid a day. (ref: The importance of hydration | British Dietetic Association (BDA), 2019)

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 have we done?

a. 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.

Patients with swallowing difficulties presenting at hospital need to be detected early in order for safe management plans to be put in place. Poor management of swallowing difficulties can lead to complications such as aspiration pneumonia, poor oral intake of fluids and diet, poor urinary health, malnutrition, general poor health, increased morbidity, and mortality risk. The IPD completed on admission should identify (Section 10) whether a patient has existing difficulties eating and drinking. If this form identifies pre-existing difficulties a separate risk assessment should be completed.

This project selected a sample of inpatient notes, identify whether IPD section on swallowing has been completed and if indicated whether the separate risk assessment form has been completed and included in the notes. From this review, any gaps will be identified, and an action plan developed.

This project has the oversight by the Nutrition and Hydration Steering Group and forms part of the Hydration and Nutrition Quality Account.

The latest version of the IPD was developed in 2021. The revised version included a greater focus on swallowing and the risk assessment was developed to identify what further action was required to safely support the patient whilst they were an inpatient. It is unknown whether this process is always complete.

This review is to determine whether the process is being appropriately followed.

Results

Total Beds Audited = 215	Total IPD Completed	%	Total Risk Form	%
Fully	100	47%	6	19%
Partially	55	26%	10	32%
No	60	28%	15	48%

Significant finding that the IPD section is not reliably being completed by ward staff with additionally further reduced compliance of completion of risk assessment form when swallowing problems identified and triggered in the IPD. It was acknowledged that overall compliance was less at CQ sites for both completion of the IPD and risk assessment form in direct comparison with EDGH. It was noted that 0% of risk assessment form were completed on the wards audited at CQ which is a statistically important finding of this audit.

The implications of this are that it is likely there will be missed opportunity for early detection or possibly no recognition of swallowing difficulties on admission to hospital for current inpatient sites leading to possible delays for treatment and/or worse outcomes for patients with swallowing difficulties.

It was noted during this audit that a potential reason for the reduced number of fully completed IPD section 10's was due to the wording and formatting of the document. It was found that many entries only completed half the form as a consequence of the questions asked which may have been a barrier to full completion.

Reduction in safety incidents scoring severity 3 or above (high risk of harm taking place) related to swallowing

One of the aims of the training was to improve staff knowledge and awareness of swallowing difficulties, in order to support them with following Speech and Language therapists' recommendations on safe for swallowing consistencies for patients.

In the last year we have seen a 47% reduction in the number of incidents raised relating to staff not following Speech and language therapy recommendations. In 2021, 17 incidents were raised and in 2022 this reduced to 9. There has been no severity 2 or 3 (the most severe level of incident where harm occurs to the patient) since the introduction of the training. We are continuing to support staff to access training and hope that the number of incidents continues to fall.

b. Ensure every ward has access to adapted equipment for eating and drinking.

Bedded areas cross site are able to order a range of specialist feeding and drinking equipment from the catering department for those that require it to increase independence with eating and drinking or to improve swallow safety.

Over the last 12 months, Occupational Therapy, Speech and Language Therapy, Dietetics and Catering have been working together to increase the range of items available and streamline the ordering process.

The new ordering form was launched in March 2023. A catalogue of what is available, and details of items that require liaison/assessment by Occupational Therapy/Speech and Language Therapy prior to ordering can be found on the Catering Department page of the Extranet.
Items will be stocked by catering and when ordered will be charged to the ward. On receipt of the order catering will aim to deliver the items to the ward the same day where possible.

Increasing the choice of texture modified for those with swallowing difficulties (pureed meals, soft and bite sized), above current number of choices.
The current contract for providing modified texture meals is out for tender. The Catering Department, Dietetic Department and Speech & Language Therapy Department have been carrying out tasting sessions of the different companies' meals and have been scoring these based on preparation, presentation, taste, suitable texture and nutritional content. The results of the tasting sessions will be fed back to Procurement to help determine the new contract provider.

Once the new contract provider has been decided, Catering, Dietetics and Speech & Language Therapy will then meet to make changes to increase the choice of modified texture diets across the different IDDSI levels.

c. 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.

The training has now been uploaded to MyLearn for all staff to access. Where previous training has been completed in a different format e.g., face to face or via MST, details of attendees have been provided to L&D to add to their learning account. Various methods to raise awareness of the training have been used including "focus on", communications, connect and direct targeted emails to matrons and assistants. Calculating the percentage of compliance has not been possible due to the ongoing mapping of essential training on learners profiles.

d. Increase the Vegetarian and Vegan Meal options across all sites

EDGH / Conquest menu
- Vegetarian non-Vegan dishes: 10 options per day
- Vegan dishes: 8 options per day

Bexhill
Vegetarian non-vegan dishes: 13 across the weekly menu
- Vegan dishes: 10 across the weekly menu
- Every day there is at least one hot vegetarian (non-vegan) main meal dish and one hot vegan main meal dish as well as 2 vegan jacket potatoes and 2 vegetarian (non-vegan) jacket potatoes, plus 4 vegan cold options and 6 vegetarian non-vegan cold options.

This has increased the amount of vegan and vegetarian options on each site over the past 2 years –

In 2020 EDGH / Conquest menu consisted of:
Vegetarian non-vegan dishes: 9 options per day
Vegan dishes: 5 options per day

In 2020 Bexhill offered:
On average, 10 Vegetarian / non-Vegan options across the week
Vegan dishes across the week: 2

<u>Clinical Audit work and results</u>

a. MUST Audit:
During the week commencing 19th September 2022 an audit of the use the Malnutrition Universal Screening Tool (MUST) was conducted at Eastbourne District General Hospital, The Conquest Hospital, Bexhill Irvine Unit and Rye Memorial Hospital. Information was gathered for all adult inpatients (aged 18 years or older), which gave an initial sample size of 737 patients across all four sites. 682 patients had been admitted for more than 24 hours and were therefore eligible to be included in the audit.

The aim of the audit was to identify whether the following had been achieved:
- 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 more that 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.
- The Audit results showed the following:37% of hospital inpatients should had a MUST score calculated on the day of admission (poor compliance).
- 22% of hospital inpatients had their MUST score calculation repeated weekly after the initial MUST score on admission for the duration of the patient's inpatient stay (poor compliance).
- 75% of patients were weighed or had another surrogate used to estimate their nutritional

status (e.g. MUAC) (moderate compliance).

- 72% of appropriate patients (MUST score >1) had a food record chart stated (moderate compliance).
- 44% of appropriate patients (MUST score >1) were be offered nutrition support in the form of food fortification / nourishing snacks / nourishing drinks (poor compliance).
- 58% of appropriate patients (MUST score >2) were referred to the Dietitian (poor compliance).
- 76% of appropriate patients had their MUST score calculated accurately (moderate compliance).

Did we achieve what we wanted to?

The results from the 2022 MUST show that we did not achieve what we had aimed for, although some improvements have been noted (especially in the accuracy of the calculation of the MUST) since the previous audit. Collaborative work across all disciplines is required to understand the reasons for this and to develop practical and realistic action plan to start to address these issues. It is likely that the lingering impact of the COVID 19 pandemic, as well as workforce challenges across many teams are contributing factors to this result. There has been a significant review of what and how training is delivered within the organisation as well as the tendering of a new electronic patient record and menu ordering system that has occurred in this financial year. These digital and training priorities have resulted in our quality account objectives relevance and trajectory changing.

Initial recommendations form the MUST audit include:

- Review training package available for nurses and HCAs, who undertake the majority of MUST.
- Consider virtual, face to face training and incorporating MUST and nutrition training into pre-existing packages to create holistic patient training; such as Falls or Pressure wound management
- Review the visibility and access to Dietetic Assistants on wards to help improve compliance with MUST and nutrition support actions.
- Consider joint working with clinical educators to train a core group of ‘train the trainers’ and MUST ‘superusers’.
- Review the use of currently available tools, such as nervecentre and use them to help identify priority patients requiring first line nutrition support interventions, such the use of a high calorie, high protein fortified diet and nourishing snacks and drinks.
- Identify wards with a greater number of high-risk patients, who may benefit from more targeted support from a Dietetic Assistant, e.g. Frailty.
- Identify priority patients to enable the Dietitians target attendance at the most relevant ward rounds to help identify and treat patients at risk of malnutrition.
- Identify the most appropriate patients to refer onto the dietitian, once all first line actions have been put into place.
- Review knowledge of and access to nourishing snacks and ward-based food fortification strategies that can be implemented.
- Evaluate the MUST against other newer, nationally validated screening tools, ensuring we are using the most appropriate tool to identify at risk patients in a timely and efficient way across the whole organisation.
- Continue the review and roll out of electronic patient records to enable MUST and weight to be recorded in one easy to access place and opportunities to work more innovatively to reduce malnutrition risk
- Review how the currently available electronic patient records and meal ordering system can work together to put into place first line dietary advise. For example, if a person has a MUST of 2, could the electronic meal ordering system recommend and suggest appropriate more nourishing options for the person to choose from, including reminding them about the use of nourishing snacks and drinks.

b. Patient-Led Assessment of the Care Environment (PLACE) Audit

Between 1st November and 8th November 2022, the Trust participated in Patient-Led Assessment of the Care Environment (PLACE) inspections. All assessments were completed and submitted prior to the closure of the 2022 program. The sites inspected and assessed were Eastbourne District General Hospital, Conquest Hospital, Rye Memorial Hospital and Bexhill Hospital.
The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient's experience of care. This report looks at the quality and availability of food and drink.

An overview of food and hydration which includes a range of questions relating to the organisational aspects of the catering service (e.g., choice, 24-hour availability, mealtimes, access to menus) as well as an assessment of the food service at ward level and the taste and temperature of food. It is important to note that the 2022 PLACE audit contained several revised and new questions than the audit from 2019 and this needs to be taken into consideration when making comparisons with.

Results

		Food
Bexhill	2019	87.14
	2022	92.22
Conquest	2019	94.61
	2022	84.04
EDGH	2019	95.08
	2022	80.07
Rye	2019	97.22
	2022	91.95
National Average	**2022**	**90.68%**
Organisational Average	**2019**	**94.46**
	2022	**83.03**

- The catering score for Bexhill has improved due to the introduction of steamplicity and the new pantry kitchen set up.
- Bexhill and Rye Hospitals food score remains above the national average.
- The overall catering scores for the Trust have dropped since the last full inspection of 2019.
- The overall score for catering should have been scored at 86.73%, however due to an error in our organisational questions return the central score of 83.03% has been recorded.

Areas of concern – Action planning
Food scores for EDGH, Conquest and Rye have reduced since 2019 however closer inspection of all audit responses the food quality as identified by the tasting scored highly and equal to those scores from 2019.

The reduction in the food scores is due to several dropped points either in our organisational return or from the observational audit on the day.

A follow up review meeting was held in early January 2023 with our Health Watch colleagues to discuss the outcomes and consider actions taken since the audit in November 2022.
During this meeting our Healthwatch colleagues commented that the quality of our food was exceptional and better than neighboring trusts.

Next Steps

- Actions noted from the inspections on the day have been shared with appropriate leads.
- Full results and reports for element to be shared with appropriate working groups e.g. Dementia Steering Group etc for discussion and action plan development.
- To assign a senior responsible lead for each element.
- To regularly meet with Healthwatch team to provide assurance that actions and recommendations from the audits are being addressed.

- To work with our Healthwatch colleagues to complete a smaller midterm PLACE Lite inspection in summer 2023.

Further work identified for this Priority:

- Review and agree the future of nutrition and nutrition risk training across the Trust. The launch of BAPEN nutrition e-learning across the Trust with 20% Compliance across staff groups within first year, has been suggested, as well as identifying opportunities where nutrition and nutrition risk training could be included in pre-existing training packages or during induction programmes,
- Completed training needs analysis for a minimum of ward staff including housekeepers, HCA and nurses (ideally for all staff involved in patient care)
- Introduction of Section 10 IPD being added to nervecentre. Aim to add IPD section 10/ risk assessment as electronic version alongside role out of nerve-centre development.
- To provide communication channels to all staff responsible for completing the IPD identifying expectations and rationale. This could be through a "focus on" document, cascading information to matrons assistants to be included in ward based meetings
- To review the trigger question format as possible barrier in preventing full completion of the IPD section on swallowing due to presentation of trigger questions. This shall be reviewed alongside EPR process.

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 draft NHS Complaints Standards (currently in the pilot stage), 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.

Our aims

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.

How have we done?

In April 2022, new complaints were logged against the KO41complaint subject coding, it is hoped that revising the subject codes will provide a better understanding of what the trends and themes are providing managers with more intelligent information to make changes/ improvements.

This has created a challenge, as the change will not allow us the opportunity to compare against historical subject codes.

Changing subject codes did allow us to code against more specific reasons for raising a complaint. Historically the top complaint subject was greater than 2022/23 subject coding (2021/22 standard of care =233, 2022/23 clinical treatment = 111).

April 2022- March 2023 Primary Complaint Subjects

Primary Complaint Subject	Count	% of All Complaints
Clinical treatment	111	25%
Patient care	78	18%
Communication	75	17%
Values and behaviours (staff)	47	11%
Admissions and discharges	38	9%
Proportion of all complaints in top five categories	349/436	80%

Clinical treatment is a new subject code, this subject had the highest number of complaints assigned and themes of these were, post treatment complications, delay, or failure to diagnose, missed or incorrect diagnosis, pain management and follow up care and treatment.

Patient Care= 78, this subject had the second highest number of complaints assigned and themes of these were, failure to provide adequate care, care needs not met, acquired infection, care pathway issues and failure to respond to call bell.
Communication =75 themes within this subject code were, communication with patients, relatives, and carers, breaking bad news, patient did not feel listened to and communication failure between departments.

Values and behaviours (staff)= 47, themes within this subject code were, attitude of staff (medical, nursing, admin/clerical), failure to act in a professional manner.

Information relating to trends and themes of complaints and concerns raised via Patient Advice Liaison Services are shared monthly at both local (service level), divisional and Patient Safety Quality meeting and Quality and Safety meetings.

Within individual complaints learning and actions were identified and shared with complainants providing assurance that there was action where appropriate as a result of their complaint.

Further improvements identified for 2023/24

The patient experience team will continue to review how data relating to trends and themes is shared with divisions/ services to help inform opportunities for learning and improving patient experience.

Future plans are for the complaints data (trends and themes) to be included in the analysis which forms part of Patient Safety Incident Response Framework (to inform Trust safety themes).

The Interim Deputy Director of Nursing has established learning summits for complaints Trust-wide. The first meeting is due to take place in quarter one of 2023/24.

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 is 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 2022/23.

The percentage of patients aged 16 and over admitted in the year who were assessed for risk of VTE on admission to hospital 2022/23 ESHT achieved **88%** 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.

The NHS Standard Contract 2022/23 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of both Clostridioides difficile (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement.

Trust thresholds
Trusts are required under the NHS Standard Contract 2022/23 to minimise rates of both C. difficile and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement.

***Clostridioides difficile* Infection**
Since April 2017, reporting trusts have been asked to provide information on whether patients with C. difficile had been admitted to the reporting trust within the three months prior to the onset of the current case.

Table 1: The six prior healthcare exposure groups for C. difficile

Prior healthcare exposure group	Definition
Hospital-onset healthcareassociated (HOHA)	Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
Community-onset healthcareassociated (COHA)	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
Community-onset, indeterminate association (COIA)	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date (where day 1 is the specimen date)
Community-onset, community associated (COCA)	Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date)
Unknown	The reporting trust answered 'Don't know' to the question regarding previous discharge in the 3 months prior to the case

Gram-negative bloodstream infections

From April 2020, reporting trusts were asked to provide information on whether patients with Gram-negative bloodstream infections had been admitted to the reporting trust within one month prior to the onset of the current case.

Table 2: Prior healthcare exposure groups for gram negative bacteraemia

Prior healthcare exposure group	Definition
Hospital-onset healthcareassociated (HOHA)	Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
Community-onset healthcareassociated (COHA)	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
Community-onset, community associated (COCA)	Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)

Baseline period

All thresholds are derived from a baseline of the 12 months ending November 2021, as this is the most recent available data at the time of calculating the figures.

Trust-level thresholds comprise total healthcare-associated cases (i.e., HOHA and COHA). The pandemic has resulted in greater variation in bed days; therefore thresholds have been reported as cases instead of rates per 100,000 bed days during the pandemic.

Performance

EAST SUSSEX HEALTHCARE	Case thresholds for 2022/23	Actual Cases reported for 2022/23		
Organism		**Total**	**HOHA**	**COHA**
C. difficile	56	93	74 (68)	19
E.coli	81	89	45	44
Pseudomonas	18	11	6	5
Klebsiella sp.	43	39	23	16

Source: ESHT 22/23 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 22/23 surveillance report had not been published.

The annual surveillance report for 2022/23 has yet to be published so the 2022/23 data has been taken from the data capture system and is subject to slight variation.

A total of 93 cases of CDI were attributed to ESHT for 2022/23 which is significantly higher than the threshold. For 2022/23 we have reported 93 cases against a limit of 56. 73 hospital onset healthcare associated (from 68 patients) and 19 community onset healthcare associated infections.

Since the reporting algorithm has changed to include a prior healthcare exposure element for community onset cases it has been much more challenging to reduce infection cases. Infections of CDI and gram negative bacteraemias 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. Prior healthcare exposure now includes attendance for planned day case care and attendance at emergency assessment units- even if this is a few hours.

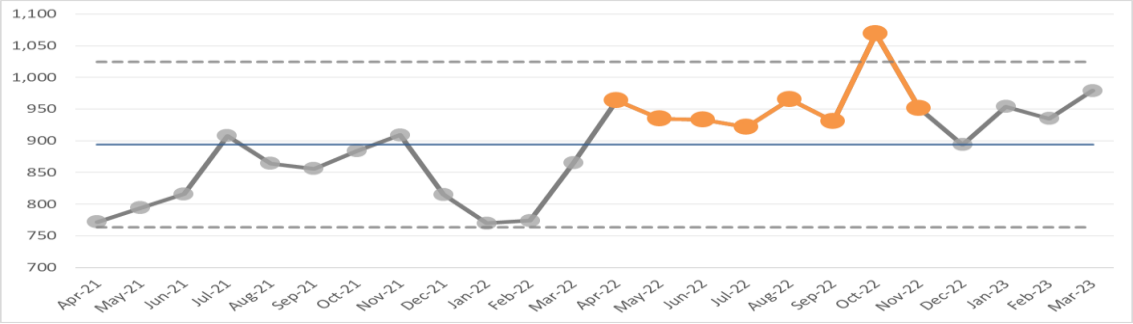
The reason for increased numbers of CDI nationally, is not fully understood but is believed that the COVID pandemic has had a negative impact. Post infection review has been undertaken on many of the hospital onset cases although this has been more difficult to achieve due to the additional workload 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 National Reporting and Learning System (NRLS) have not yet published the national patient safety incident reports commentary for April 2022 to March 2023. Their summary for the year 2021 to 2022 states: “The overall profile of incident characteristics (incident type, degree of harm, care setting where the incident occurred) was consistent between April 2020 to March 2021 and April 2021 – March 2022. Most incidents are reported as causing harm (70.6%) or low harm (26.0%). Fewer than 4% of incidents reported caused higher degrees of harm.”

Of the incidents reported by and attributed to ESHT 69.9% caused no harm and 28% caused low harm. Fewer than 3% (2.06%) of incidents reported caused higher degrees of harm.

Table 1 - Total Incidents ESHT only from April 2021 – March 2023

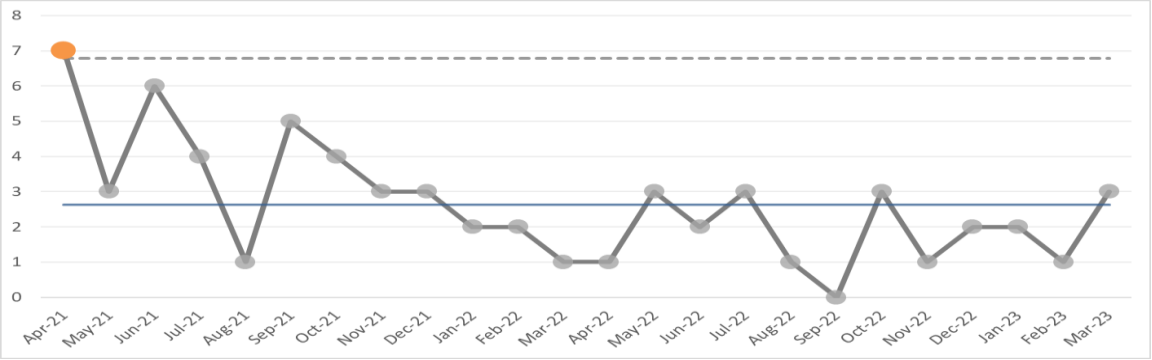


The graph indicates a series of months where the incident totals are above previous months. This is due to the increased reporting and activity following the Covid-19 pandemic and is now at level similar to pre-pandemic.

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 severity) 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 of outstanding provided to the Patient Safety and Quality Group monthly.

Table 2 – Serious Incidents



The graph shows a decline in the number of severity 4 and 5 incidents reported. This is due to reduction in Covid-19 cases and the number of serious incidents is now similar to pre-pandemic levels.

The number of serious incidents reported per 1000 bed days is 0.1 which is the same as in 2021/22.

Clinical Effectiveness Quality Indicators

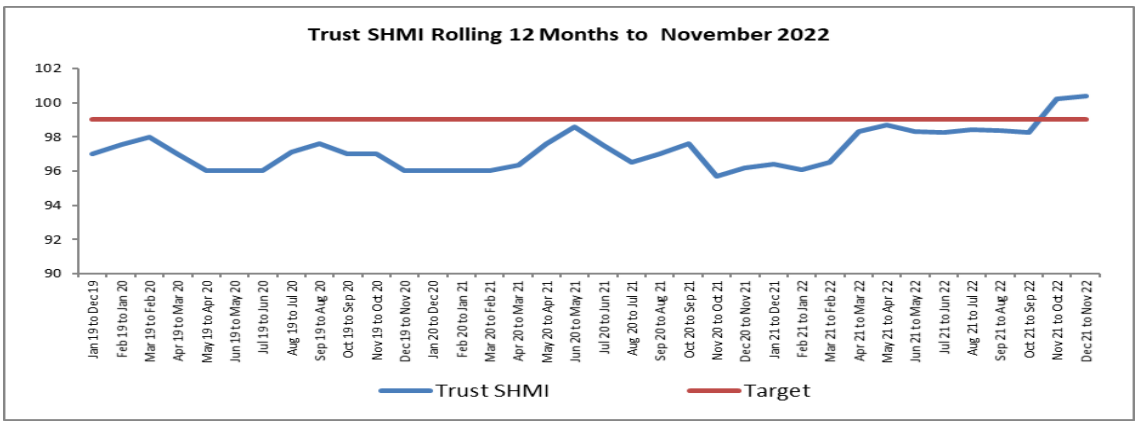
Summary Hospital-level Mortality Indicator (SHMI) Risk Adjusted Mortality Index (RAMI)

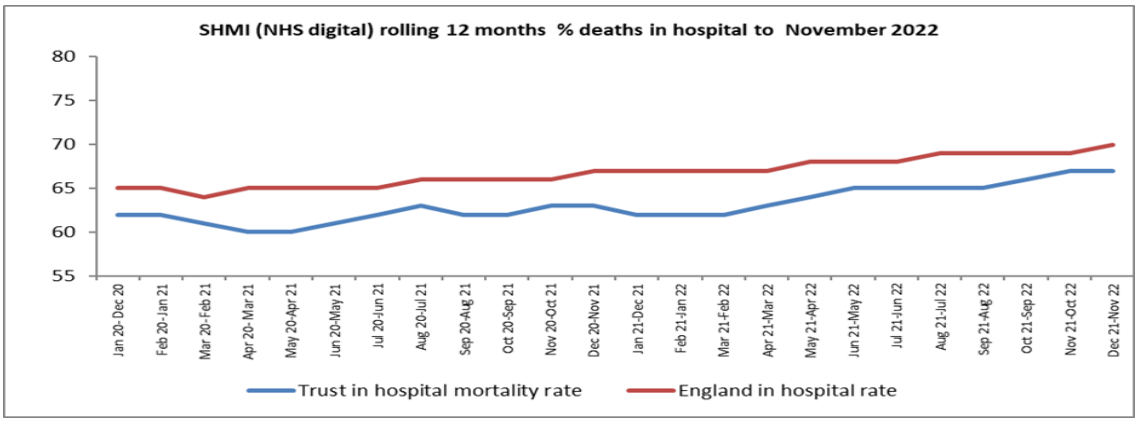
ESHT considers that this data is as described because the Trust has robust data quality assurance processes in place.

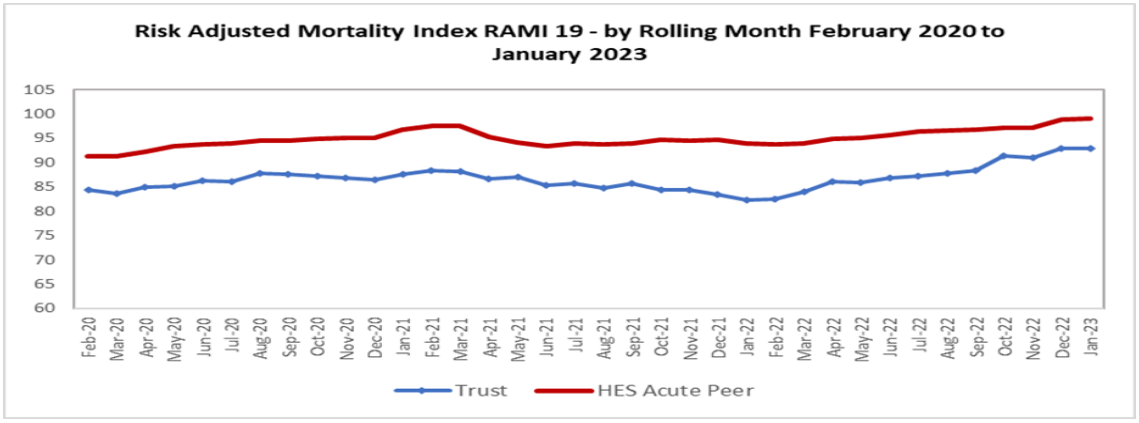
SHMI is one of several statistical mortality indicators used to monitor the quality of care provided by the Trust. We also look at the Hospital Standardised Mortality Ratio (HSMR) and the Risk Adjusted Mortality Indicator (RAMI), as well as crude death rates and associated local metrics.

Indicator	ESHT Jan 16 – Dec 16	ESHT Jan 17 - Dec 17	ESHT Jan 18 - Dec 18	ESHT Jan 19 - Dec 19	ESHT Jan 20 - Dec 20	ESHT Jan 21- Dec 21	ESHT Dec 21- Nov 22
SHMI value	1.09	1.04	0.97	0.97	0.96	0.96	1.00
Banding	2 (as 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	18.9	22.7	32	35	38	42	42

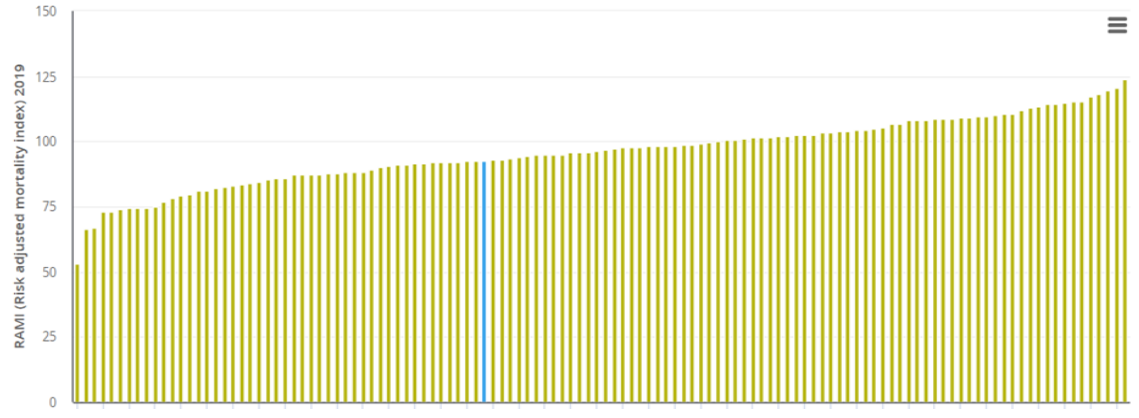
Source: NHS Digital







RAMI v Peer: our position against other acute trusts – February 2022 to January 2023 (Rank 48/122)



ESHT has taken the following actions during 2022-23, 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 Same day emergency care (SDEC), previously known as Ambulatory Care, with units open on both sites, 7 days a week, 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.
- Rockwood frailty scoring is now standard in the gateway areas and incorporated in Nervecentre Documentation and the paper admission notes (IPD).
- Further rolled out Electronic Prescribing (EPMA) across most of the acute inpatient wards, 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 Chief Medical Officer. The group also drives improvement in a number of workstreams to improve outcomes for patients.
- The quality of mortality reviews is monitored monthly.
- The programme of specialty mortality and morbidity (M&M) meetings has been re-launched, following a period, during the main waves of covid-19, in which these were somewhat less regular.
- 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.
- Deep dives, by the Mortality Review Group, into mortality associated with elective admissions and into post-operative infections, with ongoing investigations into stroke and MI mortality.
- 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 (Mortality Review Audit 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.

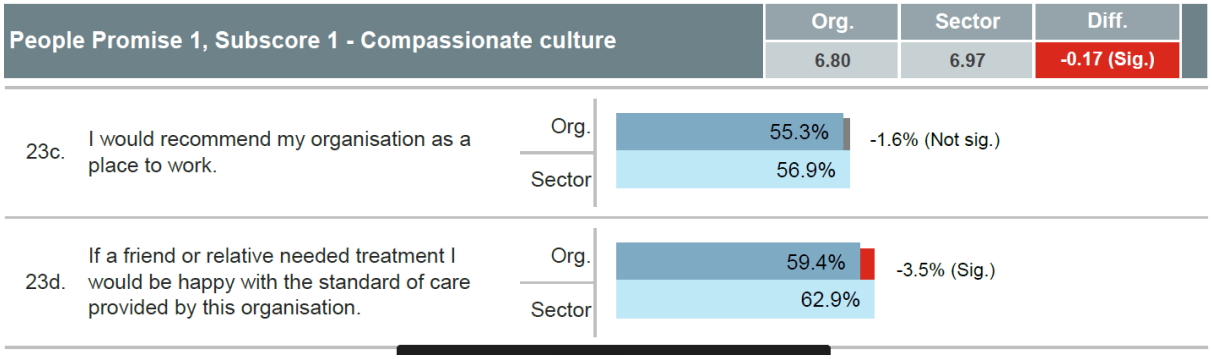
- The Trust Board is sighted on our mortality performance with formal quarterly reporting of "Learning from Deaths", which includes the number of avoidable deaths and regular updates on indices such as SHMI.
- Work is ongoing improving clinical coding of patient information to ensure mortality indicators 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.
- Planned focused groups led by the engagement team in June and July 2023 with representatives from divisions and all disciplines to 'drill' down with more focused questions relating to 23c and 23d.
- Continue to use the People Pulse results as a source of intelligence and temperature test to inform and signpost to areas for improvement in staff working life, wellbeing, conditions, and work environment.
- Continue to focus on the elements of NHS People Promise and the Trust's People strategy and deliver on the objectives laid out in both plans to support and embed change for our workforce.
- Establish and embed a Leadership Pathway, Talent Management Programme, and a clear and robust Retention Strategy for the organisation.
- Focused work through and by the Partnership Forum and Partnership Partners
- Review and refresh of the Trust Values
- Establish a multi team disciplinary team approach which will be led by each divisional HRBP, with a focus on each division and support for improvement and targeted work, will include the Engagement Team, Organisational Development and Culture, divisional leads, and the Wellbeing team.

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 2021
"care and treatment"	7.9

*CQC National Inpatient survey was published in October 2022.

The Adult Inpatient 2020 survey was 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 2021 results are therefore only comparable with 2020 data.

Patient Perspective who facilitates ESHT national surveys, noted that across the 33 Trusts they work with some results were worse than 2020, in areas that might be expected- length of time on waiting list, time waiting to get a bed on a ward and number of nursing staff.

Questions are 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 3 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 1 questions.

Banding (same)
- ESHT results were about the same as other trusts for 42 questions.

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 giving NHS Sussex ICB the opportunity to comment on your Quality Account for 2022/23. We appreciate the on-going collaborative working and open communication with the Trust's senior clinicians at the quarterly Quality Review Meetings and in the other quality meetings which commissioners are invited to attend.

NHS Sussex ICB has reviewed this Quality Account for 2022/23 and consider it to be a fair and accurate reflection of your performance during the year.

The Trust has achieved sustained improvement during the 2022/23 year, most notably the Trust:

- is performing in excess of the national average in terms of patients who have had a multifactorial fall risk assessment (MFRA) in hospital before sustaining an inpatient femoral fracture (88% vs 76%) as per the findings National Inpatient Falls Survey (2022).
- has developed a Fractured Neck of Femur pathway as a result of Royal College of Emergency Medicine Fractured Neck of Femur Audit findings.
- is continuing to work proactively to improve its position on behalf of patients in relation to managing unwell patients on medical wards. Emergency medicine remains the most common route of referrals, with many units seeing a high proportion of their patients within the Emergency Department. The Trust has completed all actions to improve the quality of care offered to patients in line with the Society for Acute Medicine Benchmarking Audit (SAMBA) (2022) findings.

NHS Sussex ICB looks forward to supporting you deliver your three strategic improvement priorities around the following areas, amongst a range of wider improvement projects, during the 203/24 year:

- Implementing the Patient Safety Incident Response Framework (PSIRF).
- Reducing insulin prescription and administration errors.
- Improving End of Life Care processes.

NHS Sussex ICB supports these priorities and the detailed work that underpins them and will continue to seek assurance regarding progress of implementation throughout the year via our established assurance processes.

My colleagues and I look forward to the continued collaborative working with the team at ESHT and wider system partners.

Yours sincerely,

Allison Cannon
Chief Nursing Officer
NHS Sussex

Statement from Healthwatch East Sussex

East Sussex Healthcare NHS Trust

As the independent voice for patients, Healthwatch East Sussex is committed to ensuring the public are involved in the improvement and development of health and social care services.

As one of the largest organisations in East Sussex in terms of turnover and staff numbers, and the only integrated provider of acute and community care in the county, it is right that Healthwatch reviews the performance of East Sussex Healthcare NHS Trust and its services via its Quality Accounts for 2022-23.

These are an important way for local NHS services to report on patient safety, the effectiveness of treatments patients receives, and patient feedback about the care provided.

As has been well documented, the NHS faced significant pressures during the last financial year. Despite this, the Trust highlights a number of achievements, with its Special Care Baby Unit at the Conquest Hospital becoming the first level one unit in the country to receive a Gold accreditation in the Bliss Baby Charter, the creation of a sensory garden for critical care patients at the Conquest and the opening of a new discharge lounge at Eastbourne General.

It is also positive to see the ongoing development of innovation such as the introduction of e-Triage in Emergency Departments and the opening of the Bexhill Diagnostic Centre, with the latter hopefully becoming the focus of a Healthwatch 'Enter and View' exercise later in 2023-24.

It will be re-assuring to patients and local people that throughout 2022-23:

- the independent regulator of health and social (the Care Quality Commission) found no breaches that justified regulatory action, no requirement notices were issued, and no enforcement actions were taken.
- ESHT continued to meet all standards of the Data Security and Protection Toolkit (based on 2020/21 data)
- The number of serious incidents reported remain the same as in 2020/21.

Over the last 12 months we have supported the Trust's development of a learning culture around complaints, so that staff and services learn, change and improve in response to patient feedback, and hope this is sustained moving forwards.

We welcome ESHT's three quality improvements identified for 2023-24: Implementing the Patient Safety Incident Response Framework (PSIRF); Reducing insulin prescription and administration errors, and End of Life Care.

The last of these is especially important in personalising care, and in creation of a culture where death and dying is more openly discussed, and people's wishes are discussed, explored, and acted on.

Over the next 12 months we will maintain a constructive, collaborative, and critical friend relationship with the Trust, with the goal of ensuring that staff, patients and the public are pro-actively involved in the development of patient-centred health and care services that deliver high quality outcomes.

Areas of particular focus for Healthwatch during 2023-24 will be:

- People's experiences of the implementation of the planned changes to cardiology and ophthalmology services.
- Implementation of the changes in End-of-Life care.
- The implementation and effectiveness of digital services, including virtual wards.

Veronica Kirwan
Executive Director

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

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 2022/23.

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 dealing with the impact of the pandemic, the pressures on the healthcare system, workforce issues and the recent industrial action. The Committee, therefore, welcomes the success ESHT has achieved in 2022/23, despite the considerable pressures placed on it.

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 new Elective Hub at Eastbourne, and the healthcare system's winter plan. The Committee thanks those Trust officers and clinicians who gave their time to attend.

ESHT's proposals to reconfigure cardiology and ophthalmology were scrutinised by two HOSC review boards, whose findings and recommendations were reported to the HOSC in June 2022 ahead of the Trust and ICB's decision on both reconfigurations. The HOSC welcomes the Trust's acceptance of all the review boards' recommendations and their inclusion in the Decision-Making Business Case. The Committee looks forward to further updates as the reconfigurations are implemented.

Quality Priorities

The 2022/23 priorities for improvement focussed on Safe Staffing, Hydration and Nutrition, and Learning from Complaints. Although there is no information in the draft Quality Account for Safe Staffing, data contained in the Trust People KPIs in appendix 1 indicates a vacancy rate of between 6.9% and around 9% throughout the year, peaking at 9.9% in December 2022. Staff turnover rates have been between 12% and 13.9% (November 2022) but have started to fall. This suggests working on staff recruitment and retention will remain a priority issue for the Trust. The HOSC also notes the positive work on staff support programmes, particularly for mental health, trauma and financial support during the cost-of-living crisis. For hydration and nutrition, the MUST audit results indicate that there remains some room for further improvement in this area.

The HOSC is pleased to see the Trust's high levels of the participation in national clinical audits (96%) and national confidential enquiries (100%), as well as taking part in six additional (non-mandatory) national studies. The Committee also notes the Trusts continued participation in over 35 clinical studies which benefits patient care.

In the section covering statements from the CQC reference is made to the CQC inspection of Maternity Services in October 2022 and an action plan has been developed for the 'must do' recommendations regarding the 'Safe' domain of the inspection. The HOSC considers that the Quality Account would benefit from having more detail on positive progress being made against these actions.

The Committee notes the Priorities for Improvement in 2023/24 and is supportive of the Trust's patient centred approach to improving services which include:

- Implementing the Patient Safety Incident Response Framework (PSIRF)
- Reducing insulin prescription and administration errors
- End of Life Care; and

- Reconditioning our Patients, which aims to prevent the deconditioning of patients after admission to support physical and mental wellbeing.

The Committee looks forward to continuing to work with the Trust during the coming year on areas that are of interest to the residents of East Sussex.

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
27th June 2023

Steve Phoenix
Chairman
27th June 2023

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

The guidance from NHS England has specified that an assurance report is no longer required.

Appendix 1 – National Clinical Audit and National Confidential Enquiries Programme

National clinical audits and national confidential enquiries we were eligible to participate in during 2022/23.

National Confidential Enquiries	**ESHT Eligible**	**ESHT Participation**
Maternal, newborn and infant and perinatal mortality (MBRRACE-UK) (and all applicable studies)	**Y**	**Y**
Child Health Clinical Outcome Review Programme (and all applicable studies)	**Y**	**Y**
NCEPOD – Transition from child to adult health	**Y**	**Y**
NCEPOD - Community Acquired Pneumonia	**Y**	**Y**
NCEPOD – Crohn's	**Y**	**Y**
NCEPOD – Testicular Torsion	**Y**	**Y**
National Clinical Audit	**ESHT Eligible**	**ESHT Participation**
2022 Audit of blood sample collecting and labelling for blood transfusion	**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**
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**
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 Safety Audit	**Y**	**Y**
National Diabetes Foot Care Audit (NDFA)	**Y**	**Y**
National Diabetes Adult Audit	**Y**	**Y**
National Diabetes Transition Audit	**Y**	**Y**
National Diabetes Audit Integrated Specialist Survey	**Y**	**Y**
National Ophthalmology Database (Adult Cataract Audit)	**Y**	**Y**
Perioperative Quality Improvement Programme	**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**
Pulmonary Rehabilitation Organisational Audit	**Y**	**Y**
Society for Acute Medicine's Benchmarking Audit (SAMBA)	**Y**	**Y**
Pain in Children	**Y**	**Y**
Mental Health and Self Harm	**Y**	**Y**
Infection Control in Emergency Departments	**Y**	**Y**
National Audit of Dementia (NAD) - Care in general hospitals	**Y**	**Y**
National Audit of Care at the End of Life (NACEL)	**Y**	**Y**
UK Parkinson's Disease Audit	**Y**	**Y**
Management of muscle Invasive Bladder Cancer at Transurethral Resection of bladder audit (MITRE)	**Y**	**Y**
Emergency Ureteric Injury Management (REJOIN)	**Y**	**Y**
Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery	**Y**	**Y**

*National IBD Audit – The Trust agreed to cease participation in this national audit in 2019, due to significant and ongoing resource issues.

**Adult Asthma Audit - although keen to participate, the respiratory department were unable to submit data to this national audit during 2022/23 due to significant resource issues, coupled with the ongoing impact of Covid care during this timeframe. This audit has now restarted at both the Conquest and the EDGH.

Appendix 2 – Participation in Mandatory Clinical Audits

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Number of Cases submitted	% Submitted of those required
National Audit of Dementia (NAD) - Care in general hospitals	EDGH – 40 CONQUEST - 40	100% (all required data submitted)
National Adult Diabetes Audit	Trust - 2888	100% (all required data submitted)
UK Parkinson's Disease Audit	EDGH - 20 CONQUEST - 20	100% (all required data submitted)
National Paediatric Diabetes Audit	Trust - 196	100% (all required data submitted)
National Pregnancy in Diabetes Audit	EDGH - 14 CONQUEST - 8	100% (all required data submitted)
Management of muscle Invasive Bladder Cancer at Transurethral Resection of bladder audit (MITRE)	Data unavailable from the national team	Data unavailable from the national team
Emergency Ureteric Injury Management (REJOIN)	Trust – 1	100% (all required data submitted)
2022 Audit of blood sample collecting and labelling for blood transfusion	Trust - 237	100% (all required data submitted)
Society for Acute Medicine's Benchmarking Audit (SAMBA)	EDGH - 42 CONQUEST - 42	100% (all required data submitted)
Pulmonary Rehabilitation Organisational Audit	Trust - 56	100% (all required data submitted)
Pain in Children (RCEM)	EDGH - 205 CONQUEST - 229	EDGH – 79% CONQUEST – 88%
Infection control (RCEM)	EDGH - 125 CONQUEST - 201	EDGH – 48% CONQUEST – 77%
Consultant sign off (RCEM)	EDGH - 34 CONQUEST - 122	EDGH – 13% CONQUEST – 47%
Transition (NCEPOD)	11 x Clinical Questionnaires 11 x Case notes 2 x Organisational Questionnaires	100% (all required data submitted)
Community Acquired Pneumonia (NCEPOD)	13 x Clinical Questionnaires 13 x Case notes 2 x Organisational Questionnaires	100% (all required data submitted)
Crohns Disease (NCEPOD)	4 x Clinical Questionnaires 4 x Case notes 2 x Organisational Questionnaires	100% (all required data submitted)

Appendix 3 – Other Non-Mandated National / Regional studies

The Trust participated in six non-mandated national studies in 2022/23, as follows:

National Study	Specialty
NAP 7 - Perioperative Cardiac Arrest	Anaesthetics
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
Consultant Sign Off	Emergency Department
Infection Prevention and Control	Emergency Department
The CONTACT audit – a national multi-centre audit on the COVID-19 impact on pancreatic cancer	Gastroenterology

Appendix 4 – 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>All of the Quality Improvement priorities for 2023/24 support patient safety.
The PSRIF priority will fundamentally change the approach to responding to patient safety incidents with a focus on quality improvement across themes and no just individual incidents.

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 implementing Datix iCloud (DCIQ) which is an upgrade to the current DatixWeb incident reporting and risk management system. This will support, along with PSIRF in identifying protected characteristics affected by incidents or risks.

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>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<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>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
</table>
</td></tr>
<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>PSIRF will enhance and add to systems in place to report, investigate and identify learning from patient safety incidents to develop actions to reduce the possibility of the same or similar incidents occurring. It is anticipated this will facilitate an increased focus on the learning and quality improvement change.
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 and improve experience.</td></tr>
</table>

Equality Consideration *Highlight the protected characteristic impact*		**Race** ☒ | **Gender** ☒ | **Sexual orientation** ☒ | **Age** ☒ | **Disability & carers** ☒ **Gender reassignment** ☒ | **Marriage & Civil Partnership** ☒ | **Religion and faith** ☒ | **Maternity & Pregnancy** ☒ | **Social economic** ☒
What impact will this have on people receiving a positive experience of care?	Positive	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 PSIRF priority will change the approach to learning and encourage patient, carer, and family involvement in quality improvement. The priority for reducing insulin prescription and administration errors will support the exploration of why errors occur and test interventions. Patients and other stakeholder engagement is part of the aims of the priority. For End-of-Life Care there will be a more personalised care based on what matters to patients, carers and families with hones conversations to facilitate informed decisions The Reconditioning project is part of a national focus on preventing the deconditioning of patients who are admitted to healthcare. It will be looking at many opportunities to support activities for patients.
Equality Consideration *Highlight the protected characteristic impact*		**Race** ☒ | **Gender** ☐ | **Sexual orientation** ☐ | **Age** ☒ | **Disability & carers** ☒ **Gender reassignment** ☐ | **Marriage & Civil Partnership** ☐ | **Religion and faith** ☒ | **Maternity & Pregnancy** ☐ | **Social economic** ☐

<table>
<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Positive</td><td>The priorities recognise that communication and engagement with carers and patients from all 9 protected characteristic is needed to ensure improvement in responsiveness to patient and delivering care in a patient centred and inclusive way.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☐</td><td>☒</td></tr>
<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>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</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 metrics.

The Trust is also part of the ICS Race Equality Transformation Board. Partner organisations have a system wide approach to race equality, have coproduced an anti-racist statement and supported the development of a race equality action plan.

Our staff networks have expanded to include disability, multicultural. LGBTQI, faith and belief and Women’s networks. The networks continue to celebrate difference, inspire 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
Highlight the protected characteristic impact</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☒</td><td>☐</td><td>☐</td><td>☐</td><td>☒</td></tr>
<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>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</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>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☐</td><td>☒</td></tr>
<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>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☐</td><td>☐</td></tr>
</table>
</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.</td></tr>
<tr><td>Equality Consideration

Highlight the protected characteristic impact</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<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>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</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 5 – 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.

After Action Reviews (AARs)

A tool used to debrief a project or event to understand what took place, why it happened the way it did, and how to improve on it. When used correctly, it can highlight areas of strength or concern in your project and team

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

DOLS (Deprivation of Liberty Safeguards)

The procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

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

eTriage System
Digital triage solution for NHS Emergency Departments and Urgent Treatment Centres, developed by clinicians. eTriage was designed to automatically check-in and prioritise (triage) patients upon arrival based on clinical need.

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.

Integrated Care Board (ICB)

A statutory body responsible for local NHS services, functions, performance and budgets. It is directly accountable to the NHS and is made up of local NHS trusts, primary care providers, and local authorities

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'.

PSIRF Patient Safety Incident Response Framework
The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

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.

Rockwood score
Scoring Frailty in people with dementia, the degree of dementia. Common symptoms in mid dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal

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.

Supportive and Palliative Care Indicators Tool (SPICT)

Identify people with deteriorating health due to advanced conditions or a serious illness and prompts holistic assessment and future care planning.

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

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.

Virtual Wards
Virtual wards allow patients who are acutely unwell to get the care they need at home safely and conveniently, rather than being in hospital.
In a virtual ward, new technology such as wearable devices, oxygen and blood pressure monitors along with apps, are available where necessary to provide real-time information on people’s vital signs

VOICE
National Survey of bereaved people, collects information on bereaved people’s views on the quality of care provided to a friend or relative in the last 3 months of life, for England.