East Sussex Healthcare
NHS Trust

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 0300 131 4500
Website: www.esht.nhs.uk

FOI REF: 23/828

29th December 2023

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

1) a) What is the annual cost for your TIE environment support contract?

Whilst East Sussex Healthcare NHS Trust holds the information requested, it is applying a Section 43(2) exemption in relation to this part of the request as the release of the information is likely to prejudice its commercial interests.

In applying the exemption consideration has been given to the public interest in enabling scrutiny of public sector decision making and the general public interest in accountability and transparency.

We have concluded that sharing commercials could disadvantage the incumbent supplier against their competitors. The information could provide competitors with the suppliers pricing, which could result in these suppliers obtaining a competitive advantage which could result in the Trust not obtaining best value for money.

In this instance, we consider that the public interest in withholding the information is greater than the public interest in disclosing the information.

b) Does it cover out of hours support?

Yes.

Cont…/

c) **Who is the supplier?**

Interoperability Health (UK) Limited.

d) **When does the contract end?**

28th February 2025.

2) **What solution(s) do you use to manage / improve data quality and what is the scope, e.g., is clinical data included?**

The Trust does not have a named solution but uses various national dashboards to check our compliance on central data items in comparison to others.

3) **How do you manage care planning (e.g. ReSPECT) across multiple providers and teams, e.g., acute, mental health, social care?**

Please see attached the Trust's ReSPECT policy and note that this is currently in the process of being updated.

4) **What are your plans around creating your system level data/integration strategy?**

Please see the attached 'ESHT Digital Strategy' and review the following links:

Digital technology and data - Sussex Health & Care (ics.nhs.uk)
Improving the use of digital technology and information (ics.nhs.uk)

Please also note that the Trust is part of the Sussex ICS and we work closely as a system on key digital strategies.

5) **Please provide the email address of your main point of contact to discuss the above.**

esht.servicedesk@nhs.net

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

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Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Linda Thornhill (Mrs)
Corporate Governance Manager
esh-tr.foi@nhs.net

East Sussex Healthcare
NHS Trust

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) incorporating Decisions about Cardiopulmonary Resuscitation (CPR) - Policy and Procedure

Document ID Number:	1775
Version:	V2.0
Ratified by:	Policy Ratification Group
Date ratified:	September 2018
Name of author and title:	Nick Watson, Consultant Anaesthetist
Date Written:	June 2018
Name of responsible committee/individual:	Resuscitation Committee
Date issued:	September 2018
Review date:	September 2021
Target audience:	All Trust staff
Compliance with CQC Fundamental Standard	Person Centred Care Dignity and Respect Safe Care and Treatment
Compliance with any other external requirements (e.g. Information Governance)	N/a
Associated Documents:	End of Life Care Policy Guidance for staff on the Implementation of the Mental Capacity Act (MCA) Patient Documentation and Record Keeping Policy Policy for Advanced Decisions Policy for Palliative and End of Life Care for babies, Children and Young People Policy and Procedure for Consent Policy and Procedure for the Management of Resuscitation ReSPECT National Templates and advice leaflets

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0	June 2018	Nick Watson	New document to meet national requirements	New document
V1.1	August 2018	Nick Watson	Updated following feedback	Added to responsibilities, other minor changes including additional appendices/hyperlinks etc
V1.2	September 2018	Nick Watson	Policy group advice	Removed reference to children until the children's service agree date to adopt ReSPECT Adjust wording against provision of interpreting services
V2.0	March 2019	Nick Watson	Minimal Changes	Section 3, 5.9, 6,7 and 8.
V2.0	May 2019	Nick Watson	1 addition	ReSPECT Core Skills Portfolio added as Appendix B
V2.1	July 2019	Nick Watson	Minor amendment	Amendment to Appendix 3, section 4, last bullet point

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
David Barclay		June 2018
ReSPECT Project Board members		August-September 2018

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a process of advance care planning, designed to be used as a guide for healthcare professionals in the event of a clinical emergency or deterioration which renders a person unable to make or express decisions.

The process begins with a conversation to establish a shared understanding of the person's current condition, the likely course and prognosis of any illness, and which forms of treatment that person would or would not want to receive. Such treatments may include Cardiopulmonary Resuscitation (CPR), admission to Intensive Care, organ support, intravenous fluids or antibiotics. The discussion may also be used to explore broader issues, such as whether the person would want to be admitted to hospital in an emergency. Following this discussion, the ReSPECT form is used to record the person's wishes, together with clinical recommendations for care in a future emergency.

ReSPECT is concerned as much with treatments and forms of care which people would want and are appropriate in an emergency as with those which are not wanted or not appropriate.

The ReSPECT form is a summary document, which records information necessary for clinical decision-making in an emergency. Full notes must still be made in the person's health record, including details of discussions and the rationale for decisions.

The ReSPECT form is not a legally-binding document, but is designed to guide best-interests decision-making by healthcare professionals in the event of acute deterioration in a person's condition or cardiorespiratory arrest. Healthcare professionals must have valid reasons for overriding the recommendations recorded, including decisions concerning CPR.

2. Rationale

It is vital that a person's wishes are taken into account, should a clinical emergency or deterioration occur which renders them unable to make or express decisions. It is equally important, that decisions relating to resuscitation should be taken in the context of wider goals of care, including escalation plans and ceilings of care. ReSPECT supports healthcare professionals in providing care which meets these criteria.

ReSPECT has been developed since 2014, by a UK-wide group, facilitated by The Resuscitation Council (UK) and the Royal College of Nursing. This development has occurred against the background of a growing demand for a national form which records decisions about CPR in the wider context of other forms of care and treatment. It has been informed by a systematic review of DNACPR decision-making, the NCEPOD report 'Time to Intervene', national guidance on 'Decisions Relating to Cardiopulmonary Resuscitation' and the court judgements in the Tracey and Winspear cases.

3. Scope

ReSPECT replaces previous 'Do Not Attempt Cardiopulmonary Resuscitation' forms, and complies fully with national guidance on CPR decisions published by the British Medical association, the Resuscitation Council (UK) and the Royal College of Nursing.

The ReSPECT process and documentation

- Can be undertaken in any healthcare setting, including hospitals, hospices, care homes and the community. It is transferable between different settings and is valid in all of them.

- **Can be used for all age groups,**

It is particularly appropriate for the following groups:

- people with long-term or life-limiting conditions or disabilities
- people who have deteriorated over a short period of time
- people at significant risk of death or cardiorespiratory arrest
- people undergoing an intervention, such as surgery
- people who are nearing the end of life
- people who request a ReSPECT form

4. Accountabilities/Responsibilities

Nurse and Medical Director
Accountable to the Trust Board for nursing and medical standards and practices and for ensuring governance and overall monitoring of this policy.

The Resuscitation Committee
Responsible for monitoring process compliance and quality for ReSPECT.

The healthcare professional with overall clinical responsibility for a person's care is responsible for ensuring that the ReSPECT process and documentation, including review, amendments or cancellations, are carried out in compliance with Trust policy. They are also responsible for ensuring that a clear plan for review, (including frequency), is documented in the medical record.

Other members of the healthcare team may initiate and lead a ReSPECT conversation, make decisions concerning care in an emergency and complete the form, provided they have completed appropriate training and are competent.

5. Process

5.1 When to initiate ReSPECT

The process is best started early, when the individual is well enough to participate in decision-making, so that personal preferences and clinical recommendations are known and recorded in the event of deterioration. However, a form can be completed at any stage of a person's care, including during a period of severe illness.

5.2 Who can initiate ReSPECT?

The process can be initiated, and the form completed, by any health or social care professional who knows the person and their circumstances. This may be a GP, hospital doctor, senior nurse or other competent healthcare professional. The senior clinician in charge of the individual's care must be made aware of the plan.

For acute hospital admissions, the responsible consultant should review and countersign the form within 72 hours of its completion (considered best practice).

5.3 Initiating ReSPECT: Capacity

Adults should be presumed to have capacity unless there is clear evidence to the contrary. A person lacks capacity – i.e. is regarded as legally unable to make a decision – if they are unable to do all of the following:

- understand the information relevant to the decision

- retain that information
- use or weigh that information as part of the process of making a decision, and
- communicate their decision (whether by talking, sign language, visual aids or other means)

The Mental Capacity Act 2005 (MCA) sets out the following five statutory principles:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under the MCA, for or on behalf of a person who lacks capacity, must be done or made in his best interests.
- Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of a person's rights or freedom of action.

5.4 Initiating ReSPECT: Sharing information

Relevant information should be shared with those close to the person unless, when previously competent to do so, the person has expressed the wish that information be withheld. Such information includes decisions taken about CPR.

When the person has capacity, their agreement should be obtained before discussing their condition and treatment plan with others, including family members.

If the person lacks capacity, and their views on involving family and friends are not known, healthcare professionals may disclose confidential information to these people, if it is necessary to make a decision in the patient's best interests.

5.5 Initiating ReSPECT: Preparing for the conversation

See appendix 1 for detailed advice on preparing for the ReSPECT conversation.

If the person has capacity, there must be a presumption in favour of their full involvement in the decision-making process. Family members or other representatives may also take part, if the individual so wishes. Separate conversations with family or other representatives should only take place with the person's permission, and requests for confidentiality must be respected.

For anyone who lacks capacity and has an appointed legal proxy (e.g. with Power of Attorney for Health and Welfare), the proxy must be involved in decisions made on their behalf. If there is no legal proxy, family or friends must be consulted and should be asked about any views or wishes previously expressed by the person. However, the responsibility for making clinical decisions rests with the senior responsible clinician, and this should be made clear to all involved.

Where there is any barrier to communication (e.g. deaf, blind, non or partial English speaker), the services of an interpreter must be sought. (See Delivery of Accessible Information policy). Use of family members or other representatives for this purpose is not recommended.

People with impairment of hearing or eyesight should have appropriate aids, and allowance should be made for poor functional literacy.

If the person does not wish to be involved in discussions about potentially life-sustaining treatments, the reasons should be sensitively explored and documented in the medical record. Discussions with relatives, friends or legal representatives of a person with capacity should only take place with the person's agreement.

5.6 Conducting the conversation (people with capacity)

(See appendix 2) for detailed advice on the ReSPECT conversation.

The purpose of the discussion is to reach a shared understanding of the person's current health status and potential for improvement or deterioration, and to make plans concerning appropriate care in a future emergency in which they are unable to make decisions.

A decision not to engage in discussion must be respected and documented.

Determine whether or not the individual has an Advance Care Plan or Advance Directive to Refuse Treatment (ADRT), and if so, where the document can be found.

The implications of clinical interventions, negative as well as positive, should be explained in realistic terms. There is no compulsion to offer interventions which are clearly inappropriate, or to provide treatment which the healthcare professional judges to be ineffective. However, the presumption in favour of involving the person requires a sensitive discussion of the reasons for not recommending these interventions.

An adult with capacity has the right to refuse CPR without giving a reason, but not to demand CPR if there is no prospect that it will be effective. If CPR has the potential to restart the heart and breathing for a sustained period, the potential benefits of prolonging life must be weighed against possible harm and suffering. The fact that a DNACPR order is signed does not preclude other interventions, including surgical procedures and ICU admission.

The final decision whether or not to attempt CPR is a clinical one, but there is a legal presumption in favour of explaining that decision to the person or their representatives.

5.7 Conducting the conversation (people lacking capacity)

The person's previously-expressed wishes should be considered when making decisions about treatment, bearing in mind that such wishes may not relate to current circumstances. Relevant documents, (ADRT, Advance Care Plan), should be consulted and details of these documents recorded in section 2 of the ReSPECT form.

The Mental Capacity Act requires that best-interest decisions must involve, whenever possible, the views of anyone named by the patient as someone to be consulted and anyone involved in caring for the person or interested in their welfare. Unless they have been given legal authority to make decisions on behalf of the person, the role of friends and relatives is solely to help inform the decision-making process. They should be made aware that they are not responsible for clinical decisions and can neither demand nor refuse treatment.

If the person has appointed someone with Lasting Power of Attorney (LPA) for Health and Welfare, it will be necessary to consult them when completing the ReSPECT form. Before doing so, the healthcare team must be satisfied that the patient lacks capacity to make decisions for themselves, that the LPA document provides specific authorisation regarding decisions about life-sustaining treatment (including CPR), and that the LPA has been registered with the Office of the Public Guardian. If authorised to make decisions concerning life-sustaining treatment, it is likely that the Welfare Attorney can make an advance decision that such treatment, including CPR, should not be attempted.

A Property and Affairs Attorney may be consulted, in the same way as a family member or friend, but does not have the authority to make decisions about medical treatment. A court-appointed Welfare Deputy has similar powers to a Welfare Attorney, but cannot refuse life-sustaining treatment. Neither Welfare Attorneys nor Welfare Deputies have the power to demand treatment which is clinically inappropriate.

For adults who lack capacity and have no family, friends or appointed advocate, the Mental Capacity Act requires consultation with an Independent Mental Capacity Advocate (IMCA), for all decisions where what is proposed would be likely to involve serious consequence for the person. An IMCA does not have the power to make decisions about life-sustaining treatment and CPR, but must be consulted as part of the process of determining the person's best interests.

If there is disagreement between the healthcare team and a Welfare Attorney or Deputy, and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration.

If it is not possible to contact family members, carers, a Welfare Attorney, court-appointed Welfare Deputy or IMCA, and a medical decision is required urgently, healthcare workers have a duty of care to act immediately in the person's best interests. A ReSPECT form may be completed, including the section on CPR, and the reasons for not undertaking discussion with those close to the person must be documented. Appropriate discussions should be conducted as soon as is practicable, and the form amended appropriately.

5.8 Children and young people under 18 years of age

ReSPECT is fully compatible with the Child and Young Persons Advance Care Plan (CYPACP), and can be used to provide a universally recognised, concise summary of the family's preferences regarding treatment in an emergency. The ReSPECT form can usually be completed using the emergency preferences which have already been recorded in the advance care plan.

Clinical decisions should be taken in discussion with the child/ young person and their parents or those with parental responsibility. In most, but not all, cases, those with parental responsibility will be the principal decision-makers.

Depending on age and capacity, young people should be involved in the decision-making process and due weight should be given to their views. This approach is supported by the Children's Act, the United Nations Convention on the Rights of a Child, and GMC guidance. If the wishes of the child or young person conflict with those of the parents, and this conflict cannot be resolved, it may be necessary to seek legal advice before completing a ReSPECT form.

Young people aged 16-17 years are presumed competent to consent to medical treatment, unless there is evidence to the contrary, but cannot refuse treatment which is considered to be in their best interests. The Mental Capacity Act applies, as it does to adults. Children under the age of 16 years may also be assessed to be competent to provide consent.

In England, Wales and Northern Ireland, a young person under the age of 18 years may only refuse life-sustaining treatment if this is agreed by parents and clinicians to be in their best interest. In the absence of such agreement, the child's refusal may be overridden by those with parental responsibility or by the Court.

When a young person reaches the age of 18 years, they must be treated according to adult guidelines, policies and laws. If the ‘modified CPR’ box in section 4 of the ReSPECT form has been completed, it will usually be necessary to discuss this with the person and their family, and to amend the entry to one of the adult options.

5.9 Completing the ReSPECT form

See Appendix 3 for more detailed guidance on completing the form.

The recommendations agreed must be documented using the ReSPECT form, and communicated with the rest of the healthcare team and all relevant parties. ReSPECT is a summary recommendation only, and more detailed documentation must be entered into the medical record, together with the date and time of completion of the ReSPECT document.

When completing the paper form, handwriting must be legible (see Trust Documentation Policy). All patient details must be recorded in full to ensure the validity of the form and acceptance in all healthcare settings.

Section 2 should include any communication difficulties the person has and ways to overcome them. This is also the place to record details of other relevant documents and where to find them e.g. ADRT, advance care plans, advance statements, organ donor cards.

In section 4, Only **one** of the boxes must be signed, to indicate **either** an emphasis on life-sustaining treatment **or** on symptom control.

In Section 4: CPR Recommendations, **only one box must be signed**. For children, there are circumstances in which modified CPR would be appropriate, and details of these must be recorded. For a more detailed guidance on resuscitation decisions, see Appendix 3.

In section 6: Involvement in making this plan, at least one of the four statements must be circled, but more than one may apply. If D is circled, indicating that that there has been no shared decision-making with the patient (or family or other representative of a patient who lacks capacity), the reasons must be recorded and also detailed fully in the medical record.

In section 7: ‘Clinicians’ signatures’. For hospital in-patients, if the person completing the form is not the Consultant in Charge, the Consultant’s name should be documented in the last line of section 7 (‘Senior Responsible Clinician’) and he or she should be informed as soon as is convenient. The Consultant in Charge should review and countersign the form within 72 hours of its completion.
In the community, nurses and AHPs may initiate the ReSPECT process and sign the form. Countersignature is not required in these circumstances, though it may be considered appropriate to inform the Senior Responsible Clinician (often the GP).

Section 9: Confirmation of validity is only used when the ReSPECT form is reviewed and the recommendations confirmed to be still valid

5.11 Caring for a person with a ReSPECT form

When a ReSPECT form is completed, it is essential that knowledge of the form and its recommendations is communicated to all who may be involved in the care of the person. This includes all members of the hospital admitting team, ward staff, the patient’s GP, community nurses, ambulance crews, nursing staff and managers of care homes and hospices.

The paper copy of the ReSPECT form should accompany the person, regardless of the healthcare setting. The form may also be stored digitally, in general practice or in hospital. In the event that there are different versions of the ReSPECT document, whether in electronic or paper format, decision-makers should proceed on the principle that the paper copy accompanying the person is the current, active version.

An alert should be set up in any shared electronic patient record, indicating the existence of the ReSPECT document and detailing the recommendations therein (including CPR decisions).

Avoid photocopying the form, unless for audit or administrative purposes. If a copy is made, it should be crossed through with two diagonal lines in black ink, with the words “Copy – Not for Clinical Use” written between them.

Any changes to the form must be recorded on all versions, paper and electronic.

When at home, the person should keep their ReSPECT form in a readily-accessible place. Family members, other representatives and community care teams should know of its existence and where to find it.

For hospital in-patients, the ReSPECT form should be kept at the front of the patient record.

If the person is resident in a care home or hospice, all staff should be aware of the ReSPECT form and recommendations, and should know where to find it.

In an emergency, when the person is unable to make or express choices, **confirm** the identity of the person with the ReSPECT form, and ensure that this is the latest version of the form. **Read** the form, to understand which recommendations may relate to your role in their care. **Act** on those recommendations relevant to your role in caring for the person, providing the recommendations apply to the current emergency.

If the patient has capacity, they must be involved in the decision-making process, regardless of whether or not they have a ReSPECT form.

If a situation arises which is not addressed by the form, or staff are unsure what to do, advice should be sought from more senior members of the healthcare team. In the community, this may be the GP or Community Nurse; in a care home, the senior nurse or manager. In cases of uncertainty, there should be presumption in favour of providing treatment which is potentially life-sustaining, including CPR.

Clinical responsibility for emergency treatment decisions, including those relating to CPR, always rests with the most senior healthcare professional attending the person. Decisions must be made in accordance with legal requirements, good clinical practice, the best interests of the person and local policy. The ReSPECT form should be used to inform decision-making, but is not legally binding.
A healthcare professional has no legal duty to provide treatment which is judged to have no reasonable chance of success or to be clinically inappropriate, including CPR. However, any decision not to follow the recommendations in the ReSPECT form must be justified, with an entry in the person’s medical record.

If the form is not available during a medical emergency, and the person is unable to make or express choices, healthcare professionals must act in their best interests. Family members and other representatives of the person may be able to recall the person’s wishes and to assist in decision-making.

Minor discrepancies on the ReSPECT form (completion date a long time in the past, wrong date of birth, misspelled name, lack of a signature) do not necessarily invalidate the form or recommendations. The validity of the form is based on the extent to which it relevantly reflects the patient-centred conversations which have taken place, and on whether due process has been followed with regard to capacity and human rights law.

When a person dies, a copy of the most recent ReSPECT form should be added to the current health record.

5.12 Transfer and Discharge

The ReSPECT form should always travel with the patient.

When a person is admitted to hospital with a ReSPECT form, it must be reviewed, to make sure that the recommendations remain valid and that the recommendations are consistent with the person's condition and preferences at that time.

The ReSPECT form should be reviewed prior to transfer of a person between wards or between hospitals. When handing over, the healthcare team must make sure that the receiving team is aware of the ReSPECT form and treatment recommendations.

When a person is discharged from hospital, the ReSPECT form must be reviewed, to make sure that the recommendations remain valid and that the recommendations are consistent with the person's condition and preferences at that time. Every person discharged from hospital with a ReSPECT form should have the recommendations discussed with them and with family members or other representatives. The purpose of the form should be reiterated, as should the need to keep the form in an appropriate place. The discharge letter to the GP should include details of the ReSPECT form. If possible, a photocopy or scan of the agreed, final ReSPECT form should be made before the patient leaves and should be sent via secure means to the GP surgery for additional information. Appropriate community teams (nursing services, out-of-hours providers, ambulance services, palliative care etc.) should also be informed.

In the case of a child or young person under the age of 18 years, the ReSPECT form should be given to the parents or those with parental responsibility. They may keep the form themselves, or may choose to keep it with the child (e.g. in their school bag).

The responsible healthcare team should ensure that healthcare workers taking over responsibility for the person are aware of the form and treatment recommendations.

Whenever someone is transferred from one healthcare setting to another, the form should be shown to the ambulance staff or to whoever is providing transport, and should travel with the person.

5.13 Reviewing, amending and cancelling ReSPECT

The ReSPECT form should be reviewed:

- If the person moves from one care setting to another, both before and after transfer
- If the person's condition changes
- At the request of the person, those close to them or other representatives
- In the community, ideally, at each encounter of healthcare professionals with the person.

The recommendations on the ReSPECT form do not have an expiry date, but the need to review the form should be considered at each stage of an individual's progress.

A ReSPECT form which is no longer valid should be clearly marked with the word "CANCELLED" in black ink between two diagonal lines, a legible signature and registration number, and the date. The cancelled version should be added to the person’s medical record, and an entry made in the record stating the time and date of cancellation.

Amendments should not be made to a ReSPECT document. If a change is required, the form should be cancelled and a new one completed.

Updated recommendations should be shared with all relevant health and social care staff. An entry should be made in the person’s health record, recording the date and time that the document has been amended together with details of the new form.

If there is more than one version of the ReSPECT form (including electronic versions), any changes or cancellations must be reflected in all versions.

6. The Treatment Escalation Plan and ReSPECT

Some patients may have a Treatment Escalation Plan (TEP). This is similar in some ways to ReSPECT – it documents a clinical management plan, including treatment limitations – but is more focussed on the medical management of the acutely-ill patient at risk of sudden deterioration. There is less emphasis on long-term decision-making and on the wishes of the patient.

In many cases, either ReSPECT or TEP will be appropriate. A patient with a long-term illness or disability, admitted to hospital with a ReSPECT form, may not require an additional TEP. For other patients admitted with acute illness, including those who are at risk of sudden deterioration, TEP may be the appropriate document.

ReSPECT is the only document available in the Trust where decisions related to resuscitation can be recorded. Any patient requiring a DNACPR order must have a ReSPECT form, even if they already have a TEP. When completing ReSPECT for a patient with a TEP, it is appropriate to fill in ReSPECT with references to the TEP, rather than duplicating documentation. TEP is designed to work alongside ReSPECT.

The TEP is used only for hospital in-patients, and becomes invalid upon discharge. If a summary plan is required for long-term decisions about treatment and resuscitation, ReSPECT must be used, and should ideally be completed before the patient is discharged from hospital. ReSPECT is the only document suitable for use in the community.

7. Evidence Base/References

Decisions relating to cardiopulmonary resuscitation (3rd Edition, 1st revision). Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.

Do Not Attempt Resuscitation (DNAR) Decisions in the Perioperative Period. The Association of Anaesthetists of Great Britain and Ireland, 2009.

Equality Act 2010.

Human Right Act 1998.

Mental Capacity Act 2005 (Code of Practice).

ReSPECT website: www.respectprocess.org.uk

Time to Intervene: A review of patients who underwent cardiopulmonary resuscitation as a result of in-hospital cardiopulmonary arrest. A report by the National Confidential Enquiry into Patient Outcome and Death (2012).

Trust Guidelines and Policies:

End of Life Care Policy
Guidance for staff on the Implementation of the Mental Capacity Act (MCA)
Patient Documentation and Record Keeping Policy
Policy for Advanced Decisions
Policy for Palliative and End of Life Care for babies, Children and Young People
Policy and Procedure for Consent
Policy and Procedure for the Management of Resuscitation

8. Competencies and Training Requirements

Before undertaking the ReSPECT process themselves, healthcare professionals who are not doctors will be required to complete a competency programme . The programme will involve completion of the training app, a face-to-face training session, completion of and reflection on at least two ReSPECT forms.

The training available in support of ReSPECT: Appendix 5

All Foundation doctors starting work at the Trust will be provided with training, at induction, on the ReSPECT process. In addition, they will be expected to complete the training app, which is accessible through the ReSPECT website. The app will generate a certificate of completion, which can be used for the purposes of Continuous Professional Development.

Regular training sessions will be provided for all other healthcare professionals involved in initiating the ReSPECT process. Completion of the ReSPECT app will also be expected.

Healthcare professionals who are not doctors will be required to complete a competency programme . The programme will involve completion of the training app, a face-to-face training session, completion of and reflection on at least two ReSPECT forms.

ReSPECT will be incorporated into mandatory BLS training for consultant staff.

Nurses and other healthcare professionals who will be caring for people with ReSPECT forms will be provided with process and awareness training, but will not be expected to initiate the ReSPECT process or complete forms. Familiarity training will be provided by the Resuscitation Department, as part of Immediate Life Support (ILS), and by individual divisions for their own staff.

9.0 Monitoring Arrangements
Document Monitoring Table

Element to be Monitored	**Lead**	**Tool for Monitoring**	**Frequency**	**Responsible Individual/Group/ Committee for review of results/report**	**Responsible individual/ group/ committee for acting on recommendations/action plan**	**Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented**
Compliance with the use of ReSPECT forms	David Walker	Audit tool	Twice annually	Resuscitation Committee	Resuscitation Committee	End of Life Care Improvement Group
Untoward incidents related to the ReSPECT process	Divisional Clinical Leads	Datix	monthly	IPR meetings	Divisional Group	Clinical Outcome group
Trust wide trend analysis: Untoward incidents related to the ReSPECT process	Hazel Tonge	Datix	monthly	Resuscitation Committee	End of Life Care Improvement Group	End of Life Care Improvement Group

Appendix 1: Initiating ReSPECT; Preparing for the conversation

The senior clinician in charge (GP or Hospital Consultant) should, ideally, lead the conversation. However, another clinician or senior nurse may do so if personal acquaintance with the person and their clinical situation makes this appropriate.

It is useful to have another member of the healthcare team present: to provide another perspective, to demonstrate that the team is agreed on recommendations, and to ensure consistency and accurate recording of the discussion.

Involving colleagues with relevant specialist expertise, (e.g. critical or palliative care), may also be helpful. If a second opinion is required, this should be from a senior clinician with experience of the patient's condition, who is not directly involved in the patient's care.

If the person has capacity, there must be a presumption in favour of their full involvement in the decision-making process. Family members or other representatives may also take part, if the individual so wishes. Separate conversations with family or other representatives should only take place with the person's permission, and requests for confidentiality must be respected.

For anyone who lacks capacity and has an appointed legal proxy (e.g. with Power of Attorney for Health and Welfare), the proxy must be involved in decisions made on their behalf. If there is no legal proxy, family or friends must be consulted and should be asked about any views or wishes previously expressed by the person. However, the responsibility for making clinical decisions rests with the senior responsible clinician, and this should be made clear to all involved.

Ideally, the conversation should take place at the earliest opportunity, when the person is relatively well and able to make decisions. It may be necessary to complete the process during more than one session, particularly in an outpatient or community setting. Occasionally, recommendations may be required urgently, and the discussion should then take place immediately.

The conversation should take place in a quiet, private area and sufficient time should be allowed for detailed explanations and questions. Telephones and pagers should be turned off, if possible.

Prior to discussion, the responsible professional should take time to become acquainted with the individual's circumstances, the history of their condition, what they have already been told and their understanding of the situation. This may involve discussion with other specialists and members of the team, to decide which interventions and treatments are appropriate.

If required, the presence of an interpreter must be arranged. Use of family members or other representatives for this purpose is not recommended.

People with impairment of hearing or eyesight should have appropriate aids, and allowance should be made for poor functional literacy.

If the person does not wish to be involved in discussions about potentially life-sustaining treatments, the reasons should be sensitively explored and documented in the medical record. Discussions with relatives, friends or legal representatives of a person with capacity should only take place with the person's agreement.

Appendix 2: The ReSPECT conversation (people with capacity)

Explain the purpose of the discussion – to reach a shared understanding of the person's current health status and potential for improvement or deterioration, and to make plans concerning appropriate care in a future emergency in which they are unable to make decisions. The emphasis should be on doing what is best for the individual.

Establish how much information the person wants and whether they would like to include anyone else in the conversation. Discussion, including matters such as CPR, should not be forced on anyone. A decision not to engage in discussion must be respected and documented.

Establish how much the person has already been told, and what their understanding of the situation is. Correct any misunderstandings at this time.

Determine whether or not the individual has an Advance Care Plan or Advance Directive to Refuse Treatment (ADRT), and if so, where the document can be found.

Explain the current clinical situation and the possible course of any illness. Discuss which treatments are likely to be appropriate in these circumstances and which ineffective or inappropriate.

Explore the individual's priorities, wishes and beliefs, focussing on what they would or would not want to be done in an emergency situation. Discussion might include possibilities such as non-invasive ventilation, admission to ICU, invasive procedures or surgery. The implications of such interventions, negative as well as positive, should be explained in realistic terms. There is no compulsion to offer interventions which are clearly inappropriate, or to provide treatment which the healthcare professional judges to be ineffective. However, the presumption in favour of involving the person requires a sensitive discussion of the reasons for not recommending these interventions.

Discuss whether or not cardiopulmonary resuscitation would be appropriate in the event of cardiorespiratory arrest. An adult with capacity has the right to refuse CPR without giving a reason, but not to demand CPR if there is no prospect that it will be effective. If CPR has the potential to restart the heart and breathing for a sustained period, the potential benefits of prolonging life must be weighed against possible harm and suffering. This is not purely a clinical decision, and there should be open discussion and shared decision-making. The person should be informed about what CPR involves, including potential adverse effects and the likely chance of success. The fact that a DNACPR order is signed does not preclude other interventions, including surgical procedures and ICU admission.

The final decision whether or not to attempt CPR is a clinical one, but there is a legal presumption in favour of explaining that decision to the person or their representatives.

Use plain language and avoid medical jargon. At appropriate times, ask the person to describe what they have been told in their own words, and explain again if there is misunderstanding.

Finally, summarise the conversation to ensure that everyone involved understands what has been agreed and what will be recorded on the ReSPECT form. Provide the opportunity for questions and comments, and ask if anyone wishes to discuss anything else.

Appendix 3: Completing the ReSPECT form

Section1: Personal Details

Full name, date of birth and address

- Date on which the form is completed
- Identification number
- Name by which the individual prefers to be addressed, if appropriate

Section 2: Summary of relevant information for this plan

- Summary of **relevant** diagnoses, special circumstances, current and long-term state of health, normal function and expected prognosis.
- Communication difficulties should be documented here, and ways to overcome them.
- Details of other relevant documents and where to find them should be included here: e.g. ADRT, advance care plans, advance statements, organ donor cards.

Section 3: Personal preferences to guide this plan (when the person has capacity)

- The person's agreed priorities of care – sustaining life or ensuring comfort.
- If desired, a mark may be made on the scale to indicate the person's balance of priorities.
- The free text box allows the individual to express what is most important to him or her, including those treatments they want or expect and those they do not.

Section 4: Clinical recommendations for emergency care and treatment

- Recommendations to guide decision-making in the event of an acute event or deterioration.
- Only **one** of the boxes must be signed, to indicate **either** an emphasis on life-sustaining treatment **or** on symptom control.
- Specific recommendations should be recorded, concerning interventions which are or are not clinically appropriate and interventions which are or are not wanted by the person. For individuals in the community, recommendations might include whether or not to admit to hospital, and for in-patients, whether or not to admit to ICU or undertake invasive procedures.

Section 4: CPR Recommendations (see Trust Resuscitation Policy)

- Record whether or not CPR is to be attempted in the event of cardiorespiratory arrest. **Only one box must be signed**. For children, there are circumstances in which modified CPR would be appropriate, and details of these must be recorded. For all adults, CPR attempts are either recommended or not, and recommendations such as 'for up to three shocks only' are not appropriate.
- If a person with capacity refuses CPR, or someone lacking capacity has a valid and applicable Advance Decision to Refuse Treatment (ADRT) which specifically refers to CPR, this must be respected and documented. A reference to the ADRT, including where it may be found, should be included in section 2 of the ReSPECT form. An ADRT is legally binding so long as circumstances match those documented in the ADRT. If they do not, the document should still be taken into consideration but is no longer binding, and healthcare professionals must decide whether CPR is appropriate and in the patient's best interest. If there is doubt, and there is no time to make further enquiries, the presumption should be in favour of attempting CPR.
- If the healthcare team is as certain as it can be that the person is dying as an inevitable result of an underlying disease or catastrophic health event, and that CPR would not restart the heart and breathing for a sustained period, CPR should not be attempted. It is not necessary to obtain consent, either from the person or those close to them, for the decision not to attempt CPR.
- Even if CPR has no realistic prospect of success, there must be a presumption in favour of explaining why it will not be attempted - to the person themselves, those

close to them and/ or any appointed legal proxy. The explanation should be undertaken at the earliest possible opportunity.

- If CPR may be successful in restarting a person's heart and breathing for a sustained period, the potential benefits of prolonging life must be weighed against potential harms and burdens, including those associated with intensive organ support. This will involve balancing rights included in the Human Rights Act 1998, which guarantees protection for life (Article 2) but also that no one shall be subjected to torture or to inhuman or degrading treatment or punishment (Article 3). The decision is not solely clinical, and must be made following open discussion with the individual and/ or those close to them. Accurate information must be provided about what CPR involves, the potential for adverse effects and the probablity of success.
- A recorded recommendation not to attempt CPR does not override clinical judgement, in the event that there is a reversible cause of cardiac or respiratory arrest which does not match the circumstances envisaged when the decision was made. Examples include displacement or blockage of a tracheostomy or tracheal tube, and complications of anaesthesia or surgery. However, clinicians should be cautious about overriding a DNACPR decision in opposition to a person's clearly expressed wishes.
- In the case of planned surgery, for a person who does not want CPR, it should be explained that there may be circumstances under which limited CPR would be attempted despite a DNACPR order. This amounts to a temporary, partial suspension of DNACPR, without which it is unlikely that surgery or anaesthesia could be provided. The time at which the full DNACPR decision is to be re-instated, usually following discharge from the theatre recovery area, should also be discussed.
- If no explicit decision has been made or recorded, there must be an initial presumption in favour of performing CPR. However, for a person in the advanced stages of a terminal illness, where death is imminent and unavoidable, a decision not to initiate CPR may be made at the time of cardiorespiratory arrest.
- A clinician cannot be forced to perform any intervention which he or she considers harmful or against a person's best interests, and this includes CPR.
- A decision not to attempt CPR does not necessarily preclude other forms of treatment, including admission to ICU. Conversely, the fact that a decision has been made to attempt CPR does not automatically mean that other intensive treatments or procedures are appropriate.
- If a person requests that CPR is attempted, against clinical recommendation and after a sensitive explanation of the risks and benefits, a second opinion may be sought. If the patient continues to ask that no DNACPR decision be made, this request should usually be respected. This does not preclude completing the rest of the ReSPECT form, if the patient agrees, and does not compel any clinician to commence CPR in the event of a cardiac arrest. Doctors cannot be required to commence resuscitation, if this is contrary to their clinical judgement, and further decisions may be made at the time of any subsequent cardiac arrest.
- Young people aged 16 years or over are assumed to be competent to consent to CPR, unless there is evidence to the contrary, and children under the age of 16 years may also be assessed to be competent. If a competent young person makes an informed advance refusal of CPR, healthcare professionals should seek legal advice if they believe that CPR would be beneficial. Refusal of CPR by competent young people under the age of 18 years is not necessarily binding upon doctors, and courts have overridden the refusal of life-saving treatment.
- If a best-interests decision about CPR is made because the person has declined to discuss the issue, or the person asks the healthcare team to make the decision for them, this must be documented.
- Discrimination, for example in respect of a disability, must be avoided. Each CPR decision should be tailored to the individual's circumstances and guided by the quality of life that person themselves would regard as acceptable (in the case of children, taking into account the views of the child and parents). Blanket policies which deny

CPR to groups of people - such as all residents in a hospice or nursing home, or all people above a certain age - are unethical and, probably, unlawful.

Section 5: Capacity and representation at time of completion

- Record whether or not the patient has capacity to participate in making the decisions and recommendations in the plan.
- Record whether or not the patient has a legal proxy, who must be consulted if the patient lacks or loses capacity.

Section 6: Involvement in making this plan

- Completion of this section confirms that the ReSPECT process and form have been completed in accordance with capacity and human rights laws, and also documents who has been involved in discussing and agreeing the recommendations recorded. At least one of the four statements, (A,B,C,D) must be circled, but more than one may apply.
- If D is circled, indicating that that there has been no shared decision-making with the patient (or family or other representative of a patient who lacks capacity), the reasons must be recorded. These reasons should be detailed fully in the person's medical record.
- This section also records the date(s) of the ReSPECT conversation, the names and roles of those involved, and where full details of the discussion can be found in the medical record.

Section 7: Clinician's signatures

- The professional who completes the ReSPECT form must provide a legible signature, name, registration number, date and time.
- The senior responsible clinician is either the General Practitioner for out of hospital settings, or the consultant in charge of care for acute hospital admissions or out-patients.
- If the person completing the form is not the senior responsible clinician, the senior responsible clinician's name should be documented in the last line of section 7 and they should be informed as soon as convenient. For acute hospital admissions, the responsible consultant will review and countersign the form within 72 hours of its completion.
- A countersignature is not required for forms completed in situations other than acute hospital admissions, as this would require the form not staying with the patient. It is the responsibility of the clinician signing the form to ensure that the content of the form is shared and agreed with the named senior responsible clinician. Where possible, confirmatory and endorsing signatures from senior responsible clinicians are welcomed and will provide support for the clinician signing the form and the decisions documented.

Section 8: Emergency contacts

- Record contact details of key individuals who may be contacted in the event of deterioration in the person's condition, imminent death or changes which may warrant review of the recommendations in the plan.

Section 9: Confirmation of validity (e.g. for change of condition)

- This section is for use when the ReSPECT form is reviewed and the recommendations confirmed to be still valid. It should be left blank when the form is initially completed.
- The recommendations on the ReSPECT form do not have an expiry date – the need to review the form should be considered at each stage of an individual's progress. The form should be reviewed when the person is admitted to, or discharged from, hospital.

Appendix 4: Reviewing, amending and cancelling ReSPECT

The ReSPECT form should be reviewed:

- If the person moves from one care setting to another, both before and after transfer
- If the person’s condition changes
- At the request of the person, those close to them or other representatives
- In the community, ideally, at each encounter of healthcare professionals with the person.

The recommendations on the ReSPECT form do not have an expiry date, but the need to review the form should be considered at each stage of an individual’s progress. The timing of these reviews will depend on individual circumstances, usually being more frequent during an acute illness than during end-of-life care or long-term management of a life-limiting condition.

It may not be necessary to conduct a conversation with the person (or those close to them) if there has been no change in their clinical condition or goals of care since the ReSPECT form was completed. The person should be informed that their ReSPECT form continues to apply in any new healthcare setting.

When a ReSPECT form is reviewed, **confirm** the identity of the person with the ReSPECT form, and ensure that this is the latest version of the form. **Read** the form, to identify those recommendations which relate to your role in the person’s care. **Discuss** the goals of care and recommendations, in the light of the current situation, with the person and/ or their family or other representatives.

If the wishes of the person and the clinical recommendations remain unchanged, complete and sign section 9 of the ReSPECT form. If the recommendations have changed, complete a new form and cancel the previous version. A ReSPECT form which is no longer valid should be clearly marked with the word “CANCELLED” in black ink between two diagonal lines, a legible signature and registration number, and the date. The cancelled version should be added to the person’s medical record, and an entry made in the record stating the time and date of cancellation.

Amendments should not be made to a ReSPECT document. If a change is required, the form should be cancelled and a new one completed.

Updated recommendations should be shared with all relevant health and social care staff. An entry should be made in the person’s health record, recording the date and time that the document has been amended together with details of the new form.

If there is more than one version of the ReSPECT form (including electronic versions), any changes or cancellations must be reflected in all versions.

A person has the right to change their mind about what is recorded on the ReSPECT form, or to ask that the form is cancelled. They should be offered the opportunity for further discussion, to determine whether a ReSPECT form is still wanted or may be wanted at a later date, and to consider new recommendations. Details of such discussions should be recorded in the health records.

Medical staff, CMT's Registrars who will be implementing the ReSPECT process should attend a basic awareness ReSPECT session (1/2 hour) and are strongly encouraged to attend the 3 ESHT hour training and /or take the 1 hour online National ReSPECT Training (certificated)

Staff group	**ReSPECT training available**						
	Basic ReSPECT awareness For all staff working with patients. Undertaken through induction BLS/ALS training and mandated annual updates	ESHT Basic ReSPECT User training ½- 1 hour with current champions as part of current tutorial schedule	Temporary * ESHT ReSPECT training (for those who will undertake the process with patients) a 3 hour session *For those willing to be ReSPECT champions and advocates	National ReSPECT 1 hour online training (for those who will undertake the process with patients) and for any staff interested to learn more (Certificated)	Reflective practice and competency process work through 3-5 cases with reflections shared with mentor and final signed off by an authorised ReSPECT champion	EoLC mandated training ReSPECT included within this session	Advanced communication skills (provided externally) See L&D webpages for information
Consultants	x		x	x		x	x
Registrars all levels	x	x	x	x		x	x
CMT's	x	x	x	x		x	x
FY1's	x	x	x	x		x	x
FY2's	x	x	x	x		x	x
Nurses	x		x	x		x	x
Senior and specialist nurses/AHP's (who would like/need to be able to implement the process)	x		x	x	x		x
AHP'S and other health professionals	x			x			x
Ward clerks /Administrative staff	x			x			

Equality and Human Rights Statement

The Equality and Human Rights analysis for this policy has been completed and can be found in Appendix A. It has considered the potential impact of this document in a manner that recognises the Equality and Human Rights of patients and staff.

Due Regard, Equality and Human Rights Analysis

Title of document: Policy and Procedure for Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) incorporating Decisions about Cardiopulmonary Resuscitation (CPR)
Who will be affected by this work? Trust staff, patients and carers/families
Please include a brief summary of intended outcome: The document will act as a guide for healthcare professionals in the event of a clinical emergency or deterioration which renders a person unable to make or express decisions.

		Yes/No	Comments, Evidence and Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	yes	The date for implementation with children's services is not yet decided.
	• Disability (including carers)	Yes	For people with sensory disabilities, appropriate aids will be uses and allowance made for poor functional literacy. See section 6.4 Communication difficulties will be documented to ensure that all staff are aware. See section 6.8 section 2 Appendix 3 describes approach to CPR decisions including for those with disabilities
	• Race	No	
	• Religion & Belief	Yes	As the process of completing the ReSPECT form involves the patient/carers, then personal preference will be recorded if there is an effect on their religion or beliefs. See section 3.0
	• Gender	No	
	• Sexual Orientation (LGBT)	No	
	• Pregnancy & Maternity	No	
	• Marriage & Civil Partnership	No	
	• Gender Reassignment	No	
	• Other Identified Groups	Yes	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	Yes	Apart from those above, there are also those people who do not have English as their first language and those who lack capacity under the MCA. Access to translators will be made

			available to those who do not speak or understand English. See section 6.4. For those who lack capacity, the 5 statutory principles will be referred to. See section 6.2 and 6.6
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	A patient's wishes may not be respected at the time they are unable to express decisions	
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	(Ensure you comment and link to main policy with page/paragraph number)	
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	Special support and consideration will be given to those people whose characteristics maybe affected. This is outlined throughout the document. The form used is a national template and will have been reviewed in relation to equality.	
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	This document covers all patients who require a ReSPECT.	
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	The process element of the document ensures that the FREDA principles are incorporated.	
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	This form was fully 'tested' out by the national resus council with public and medical staff	
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	No	

Appendix B: ReSPECT Core Skills Portfolio

NHS
East Sussex Healthcare
NHS Trust

ReSPECT
Recommended Summary Plan for Emergency Care and Treatment

ReSPECT CORE SKILLS PORTFOLIO

Practitioner Name:

Mentor Name:

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Dear Colleague

This checklist is to assist you in the acquisition of ReSPECT core skills and sign-off for practice.

Have you:

1. The full agreement of your line manger?
2. With your line manager’s help, identify a mentor who has been signed-off him/herself on the core skills and is regularly using the Respect process in clinical practice?
3. Undertaken the national online certificated ReSPECT learning?
4. Emailed the certificate to esh-trlearninganddevelopment@nhs.net to ensure ESR has been updated?
5. Read the ESHT ReSPECT and Resuscitation policies?
6. completed the following training:
    - Safeguarding Children,
    - Safeguarding Adults;
    - Mental Capacity Act 2005 and Deprivation of Liberty Safeguarding Advanced Level Masterclass
7. Ensured you are familiar with the ‘decision-making framework’ for cardiopulmonary resuscitation?
8. Ensured you are familiar with ReSPECT resources available on ESHT’s Extranet?

If you have answered ‘NO’ to any of the above, you will not be able to progress to the next step which is working through the core skills and gathering evidence to achieve successful sign-off of the core skills with your line manager or mentor.

Guidance for the implementation of Core Skills sign off

The core skills were developed within the Surrey Sussex AHSN ReSPECT collaborative. Registered healthcare staff are expected to work within their knowledge and skills, developing enhanced/additional skills according to job role. To maintain registration each has a personal and professional duty to maintain a log and to participate in continuing professional development activities. Some of these activities will be supported by the employer, some by the individual in the interests of the requirement upon them to maintain registration and professional attitude to continued learning and development.

Taking the patient through the ReSPECT process encompasses many core skills inherent in good practice - communication skills, ability to read and understand the health profile of the patient, empathy, sensitivity, compassion, partnership with other health professionals involved in the care of the patient, knowledge and understanding of national and local policies and guidelines.

CORE SKILL	Supporting Documents	
1. Can demonstrate an understanding of the ReSPECT process & how to structure of ReSPECT conversations	having-a-conversation_adults_download.p	Respect conversation prep toc
2. Can demonstrate an understanding of the clinical situations covered by DNACPR decisions and which are not	20160123 Decisions Relating to CPR - 201	
3. Understands and can apply the decision making framework as described by RESUS Council UK	Decision making framework - DNACPR	CPR Decision process.jpg
4. Can describe the success rates of CPR in different clinical populations and situations. 4.2 Can describe the process of CPR and post arrest care (ITU).	Efficacy of CPR.jpg	
5. Can explain the relevance of Mental Capacity Act, Human Rights Act and Tracey Case in relation to the ReSPECT process & DNACPR	Human rights act - DNACPR.jpg MCA 2005 - DNACPR.jpg MCA Guiding principles.jpg MCA - decision maker responsibilities.jpg	MCA Testing capacity.jpg MCA ADRT.jpg Tracey case outcome - resus council guiden
6. Has a clear understanding of 'best interest decisions' and what factors should be considered when making those decisions	see page 19 20160123 'Decisions relating to CPR' above in section 2	
7. Can demonstrate a good understanding of the ReSPECT & DNACPR process, including when discussions should occur and who should be involved	communicating DNACPR decisions.jp	see page 16 20160123 'Decisions relating to CPR' above in section 2
8. Has a clear knowledge of the ReSPECT form and the responsibilities of the clinician completing the form (including local electronic form process)	How-to-check-a-ReSPECT-Form-download	TEP ReSPECT process_20190226.p ReSPECT webpage resources
9. Can demonstrate best practice in sharing information and ensuring the form is shared appropriately (including education to	T.B.A (organisational policy)	

patient and family)		
CORE SKILL	Supporting Documents	
10. Can demonstrate self-awareness and recognises the responsibilities of the role and utilises in their practice, relevant legislation, policies and guidelines	Clinician dependant	
11. Can describe how to raise concerns appropriately (patient/family decision disunity, clinician disunity)	Clinician dependant	
12. Is an advocate for patient centred care/ multidisciplinary decision making/ReSPECT process	Clinician dependant	

Models (or Frameworks) of Reflection

Models, sometimes known as frameworks for reflection, encourage a structured process to guide the act of reflection. There is no right model.

It is important to choose the one that feels most comfortable for you and best assists you to learn from your experience.

Often it is appropriate to use one model of reflection as a basis, but use prompt questions from other models if they best fit your particular situation. Common models include: Gibbs', Johns' & Driscoll (by Borton)

The ReSPECT Learning app https://learning.respectprocess.org.uk/ has a model de brief tool that may be helpful.

Once the core skills are signed off as all met the practitioner may register that they are accredited by ESHT.

ReSPECT PROCESS CORE SKILLS

SIGN-OFF DOCUMENT

Clinician's Name:	**Role:**	**Signature** **Date:**
Mentor Name:	**Role:**	**Signature** **Date :**

CORE SKILLS ***N.B. not all core skills need to be signed off on the same date, can be signed off over several sessions; ALL individuals must have permission from their line manager to undertake the core skills process***	**Achieved Y/N: Must demonstrate with evidence e.g. experiential learning, formal learning certificates**
1.Can demonstrate an understanding of the ReSPECT process & how to structure of ReSPECT conversations	
2.Can demonstrate an understanding of the clinical situations covered by DNACPR decisions and which are not	
3.Understands and can apply the decision making framework as described by RESUS Council UK	
4.Can describe the success rates of CPR in different clinical populations and situations. Can describe the process of CPR and post arrest care (ITU).	
5.Can explain the relevance of Mental Capacity Act, Human Rights Act and Tracey Case in relation to the ReSPECT process & DNACPR	
6.Has a clear understanding of 'best interest decisions' and what factors should be considered when making those decisions	
7.Can demonstrate a good understanding of the ReSPECT & DNACPR process, including when discussions should occur and who should be involved	
8.Has a clear knowledge of the ReSPECT form and the responsibilities of the clinician completing the form (including local electronic form process)	
9.Can demonstrate best practice in sharing information and ensuring the form is shared appropriately (including education to patient and family)	
10.Can demonstrate self-awareness and recognises the responsibilities of the role and utilises in their practice, relevant legislation, ESHT policies and guidelines	
11.Can describe how to raise concerns appropriately (patient/family decision disunity, clinician disunity)	
12.Is an advocate for patient centred care/ multidisciplinary decision making/ReSPECT process	

Please note:

If the clinician is unable to provide evidence for any of the above core skills, an action plan including timescale for completion must be agreed.

ACTION PLAN

Core Skill No:	Action(s), include any resources required e.g. training:	Time-scale for Completion:

I can confirm that the above clinician has provided evidence for all the ReSPECT core skills and has now been signed-off:

Clinician's Name: **Role:** **Signature:**

Date:

Mentor Name: **Role:** **Signature:**

Date:

ReSPECT CORE SKILLS - REFLECTIVE DE- BRIEF

GUIDANCE NOTES:

Whether you are leading the ReSPECT conversation or watching someone else, it is helpful to reflect on the conversation to help develop your practice. Learning from previous conversations will help to plan for future ones. Following a ReSPECT process conversation, it is good practice to debrief with a colleague who was present during the conversation and/or your mentor. Having more than one perspective on how the conversation went helps to put together an accurate view of what happened and receive useful feedback.

REQUIREMENTS:

- **a minimum of 4 ReSPECTIVE case study reflections from your own practice** should be completed and discussed with your mentor/line manager (this should be completed **within 3 months**). Please bring the case studies to your reflective sessions to ensure your manager/mentor is able to engage in a full and frank discussion regarding your ReSPECT process experience.
- A further review of your ResPECT professional development will be required at 6 months with your manager/mentor.
- Develop a plan for ongoing reflection and review related to your ReSPECT process continuing professional development. This should be agreed and reviewed annually by your line manager.

Models (or Frameworks) of Reflection

Models, sometimes known as frameworks for reflection, encourage a structured process to guide the act of reflection. There is no right model. It is important to choose the one that feels most comfortable for you and best assists you to learn from your experience.

Often it is appropriate to use one model of reflection as a basis, but use prompt questions from other models if they best fit your particular situation. Common models include: Gibbs', Johns' & Driscoll (by Borton) The ReSPECT Learning app https://learning.respectprocess.org.uk/ has a model de brief tool that may be helpful.

ReSPECT PROCESS
DEBRIEF CASE 1

Date of discussion:	Manager or Mentor Name/Role:
Clinician Signature:	Manager or Mentor Signature:

Reflective Notes:

Mentor Comments:

ReSPECT PROCESS DEBRIEF CASE 2	
Date of discussion:	Mentor Name/Role:
Clinician Signature:	Mentor Signature:

Reflective Notes:

Mentor Comments:

ReSPECT PROCESS DEBRIEF CASE 3	
Date of discussion:	Manager or Mentor Name/Role:
Clinician Signature:	Manager or Mentor Signature:

Reflective Notes:

Mentor Comments:

ReSPECT PROCESS ***DEBRIEF CASE 4***	
Date of discussion:	Mentor Name/Role:
Clinician Signature:	Mentor Signature:

Reflective Notes:

Mentor Comments:

East Sussex Healthcare
NHS Trust

DIGITAL STRATEGY
2021 - 2026

Outstanding care through digital
transformation, innovation and data

www.esht.nhs.uk

CONTENTS


Joe Chadwick-Bell
Chief Executive


Damian Reid
Chief Financial
Officer


Andy Bissenden
Associate Director
of ESHT Digital


Dr Kate Murray
Chief Clinical
Information Officer

FOREWORD

Welcome to "Outstanding care through digital transformation, innovation and data," our Digital Strategy for East Sussex Healthcare NHS Trust. This document describes our digital ambitions for the next five years, how we intend to achieve those ambitions and the difference it will make for our patients and staff. It sets out how we will radically change and improve the digital infrastructure and systems we provide to support the delivery of modern, digitally enabled healthcare (digital transformation), using new and emerging technologies (innovation) and the wealth of patient information we have available to us (data) to provide outstanding care.

This strategy is one of four enabling strategies that underpin and support "Better Care Together For East Sussex", the Trust's five year 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.

These are exciting times at ESHT: in recent years we've made significant improvements to the services that we provide and now, as part of the Government's New Hospital Programme, we have the opportunity to improve our hospital infrastructure.

One of the most important components of our success and continued journey of improvement will be how we take full advantage to use digital to support our changing infrastructure. Although we have introduced a number of new innovations in the last few years, we want to go much further, embarking on a programme of digital transformation until we reach our ultimate ambition, which is to become a digitally mature Trust.

We must ensure that we continue to deliver outstanding integrated acute and community services. This will only be possible if we have the digital infrastructure and solutions in place. We want to ensure that our digital systems enable our staff to work more efficiently and that they have the skills and confidence to use them to their full advantage. We also want to give patients the chance to engage more in their care, reducing unnecessary appointments and giving them easy and safe access to information to help them and others to be more involved.

Whilst this strategy is an important step forward, we recognise that it is just the start of our journey - delivering its ambitious vision will require a combined effort from us all, working closely with our staff, patients and partner organisations to realise the benefits of a digital future.

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INTRODUCTION

In recent years, the way we use technology to deliver healthcare has evolved. We developed ESHT's first Digital Strategy in 2018 and have made good progress on the aims we set out to achieve. We've already introduced a number of new innovations which have changed the way we work and the way we provide care to our patients (more information about some of these is available on page 8).

The pace of change continues to accelerate as we respond to the demands of how we deliver healthcare and so we're taking the opportunity to refresh our Digital Strategy. We want to be more ambitious with what we set out to achieve, maximising the opportunities that are now available to us to digitally transform over the next five years.

Whilst developing this document, we sought the views of our colleagues and patients and have used their feedback to develop four pledges that will underpin everything we do digitally. These are the key things that our colleagues and patients have told us are important and that we must get right if we want to achieve our digital ambitions:

- **We will get the basics right**
- **We will never digitally exclude our patients**
- **We will ensure our colleagues have the knowledge and skills to use the technology available to them**
- **We will continue to engage with our colleagues and patients**

We have also identified eight key objectives which will help us to deliver our overarching ambition to become a truly digital organisation. These aims have been developed to align and support the Trust's four key strategic aims, as outlined in Better Care Together for East Sussex:

- **Give patients electronic access to their records through a Personal Health Record**
- **Introduce a single Electronic Patient Record across all our services**
- **Empower patients by using digital to support personalised care, putting them at the heart of everything we do**
- **Work with partners in the Integrated Care System (ICS) to implement regional priorities and ensure data is used to inform the decisions we make**
- **Maximise opportunities for using Robotic Process Automation, Artificial Intelligence and Machine Learning**
- **Ensure that our infrastructure and all data held in our systems is protected**
- **Ensure the digital infrastructure in our buildings is consistent and resilient**
- **Achieve HIMSS (Healthcare Information and Management Systems Society) Level 7 by 2026**

The table on the next page shows how our pledges and objectives will support the Trust to achieve its key strategic aims. More detail on our pledges and objectives is given from page 12 onwards.

	Improving the health of communities	Collaborating to deliver care better	Empowering our people	Ensuring innovative and sustainable care
ESHT Strategic Aim	We will focus on service improvement to drive better outcomes and address inequalities of access to care	We will actively strengthen partnerships to deliver integrated care for the communities	We will nurture our culture and champion the capabilities of our people	We will embed a culture of innovative, affordable care that meets the changing needs across Sussex
How Digital will support this	We will support “digital by default” across all services, identifying and delivering priority services for fully digital pathways. We will give patients more choice, enabling greater levels of personalised care, with individuals having access to a digital patient record and empowered to manage self-care	We will work with partners across the Integrated Care System to deliver a long-term strategy for a Local Health and Care Record	We will support implementation of digitally enabled flexible working, providing a reliable infrastructure that empowers staff to work remotely. We will support staff to use new technologies to enhance their daily working practices	We will ensure we are innovative in our approach and contribute to sustainable care. We will collaborate with other Trusts to develop digital care partnership working
Our Digital Strategy Objectives	Give patients electronic access to their records through a Personal Health Record. Empower patients by using digital to support personalised care, putting them at the heart of everything we do	Introduce a single Electronic Patient Record across all our services. Work with partners in the Integrated Care System (ICS) to implement regional priorities and ensure data is used to inform the decisions we make	Ensure systems in our buildings are consistent and resilient	Maximise opportunites for using robotics and artificial intelligence. Ensure that our infrastructure and all data held in our systems is secure
	Achieve HIMSS Level 7 by 2026		**Achieve HIMSS Level 7 by 2026**	
Our Digital Strategy Pledges	We will get the basics right			
	We will never digitally exclude patients			
	We will ensure our colleagues have the knowledge and skills to use the technology available to them			
	We will continue to engage with our colleagues and patients			

ABOUT ESHT DIGITAL

Our work in ESHT Digital is far more than just Information Technology, it is about the people and the processes. We have a team of over 100 people and we deliver digital services and systems to all our Trust colleagues, at sites across the county.

We want to provide a friendly and responsive service that works in line with the Trust's values, tailored to meet individual/team/division requirements. We will offer expert advice, dealing with queries quickly and efficiently, supporting colleagues with digital transformation.

A key part of our work is influencing the move towards a digital culture, encouraging colleagues across the Trust to think digital first. We recognise the significant role that digital has in the future of healthcare and it is imperative we get this right if we are to support the Trust in achieving its overall aim to be rated as "outstanding".

In the last ten years, the way we use digital technology to provide care to our patients has changed massively. On the next page are some of the key changes we've already made:

Introduced a digital system across our inpatient wards to monitor patients'observations at the bedside and provide real time data to manage our bed and patient flow

Recruited our first dedicated Cyber Security team

Introduced a digital system in our community services, giving teams more time to focus on patient care and reducing duplication of data entry

Brought the Digital Service Desk in-house, giving a local first point of contact for help and support for colleagues

Started to introduce a Personal Health Record, giving patients access to appointment letters and information online

We also have some exciting developments planned for 2021/22:

Introducing an electronic patient record system to our maternity department, removing the need for pregnant women to carry paper notes

Improving the use of digital technology in our community services through the Digital Aspirant programme, for which we've been awarded £2,450,000 over the next two years

Introducing a new digital patient safety system to ensure robust communication and handover between our clinical teams at night

Implementing an Electronic Prescribing and Medicines Administration (ePMA) system, to improve patient safety and reduce time taken to prescribe, administer and check medicines

OUR ROADMAP

Below is our roadmap which sets out what we plan to achieve and will support delivery of our eight objectives.

🟢 In progress
🔴 Not started
🟡 Business Case
⚫ Complete

	2021	2022	2023	2024	2025	2026+
HIMSS level	2	3	4	5	6	7
Clinical Systems	🟢 Nervecentre Rollout ⚫ Hospital@Home ⚫ PHR (Phase 1) ⚫ Maternity System Implementation (Phase 1) 🟢 Maternity System Implementation (Phase 2) 🟢 ePMA Pilot 🟢 ICE Upgrade PACS, Radiology Imaging Replacement Procurement ⚫ 🟢 CRIS Upgrade	🔴 Medical Photography 🔴 eConsult/eTriage 🔴 PHR (Phase 2) 🟢 ePMA rapid rollout 🟢 Digital Aspirant for CHIC 🟡 Remote/Virtual Care/At home monitoring 🔴 ICE for Radiology 🔴 PACS, Radiology Imaging Replacement Implementation 🟢 Private Patients Hastings	🟡 Lab Information Management System 🔴 PHR (Phase 3, Appointments, Results, Pathways) 🔴 Maximisation of functionality 🔴 VNA Cardiology		🔴 VNA Endoscopy	
Electronic Patient Record	⚫ Options paper 🟡 Spec & OBC	🔴 ITT and Tender 🟡 FBC	🔴 Award of contract	🔴 Phase 1	🔴 Phase 2	🔴 Phase 3 Phase 4 🔴
Smart Tech/ Automation		🟢 Robotic Automation/AI	🔴 Phase 1 🔴 Phase 2	🔴 Phase 3		🔴 Phase 4
Service Redesign	🟡 Audiology booths (DGH) 🟢 Relocation of acute/off-site Community Paeds hub	🟢 Community Diagnostics Centre 🟢 Agile working 🟢 Ophthalmology 🟢 Cardiology	🟢 Outpatient Transformation			
Infrastructure	⚫ Orchestration Layer/Platform 🟢 Legacy OS Retirement	🟡 WiFi upgrade	🟢 Migration of Data Centre 🟡 LAN 🟡 VDI			
Cyber		🔴 Continuous improvement		🔴 Credential Accreditation		
Building Systems	🟢 Fire Compartmentation		🟡 Building Information System (BIM)			
ICS	⚫ SID 🟢 Plexus/eSearcher integration	🔴 Virtual consultation 🔴 Plexus/Nervecentre integration				

WORKING IN PARTNERSHIP

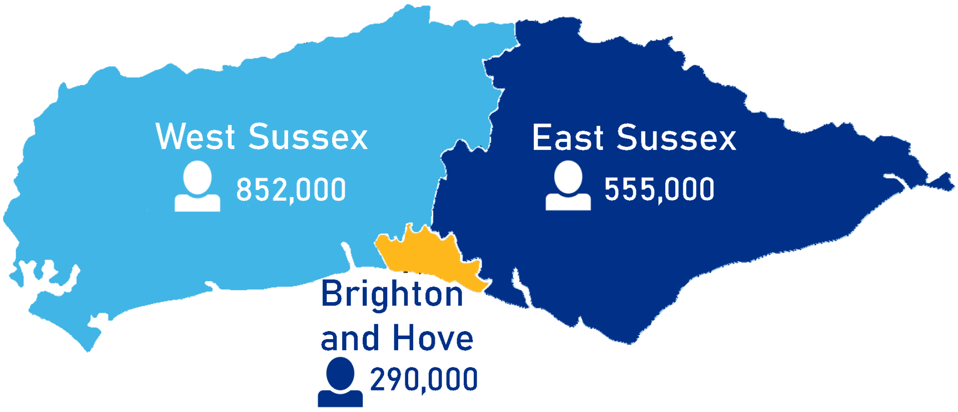
ESHT is part of the Sussex Health and Care Partnership (SHCP) which brings together 13 organisations into what is known as an Integrated Care System (ICS). The SHCP is sub-divided into three smaller regional zones, of which we are part of the East Sussex partnership.

Across the SHCP, we work collectively to improve the health of local people, ensuring that health and care services are high-quality and make the most efficient use of resources.This should enable local people to stay healthy for longer, to receive more support and treatment at home or in the community and, if they do get ill, to ensure they get the right care in the right place at the right time.

One of the ambitions of the ICS is to improve digital health and care services. The SHCP recognises that there are amazing opportunities to use technology and data to design better ways for services and patients to support each other. For example, population health data is now being shared to inform system wide pathway redesigns and to measure outcomes for patients.

However, it’s also recognised that the opportunities technology and data can bring will also bring challenges. Privacy will need to be respected and steps taken to ensure that no one becomes digitally excluded so that inequalities are reduced, not made worse.

The Sussex Health and Care Partnership (SHCP)



Improving population health is one of the key aims within the NHS Long Term Plan. To achieve this, we need higher quality, structured data to understand our patients and population.This links to work across the ICS on the Sussex Integrated Dataset (SID), which features in our objective to implement regional priorities (see page 22 for more information).

As part of the Digital Aspirant Programme, we're working closely with Sussex Community Foundation NHS Trust, to deliver a number of collaborative projects, using data and the latest innovations and technology to transform our community services. We're also benefitting hugely from the shared learning that this collaborative approach brings.

We also recognise that our patients are partners in their own care and want to give them more control over how they interact with our services. We also want to engage with them when we are introducing new digital solutions. As a first step, we will develop a virtual Digital Engagement Group, where ideas can be discussed and feedback given. Over 100 of our Trust members have expressed an interest in being part of this, and we will look to widen the membership and develop this group over time.

> **“We're already seeing great benefits in our collaboration through the Digital Aspirant programme. Sharing our work on key digital projects is helping us to move faster and lead the way in community digital healthcare, building a blueprint for community digital development which can be applied to other Trusts nationally.”**
>
> **Diarmaid Crean**
> **Chief Digital and Technology Officer,**
> **Sussex Community Foundation NHS Trust**

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OUR PLEDGES

From the feedback we received from our colleagues and patients, we have developed the four following pledges, which will underpin everything we do:

Pledge 1: We will get the basics right

When we spoke to colleagues, it was clear that things such as wifi, lack of digital storage space and hardware failures cause them the most frustration. That's why our first step will be a programme of work to ensure that our digital infrastructure can fully support the ever increasing demands being placed on it and that our colleagues can have more confidence in the reliability of the equipment and systems they use.

Pledge 2: We will never digitally exclude our patients

We believe the use of digital tools can enhance the care experience, allowing us to connect with our patients in a flexible and responsive way. We understand though that not everyone wants to use the technology that's now available. Healthcare must be accessible to all and so we will always offer alternative ways to communicate with patients who choose not to use technology. We will also train our staff to be digital health champions who can support patients and their families.

Pledge 3: We will ensure our colleagues have the knowledge and skills to use the technology available to them

Adapting to new technology can be difficult for some of our colleagues. We want to support them to get the most from the technology available, helping them to work more efficiently and ultimately to improve the care they provide patients. We want to extend the training and support we offer. We also want to increase our visibility in clinical areas so that any issues can be dealt with quickly without the need to escalate.

Pledge 4: We will continue to engage with our colleagues and patients about our plans

When asked, colleagues and the public told us they want to be more involved with the digital changes we're making. Starting early conversations with them around our digital ideas will give us a better understanding of what they need. To help with this, we have already introduced new Digital Business Partner roles, who work with our clinical and non-clinical areas to engage and collaborate. For members of the public, we plan to set up a virtual Digital Patient Experience Group to help us achieve this continuing engagement.

We also need to ensure that our digital systems are safe so we can avoid unnecessary harm. We have introduced digital clinical safety processes where both clinicians and technical staff work together to ensure there is a culture of digital safety.

We want to further improve patient safety by understanding 'what good looks like'. We can do this by looking at the benefits and cost savings associated with best practice, equipping staff, patients and partners with the opportunities and skills to improve patient safety throughout the patient pathway. We will also embed digital clinical safety in policy and regulatory documents and look for further opportunities for digital technology to solve patient safety problems. To support this, we will work with NHS Digital and local partners to share insights about what works best and why, and have an open forum for discussing potential digital safety risks and solutions.

See **Maria** and **Bens'** stories on the following two pages, which show the difference that meeting these pledges could make to our colleagues

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COLLEAGUE STORY

MARIA

Age: mid 40’s
Lives: Hastings
Works: Eastbourne DGH
Digital confidence: Good

Maria works in the digital project team, based at Eastbourne DGH. Although her role is mostly desk-based, she often attends meetings and visits clinical areas as part of her role.

Concerns: Balancing work and home life, access to technology at work that helps rather than hinders

2017

Maria worked full-time, travelling from Hastings to Eastbourne each day. She sometimes had to take her son to school on her way to work or collect him on the way home and felt like she was always rushing from one place to another.

Maria’s team enjoyed working together, there was a good atmosphere in the office. Maria often attended meetings in the hospital’s designated meeting rooms, but the equipment in each room was different so she didn’t always have the right kit, causing unnecessary stress. It was also not unusual for Maria to find the room had been changed with no notice given to attendees. Wifi coverage around the hospital was patchy, making it difficult to access systems when out in clinical areas.

2021

As the pandemic began, Maria started to work from home. She was provided with a laptop and access to systems through a Virtual Private Network (VPN) connection. As working from home became longer term, Maria was provided with a screen, keyboard and mouse to set up a home office.

The introduction of Microsoft Teams completely changed how Maria and her colleagues interact. At a glance, she can see if colleagues are available, send them an instant message and have virtual meetings. Maria and her team have regular virtual catch-ups in the diary to make sure that everyone is doing OK and not feeling isolated.

2026

Maria works two days a week in the hospital and three days at home. She has a much better work-life balance and has agreed a flexible work pattern which she can fit around the school run. Working at home every day felt quite isolating so Maria enjoys seeing colleagues on her office days and feels she has the best of both worlds.

When at work, Maria no longer has a dedicated office but books a desk in one of the agile working spaces. Equipment in the meeting rooms has been standardised and wifi coverage has improved. A smart room booking system has also been introduced, which automatically notifies attendees if the location of their meeting changes.

COLLEAGUE STORY

BEN

Age: early 30’s
Works: Conquest Hospital
Digital confidence: High

Ben is a Consultant Interventional Radiologist, performing minimally-invasive procedures guided by medical imaging such as x-rays and scans. This involves looking at very detailed images to make a diagnosis and decision on suitable treatment. Ben works from Conquest Hospital during the day but is part of an on-call rota overnight and at weekends. When on-call, Ben will review scans at home before travelling to the hospital to perform a procedure, for example, an angiogram and embolization for a patient with bleeding from the colon.

2018

At the hospital, Ben used a 32 inch screen to see all the necessary detail of scans. When on-call, he used his laptop which was much smaller, making the job more difficult. The connection to the hospital’s systems from home was slow, with no guarantee that the Virtual Private Network (VPN) would connect. Scans are large files, up to a gigabyte in size, and downloading them can take time. From being woken at night, it could take up to 40 minutes for Ben to review a scan and then make the decision to travel to the hospital to perform a procedure.

2020

The radiology team has new equipment for working from home including larger screens, a new VPN and webcams. Almost everyone in the department has the same equipment at home as what they use on site. It can now take as little as 10 minutes from Ben being woken up to reviewing a scan and making the decision to go to the hospital.

The improved equipment gives team members the option to work from home during the day. This has helped productivity as it allows a quiet space to concentrate, rather than being interrupted as happens when in the office. This has also had a positive impact on work/life balance, with Ben able to collect his children from school on the afternoon he works from home. Wherever they are, the team members are always contactable and everyone has set times to be in the hospital each week.

2026

A new Picture Archiving Communication System (PACS) will be introduced in 2022, procured by Trusts across Surrey and Sussex. Ben can now view scans taken at any hospital in the region immediately, rather than sending a request and waiting for them to be sent. Electronic requesting for radiology imaging has also been introduced, replacing the hand-written piece of card previously used to request scans. This has made the requesting process quicker and provides clearer information to clinicians.

OBJECTIVE 1

Give patients electronic access to their records through a Personal Health Record

We are working to introduce a Personal Health Record, giving patients access to their health information through any internet enabled device, such as a laptop, smartphone or tablet. We're still in the early stages of implementation – at the moment most patients can see appointments and clinical letters sent to them online. We will move to a more ambitious roll-out which will include:

- **All appointments, medical correspondence, test results, medication lists and care plans, together in one place and accessible on any device**
- **Notifications when new information is available**
- **Messaging clinicians directly, with the ability to share data, photos, videos and documents**
- **Access to tailored resources designed for the individual patient**
- **Sharing data from wearable devices with clinicians**
- **Keeping a journal and monitoring symptoms**
- **Sharing records with other people such as GP, pharmacist, paramedic, carer or next of kin**

Giving patients access to this information will empower them to be more involved in their healthcare whilst for clinicians, it will give quick and easy access to the most up-to-date information they need to make decisions about their patients' care.

What difference could this make to patients? Read **Lydia's** story to find out ❯❯❯

PATIENT STORY

LYDIA

Age: early 20's
Lives: Polegate
Digital confidence: Very high

In summer 2020, Lydia was knocked off her bike by a car. She was taken to Eastbourne DGH and diagnosed with a traumatic brain injury. As a result of her injuries, Lydia was referred to the Neurology team and worked with the Trauma Rehabilitation team and Neuro Physiotherapists, who are amongst the early adopters of the Personal Health Record platform at ESHT.

Concerns: Memory loss and reduced cognitive function due to brain injury

2015

All correspondence was sent in the post – likely that letters wouldn't have arrived in time to attend short notice appointments. Also issues with letters getting lost or being sent to the wrong place.

> "I wouldn't have been able to cope with all the bits of paper, I would have lost and forgotten things and missed appointments."

2020

Lydia could see all her appointments, letters and the information she had been sent in the Personal Health Record app. She also received an email whenever an appointment was booked. Given her memory loss, having all this in one place was a huge help. Lydia also used the app's symptom tracker to record her symptoms, which she could refer back to at appointments. She used a medication tracker which listed her medications and doses, again this was really helpful to have to hand at appointments when coping with memory loss.

Lydia also accessed services to help her recovery online through the links given and her rehab exercises were provided online rather than on paper. This meant any changes to the exercises or information could be given immediately, rather than being printed on paper.

2026

We want to have fully implemented a Personal Health Record across all our services. For Lydia, this will mean having access to all health information in one place. Lydia would be able to send messages, videos or photos securely to clinicians, saving time spent on the telephone or unnecessary appointments. The information could be shared with other clinicians involved in Lydia's care.

OBJECTIVE 2

Introduce a single Electronic Patient Record across all our services

We currently have around 400 different systems within the Trust which all collect information and use it in different ways. Many of these systems are standalone and cannot share the information they hold, which means clinicians have to log in to different systems to find the information they need to provide care. Inconsistencies in the data across these systems places a significant administrative burden on our staff but could also cause safety risks to our patients.

There is also still a large amount of paper in use and patients often have to repeat themselves, giving the same information over and over again to different people.

To overcome this, we want to introduce a single Electronic Patient Record (EPR) which is used across all our services. This would mean all patient information is available electronically, across our acute hospitals and community services and is available at all times.

Doing this will give clinicians more time to spend caring for patients as they will have faster access to information and will save patients having to give the same information to different members of staff.

Our plans have been boosted by the announcement that we have been selected to be part of the Digital Aspirants Plus programme, and will receive national funding and support to implement a full EPR.

This would also be the first step in allowing information to be shared more easily with other NHS organisations, GPs and social care providers across our acute hospitals and community services.

What difference could this make to colleagues? Read **Mark's** story to find out

COLLEAGUE STORY

MARK

Age: mid 40's
Works: Conquest Hospital
Digital confidence: High

Mark has been a nurse for over twenty years and currently works on a ward at Conquest Hospital.

Concerns: Providing best possible care for patients and adapting to new technology

2014

A system that provides bedside observations is introduced on Mark's ward. This records patient observations (such as temperature, pulse and blood pressure) digitally. The information is displayed on mobile devices which Mark and his colleagues carry round with them. The system automatically generates a National Early Warning Score (NEWS) to identify patients who may be deteriorating, improving patient safety by giving an early warning. The information is available 24/7, unlike paper charts which can go missing. The system has also removed any issues around the illegibility of handwriting.

2021

Additional digital functions have been introduced over time, such as the monitoring of patients' fluid balance. Mark and his colleagues were able to co-design other assessments and tools, which have enhanced patient care and improved collaboration between ward colleagues.

> “ The new systems make my job much easier, having all the information I need about my patients readily available has given me more time to spend with them and greater confidence in the care we give them. ”

The new systems save Mark and his colleagues time which is spent with patients and visitors. Although they've had to learn and adapt, having all the information needed readily available has given more confidence when caring for patients, leading to a higher standard of care.

2026

Further developments will see a move towards paperless wards. Colleagues from ESHT Digital visit the ward regularly to deal with questions and further support is provided by eHealth Practitioners. Digital equipment across all wards has been standardised, so Mark can do a shift on a different ward and use the same digital equipment that he is already familiar with.

Mark's role will change as patients start to take greater control of their care, with more information available to them. Data will become more important and Mark will be involved in discussions around the impact of this and how it is used as an additional nursing tool.

OBJECTIVE 3

Empower patients by using digital to support personalised care, putting them at the heart of everything we do

Personalised care is one of the five major changes to the NHS outlined in the NHS Long Term Plan. It means giving people more choice and control over the way their care is planned and delivered, recognising that the complexity of people's needs and expectations for health and care can no longer be met through a one-size-fits-all approach.

We recognise that digital solutions have a significant role to play in moving towards providing personalised care. We want to support people in East Sussex, empowering them to access health and care services via digital solutions to provide care in a way that suits them and their personal needs.

Examples of this include:

- **Choice around how they attend outpatient appointments, with the use of virtual consultations (video or telephone) where appropriate**
- **Access to clinicians and clinical advice or support online, for example, through email or web chats**
- **Using wearable technology (for example, insulin pumps, skin patches, smartwatches) so symptoms can be monitored remotely, giving patients greater knowledge about their condition and reducing the need for unnecessary appointments**

What difference could this make to patients? Read **Aisha's** story to find out

PATIENT STORY

AISHA

Age: early 40's
Lives: Heathfield
Digital confidence: Average

Aisha lives with her husband and two sons. She was generally fit and healthy until, in April 2020, she tested positive for Covid-19. Although Aisha's symptoms were fairly mild, she has struggled since with fatigue, breathlessness and anxiety. She also finds it hard to concentrate, describing a "brain fog". As a result, Aisha hasn't been able to work for over a year. Following a diagnosis of long-Covid, Aisha was referred to the Post-Covid Assessment Service (PCAS).

Concerns: Scared about the future, returning to normal life and to work, the family's finances, will she fully recover?

2015

All outpatient appointments were face-to-face, requiring travel to our hospital sites. All information provided would have been in paper copy.

2021

Aisha completed an online self-assessment form which was used as the basis for her initial assessment, held virtually via video link. All her appointments were held via video or telephone, removing the need to travel and saving time. Aisha was able to email the team directly with any questions in between appointments.

Aisha was signposted to online resources, which she could work through in her own time. Being online, the resources were quickly and easily updated, so she had access to the latest information and research. Virtual support was also given to her family, again without leaving their home. With Aisha's permission, a virtual meeting was held with her employer to discuss phasing her return to work.

The PCAS team could work remotely from different locations and access patient notes digitally wherever they were. The use of technology broke down barriers between organisations, with the team finding it easier to liaise with Aisha's GP and specialists who work for other Trusts.

2026

The PCAS team are now looking to use technology to set up virtual group sessions, where patients can support each other from the comfort of their own homes. These will be attended by other professionals, for example, GPs or specialists from out of area.

As outlined in objective 1 on page 16, the intention is to use a Personal Health Record to give patients electronic access to their records. The use of the app as an engagement and feedback tool is also being investigated.

The model of virtual appointments and the closer working with professionals from other specialties and other geographical locations that this enables is being copied in other areas.

OBJECTIVE 4

Work with partners in the Integrated Care System (ICS) to implement regional priorities and ensure data is used to inform the decisions we make

One of the key programmes being worked on by the Sussex Health and Care Partnership (SHCP) is Our Care Connected, which aims to deliver a single Local Health and Care Record (LHCR) for every person living in Sussex. This would mean that every health and social care practitioner in Sussex would have access to the right information they need at the right time to provide care. This would also remove the need for patients to repeat the same information at every appointment.

Part of this work is the Plexus Care Record which will see systems across GPs, acute, community and mental healthcare services and adult social care connected. In practice, this will mean the same patient data being accessible across organisational boundaries and, as part of the national programme, across geographical boundaries as part of the LHCR.

Sharing data is key to providing the best possible care. Having a more complete picture of a patient's journey across different services will allow clinicians to provide a better patient experience and improve safety and efficiency, ultimately leading to better care and outcomes.

Sharing data is just the first step though, we need to ensure that all data flowing in and out of our systems is correctly coded and structured, in line with NHS Digital's standards e.g. Transfer of Care. The focus is on the digital sharing of structured discharge and clinic attendance documents sent from secondary care to primary care. This will ensure that information follows the patient and continuity of care is maintained because services are better connected.

Not only is ESHT a partner in this work providing and consuming the data, but we are also the technical delivery partner for the Cloud hosted platform, building the infrastructure this sits on.

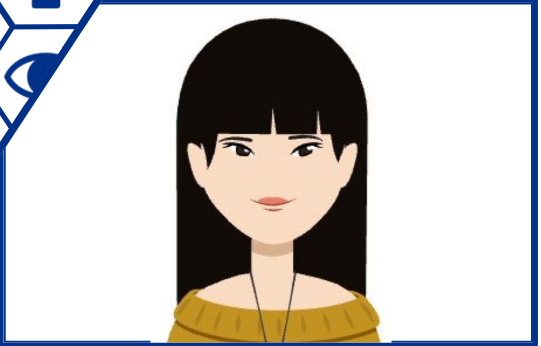
Intrinsically linked to this is the development of the Sussex Integrated Dataset (SID). This is a population health management system which takes data from all health and care providers. This data is then analysed to help redesign clinical pathways and measure patient outcomes for the population of Sussex.

Raw data sent through to the SID is depersonalised so any patient identifiable information is removed and the data is therefore anonymous. Analysis of the data is used to identify trends in population health and to inform evidence-based decisions around service delivery and reconfiguration and effectively target prevention measures.

What difference could this make to patients? Read **Louise's** story to find out ❯❯❯

PATIENT STORY

LOUISE



Age: early 30's
Lives: Rye
Digital confidence: Average

Louise has just found out that she's pregnant with her first baby.

Concerns: Nervousness around her first pregnancy, feels overwhelmed by amount of information available (some of it conflicting)

2015

Louise made an appointment with her GP and was then referred to the Maternity service. At her first midwife appointment, she was given a set of paper notes, which she had to remember to take to every appointment. Sometimes Louise forgot so the clinician seeing her had very little information available to them. Once when visiting family in Kent, Louise was taken to hospital and didn't have her notes, so they only had the information she could give them. These paper notes often became bulky as additional information was stuck in, such as ultrasound scans and blood test results. It wasn't unusual for these pieces of paper, containing highly sensitive information, to become unstuck and lost or for whole sets of notes to be mislaid.

2021

Louise self-refers using the online form on the Trust's website. A bounce back email tells her about an electronic maternity notes system and gives instructions on how to download the app to her smartphone. At all appointments, information about Louise's care is added to this secure system so any clinician she sees can access the information they need, 24 hours a day. This removes the need for Louise to remember to take her notes to appointments. Louise's midwife can send her relevant information, and she receives a notification whenever a new message or appointment is available on the app. During appointments, Louise's midwife inputs information straight in to the system and so doesn't have to spend time after writing or inputting details into other systems.

2026

Information from the electronic maternity notes system feeds in to the Local Health and Care Record. Clinical information about Louise's pregnancy is available whenever she accesses healthcare, regardless of organisational and geographical boundaries.

Anonymised data about Louise is sent through to the Sussex Integrated Dataset (SID). Analysis of data across the local population identifies those at risk of poor health and informs decisions around the services and support that are provided. For example, the data identifies areas where the number of smokers is above average, so smoking cessation services can be focussed where they can have the greatest impact to improve the health of the population. The data is also used to measure patient outcomes, so the success of interventions can be assessed.

OBJECTIVE 5

Maximise opportunites for using robotics and artificial intelligence

Within healthcare, there are a number of processes that currently have to be undertaken manually and are time intensive for staff. We want to maximise opportunities for these repetitive processes to be automated, by using robotics.

For example, all referrals that come in to the organisation have documents attached, which currently have to be downloaded and reloaded in to the system. Using Robotic Process Automation (RPA) would remove the need for this to be a manual process.

There are a number of areas where Artificial Intelligence (AI) could be used, for example, working alongside consultants to help identify and diagnose conditions, leading to improvements in patient care and patient outcomes.

Another example could be in Outpatients, where patients are sent a text message reminder in advance of their appointment. This would allow patients to be seen quicker and reduce the number of missed appointments, which cost millions of pounds each year.

Increasing our use of RPA and AI would reduce the administrative burden for colleagues, cutting mundane and repetitive tasks in both clinical areas and back office functions. However, this is not aimed at replacing humans or reducing the size of the workforce. The aim is to increase capacity and give colleagues working in support functions more time to devote to other tasks and to give those who work in clinical areas more time to devote to their patients.

What difference could this make to patients? Read **Joan's** story to find out

PATIENT STORY

JOAN

Age: mid 60's
Lives: Battle
Digital confidence: Low

During the summer, Joan was in her garden when she suddenly felt a strange sensation down one side of her body and collapsed. Luckily Joan's husband saw her collapse, recognised the signs of a stroke and called an ambulance, which took Joan to Eastbourne DGH. On arrival and after assessment, Joan was given a brain scan.

2021

Cutting edge software that uses artificial intelligence (AI) technology is being used across Sussex to improve the way people who have suffered strokes are diagnosed and treated.

The software analyses Joan's brain scan, automatically highlights the position of the clot and areas of possible damage and quickly provides an ASPECT (Alberta Stroke Program Early CT) score to show the number of areas of the brain affected. Consultants use this information, alongside the other information they have available to them, to make decisions on the most appropriate treatment for the patient.

In Joan's case, this led to her quickly being transferred to the specialist mechanical thrombectomy centre in Brighton, where she underwent an operation just a couple of hours after being diagnosed with a blood clot on the brain. Two days later, Joan was able to return home and has now made a full recovery.

2026

The stroke team can now use an app on their smartphone to view scans remotely and instant message colleagues in other hospitals. This means decisions around treatment and transfer to other hospitals can be made more quickly, which is crucial when treating stroke patients.

OBJECTIVE 6

Ensure that our infrastructure and all data held in our systems is secure

The patient information held in our systems is a high value target for cyber criminals. Ensuring that information is protected and is secure is paramount to give staff and our patients confidence in us and our work.

In 2020 we recruited a new Information and Cyber Security team who provide and coordinate expertise to influence our information security approach, helping ESHT to achieve its strategic objectives by aligning with local and national strategy and ensuring the availability, confidentiality and integrity of our information.

We have already made some progress in implementing the technical standards recommended by the National Cyber Security Centre (NCSC). The next step is to implement an Information Security Management System (ISMS) which gives a framework for policies and controls that manage security and risks systematically.

We also want to achive accreditation for International Standard ISO/IEC 27001 on managing information security, achieve a high level of compliance with the Data Security Protection Toolkit and Cyber Security Essentials+ certification.

A key component to achieve this objective is recognising that all colleagues across the Trust have a responsibility to ensure that the security of our systems and data is maintained. Our colleagues need to be sufficiently trained and understand what action they need to take to reduce the likelihood of a cyber attack succeeding, and so we will undertake an ongoing education programme to ensure all colleagues have the skills, knowledge and guidance to improve our information security posture.

What difference could this make to patients? Read **Liam's** story to find out

COLLEAGUE STORY

LIAM

Age: mid 30's
Works: Conquest Hospital
Digital confidence: Very high

Liam is a member of our dedicated Information and Cyber Security team.

Concerns: Keeping Trust systems and the data in them secure

2018

There was very little knowledge or resource within the Trust about cyber security. However, realisation about its importance was increasing following the Wannacry attack in 2017.

2021

The team has started to use the latest monitoring software to scan for possible cyber threats. This works in the background, analysing network data generated by users and their devices, looking for activity that the system believes is "not normal". Any alerts generated can then be investigated by the team, who feed their findings back in to the system, which learns from these. So for example, if the team disagree with the system and feel that an alert was not necessary, the system will learn from this and not flag the same concern again. By doing this, the system improves over time and the number of alerts that the team will need to investigate will reduce.

During June 2021, the system saw over 8,000 alerts from 5,355 devices. Although most of these were the result of normal activity, previously they would have needed investigating, which was unmanageable. The introduction of monitoring software means that normal activity is excluded automatically, so Liam and his colleagues can focus on the abnormal alerts that require investigation – in June, this was just 59 alerts across 5 devices.

2026

Further developments in artificial intelligence and automation will increase efficiency in dealing with alerts and allow the Trust to respond in a more timely way to emerging cyber security threats at any time of day or night. This will free up time for Liam and his colleagues to spend on other tasks.

OBJECTIVE 7

Ensure the digital infrastructure in our buildings is consistent and resilient

Our hospital buildings were designed many years ago, long before the start of the digital age in which we now live. New technology has had to be installed within the limitations of these buildings, which has led to a digital infrastructure that is inefficient and unreliable.

The Building for our Future programme gives us an exciting opportunity to transform the environment in which we provide care and ensure that our buildings support technology, both now and in to the future. We want to move towards our hospitals becoming smart buildings, where the technology is fully integrated and enhances the experience of patients, colleagues and visitors.

The first step to achieve this will be to ensure the fabric of our buildings is fit for purpose and able to support the necessary digital infrastructure. We will then look at the many existing systems that we currently have in our buildings and network them so they are joined up, share information and work together to improve the experience of everyone using the buildings.

We will also ensure that the digital infrastructure in our buildings supports the Trust's aims around sustainability, in line with the Estates Strategy. This sets out our commitment to improve our carbon footprint and reduce the environmental impact of our services, to support the national aim for the NHS to become the world's first net zero national health service.

What difference could this make to colleagues? Read **Frank's** story to find out

PATIENT STORY

FRANK

Age: late 70's
Lives: Uckfield
Digital confidence: Low

Frank is attending an outpatient appointment at Eastbourne DGH. Whilst his husband uses technology frequently, Frank is not so keen. However, after persuasion from his children, he has recently got his first smartphone and, with their help, is starting to get to grips with it.

Concerns: Stress of appointment (will it be bad news?), made worse by stress of going to hospital - finding a parking space and finding way around the building

2019

Frank left home in plenty of time to make sure he wasn't late for his appointment. It was fairly busy when he got to the hospital but after driving round the car park for a while, he found a space.

Once in the hospital, Frank queued at the desk to book in for his appointment and was given directions to the clinic. However, he took a wrong turn, got lost and had to ask someone for help. He was almost late for his appointment, stressed and out of breath from rushing.

> "Attending hospital, whether you're a patient or visitor, can be really stressful. Although I'm not a big fan of new technology, if there are simple things that can be introduced to make the experience a bit less stressful, that's got to be a good thing."

2026

The first phase of the re-development of the hospital has seen a new car park built, with more spaces available to patients. Lighting is used to direct people to available spaces so Frank is able to drive directly to a space on level 3 and there is no need to leave home quite so early.

As he walks in to the hospital, scanners pick up the signal from his mobile phone and book Frank in for his appointment automatically. He then gets a text message to tell him that the appointments are running a little behind schedule so he goes and gets a cup of tea from the café. Directions to the clinic are then given on his phone via a way finding app, supported by new digital signage which can be updated immediately when departments or clinics move. Frank arrives for his appointment feeling relaxed and calm.

OBJECTIVE 8

Achieve HIMSS Level 7 by 2026

HIMSS (Healthcare and Information Management Systems Society) is an internationally recognised model used to assess the digital maturity of healthcare organisations.

There are eight stages in the HIMSS model and each stage must be fully met before an organisation is assured as compliant. To reach the highest level, an organisation will have become truly digital, achieving digital maturity resulting in improved patient care, better workforce experience, financial efficiencies and innovation benefits. Only a handful of NHS Trusts have achieved this.

We had a HIMSS assessment in 2020, which rated us at Stage 0. Although it was acknowledged that we were making good progress towards some of the higher stages, we were not yet fully compliant with Stage 0 and so could not be rated any higher.

Our aim is to achieve HIMSS Level 7 by 2026. Achievement of the objectives outlined above will help us to reach this. In particular, we will need to:

- **Ensure that departments who support clinical care, (e.g. pathology laboratories, pharmacy and radiology) are fully digital with requests ordered electronically and all results available digitally and visible across systems**
- **Integrate the Plexus Care Record in to other systems so it is visible at point of care**
- **Implement a new Trust-wide system for digital imaging and for the storage and archive of images**
- **Introduce closed loop systems so that the ordering, prescribing, verification, dispensing and administering of medication and blood is fully electronic**
- **Use data and analytics for decision making around patient care**
- **Integrate data into the Health Information Exchange and the Patient Health Record**
- **Ensure robust business continuity plans for all systems are in place**

What difference could this make to patients? Read **Sophie's** story to find out

COLLEAGUE STORY

SOPHIE

Age: late 20's
Works: Eastbourne DGH
Digital confidence: High

Sophie is a pharmacist working at Eastbourne DGH. The majority of her time is spent out on the wards supporting clinical teams and talking to patients.

2017

Sophie would visit a ward to review patients' medication charts, these were handwritten on paper. If a chart was mislaid, staff would spend valuable time searching, delaying care for the patient. Information on the chart was sometimes illegible and it took Sophie time to read what some of her colleagues had written. Illegible handwriting could also lead to administration errors due to the dose or drug being misread. When any changes were made to a prescription, the process to order new medicines could take over three and a half hours, relying on nurses writing the order in a book, which Sophie checked when she was on the ward.

An Electronic Prescribing and Medicines Administration (ePMA) system has been introduced, so inpatient medication charts can now be updated electronically. Sophie can view medication charts from her office before she visits the ward and can prioritise the patients to review and speak to first. The time colleagues previously spent searching for paper charts is now spent caring for patients.

2022

Sophie accesses online resources through the ePMA software such as the British National Formulary, NICE guidance and Trust guidelines to aid safe, effective and evidence based prescribing. The system is linked to Pharmacy so Sophie can order medicines remotely from the electronic drug chart straight to the dispensary rather than having to check the ward book.

The overall time to order and supply medicines has reduced to approximately 90 minutes. The information in the chart is typed, so there are no issues with illegible handwriting. If, for any reason, the system fails, a robust Business Continuity Plan is in place to ensure patients will continue to receive the treatment and care required.

2026

A complete closed loop system means the ordering, prescribing, verification, dispensing and administering of medicines is fully electronic. Barcode scanning has been introduced so the barcode on any medicine given to a patient is scanned, alongside the barcode on the patient's wristband. The system alerts if a patient is about to be given the wrong medicine and there is a complete audit of the patient's journey through the hospital so if ever there is a recall on a particular product, those patients who may be impacted can be easily traced.

We have a wide range of volunteering opportunities and you don’t need previous experience in a health setting to volunteer for us.

For more information visit our website:

esht.nhs.uk/volunteering

4

GLOSSARY

of words used in this document

Artificial Intelligence (AI)

The theory behind and development of computer systems able to perform tasks normally requiring human intelligence such as visual perception, speech recognition, decision-making and translation between languages.

Building for our Future

This is the name of the Trust's programme co-ordinating both the new developments to be funded by the national Health Infrastructure Plan and the Trust-wide transformation initiatives.

Care Quality Commission (CQC)

The Care Quality Commission (CQC) is an executive non-departmental public body of the Department of Health and Social Care. It was established in 2009 as the independent regulator of all health and social care services in England. The CQC monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety and publishes what it finds, including performance ratings to help people choose care.

Digital Aspirant

A national programme which aims to accelerate procurement, deployment and most importantly, uptake of the technology that is needed to underpin digital transformation in NHS Trusts.

Healthcare and Information Management Systems Society (HIMSS)

The Healthcare and Information Management Systems Society (HIMSS) is an internationally recognised model used to assess the digital maturity of healthcare organisations. There are eight stages in the HIMSS model and each stage must be fully met before an organisation can be assured as compliant. To reach the highest level, an organisation will have become truly digital, achieving digital maturity resulting in improved patient care, better workforce experience, financial efficiencies and innovation benefits.

Integrated Care System (ICS)

Integrated Care Systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. The central aim of ICSs is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care. Since April 2021, all parts of England have been covered by one of 42 ICSs.

Place

The term “Place” refers to collaboration at a local level (meaning over a smaller area than an ICS). In Sussex, there are three Places; Brighton and Hove, East Sussex and West Sussex. The collaboration is between sovereign organisations working together to improve population health outcomes. These organisations will include health, social services, third sector and other local networks.

Plexus

A care record which will see systems across GPs, acute, community and mental healthcare services and adult social care connected, allowing practitioners to securely access and update relevant information anywhere anytime.

Sussex Integrated Dataset (SID)

A population health management system which takes data from health and care providers and analyses it to help redesign clinical pathways and measure patient outcomes for the population of Sussex. Raw data sent through to the SID is depersonalised so any patient identifiable information such as name, date of birth or address is removed and the data is therefore anonymous. Analysis of the data is used to identify trends in population health and to inform evidence-based decisions around service delivery and reconfiguration and effectively target prevention measures.

Voice Over Internet Protocol (VOIP)

Technology that allows users to make voice calls using a broadband internet connection rather than a regular phone line.

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Contact

Bexhill Hospital
Holliers Hill, Bexhill-on-Sea, East Sussex, TN40 2DZ
0300 131 4500

Conquest Hospital
The Ridge, St Leonards-on-Sea, East Sussex, TN37 7RD
0300 131 4500

Eastbourne District General Hospital
Kings Drive, Eastbourne, East Sussex, BN21 2UD
0300 131 4500