



East Sussex Healthcare
NHS Trust



Quality Account 2023/24



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Part 1 – Introduction





Statement of Quality from the Chief Executive

I am delighted to introduce our Quality Account 2023/24

This report is a summary of the trust's quality achievements during 2023/24 and is designed to assure our patients, partners and communities of the high quality clinical care we provide across our hospital and community services. It also provides a focus on those areas identified for further improvement and outlines what we are doing to improve, in addition to activity for our quality priorities in the coming 2024/25 period.

As we review this past year, when the NHS celebrated its 75th anniversary, it is a time to reflect on all our successes and challenges. Although there have been challenges for the NHS generally, we have remained focused on improving the quality of care we provide to our patients. We are also incredibly proud of all our hard working colleagues and volunteers who continue to go above and beyond, to ensure we provide the best possible care to our communities.



We continue to find innovative ways of working to build-on the changes adopted in recent years, including those developed during the pandemic. These include digital, virtual and robotic delivery, as well as exploring Artificial Intelligence through research to continue innovating. These have enabled many patients to receive services and interventions that provide a better patient experience.

The past year has also seen the development of our new values; kindness, inclusivity and integrity, with the work being led by our Partnership Forum – a group of staff representatives from across all areas of the trust. To ensure the views of as many of our colleagues as possible were considered, we undertook a series of face-to-face and online engagement events that involved 800 colleagues. The feedback around the new values has been overwhelmingly positive so far but this is just the start - we now begin work on embedding the values in everything we do.

Thank you all for your ongoing support.



Joe Chadwick-Bell
Chief Executive

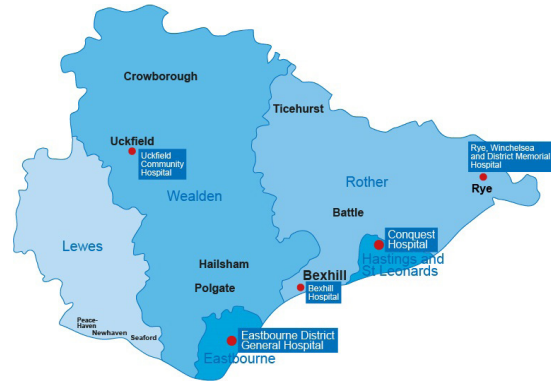


About the trust

East Sussex Healthcare NHS Trust provides safe, compassionate and high-quality hospital and community care to the half a million people living in East Sussex and those who visit our local area.

We are one of the largest organisations in East Sussex with an annual income of £669 million and we are the only integrated provider of acute and community care in Sussex. Our extensive health

services are provided by over 8,700 dedicated members of staff working from two acute hospitals in Hastings and Eastbourne, three community hospitals in Bexhill, Rye and Uckfield, over 100 community sites across East Sussex, and in people’s own homes.



In 2020 the Care Quality Commission (CQC) rated us as ‘Good’ overall, and ‘Outstanding’ for being Caring and Effective. The Conquest Hospital in Hastings and our Community Services were rated ‘Outstanding’ and Eastbourne District General Hospital (EDGH) was rated ‘Good’.

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

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

At Uckfield Hospital we provide day surgery and outpatient care. We also provide rehabilitation services jointly with East Sussex County Council Adult Social Care.

Social Media

YouTube: @ESHTNHS

X: @ESHTNHS

Facebook: @ESHTNHS

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

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





Purpose of the Quality Account and how it was developed

The Quality Account is an annual public report which allows us to share information on the quality and standards of the care and services we provide. It enables us to demonstrate the achievements we have made and identify what our key priorities for improvement are in the forthcoming year.

Since 2010 all NHS Trusts have been required to produce a Quality Account. The report incorporates mandatory statements and sections which cover areas such as our participation in research, clinical audits, a review of our quality performance indicators and what our regulator says about the services and care we provide.

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



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





Part 2.1 – Priorities for Improvement in 2024/25

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

Priorities for improvement in 2024/25

- Patient Safety - Safe Administration/ Prescribing of Paracetamol
- Clinical Effectiveness - Reducing the number of rejected pathology samples
- Patient Experience - Improving the Quality of Decision making for people who lack capacity





Patient Experience Priority

Improving the quality of decision making for people who lack capacity

Why this has been chosen as a priority?

People with cognitive impairment frequently lack capacity. This could be temporary or permanent and could be caused by a number of reasons e.g., dementia, a mental health condition, or substance misuse. Where the Mental Health Act is not applicable, those that do lack capacity are protected by a legal framework, the Mental Capacity Act, that health care professionals must legally follow when making decisions about treatment. Occasionally, however, this process is not properly followed or considered, leading to patients having unnecessary delays or the cancellation of their treatment. This can lead to distress for the patient and their families and/or carers.

What is mental capacity?

Your mental capacity means your ability to understand information and make decisions about your life. It can also mean the ability to communicate and utilise decisions about your life. Your capacity to make a decision can vary depending on the time that the decision needs to be made and the type of decision you need to make.

What does 'lacking capacity' mean?

If you lack capacity, this means that you're unable to make decisions. This might be permanently, or in the short-term:

- Permanent lack of capacity. This is where your ability to make decisions is always affected. For example, this might be because you have a form of dementia, a learning disability or brain injury.
- Short-term lack of capacity. This means your ability to make decisions changes from day-to-day. For example, this might be because of some mental health problems, if you're experiencing confusion as a side-effect of medication or if you're unconscious.

The Mental Capacity Act 2007 (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery. Several barriers are stopping people with a learning disability from getting good quality healthcare.

These barriers include:

- A lack of accessible transport links.
- Patients not being identified appropriately e.g. having a learning disability.
- Staff having little understanding about a person's condition.
- Failure to recognise that a person is unwell.
- Failure to make a correct diagnosis.
- Anxiety or a lack of confidence around people who lack capacity.
- Lack of joint working from different care providers.
- Not enough involvement allowed from carers.
- Inadequate aftercare or follow-up care.

People with a learning disability have worse health than people without a learning disability and are more likely to experience several health conditions.

What are we going to do?

We would propose choosing one or two of these areas and auditing the decision making that affects patients as they access treatment and journey through the pathway from referral to definitive treatment. The audit would look at the process of the decision making in this group of patients, compliance with the requirement of the Mental Capacity Act, involvement of appropriate support professionals, the involvement of carers and relatives, documentation, and the number or delays or cancellations that this group incurs and the reasons for them.

Where we identify issues, we would look to target these areas with improved documentation and guidance and training.

We would also look to raise awareness around these issues more generally amongst healthcare professionals in trust.

What will success look like?

Improved outcomes for people with cognitive impairment who are accessing our services. Improved compliance and adherence with the legislative framework, a reduction in cancellations or delays in procedures and a reduction in incidents reported.

How will we monitor progress?

Re-audit to assess decision making in the areas targeted and look for evidence of improved outcomes when re-audited such as improved compliance and adherence with the legislative framework, better documentation, a reduction in cancellations or delays in procedures and a reduction in incidents reported.



Patient Safety Priority

Safe Administration/Prescribing of Paracetamol

Why this has been chosen as a priority?

There have been incidents reported nationally where patients have been prescribed and administered the wrong dose of Paracetamol based on their weight. There has been a national safety report released which has recommended actions to ensure Paracetamol is prescribed and administered safely. Paracetamol, although thought to be a "safe drug", is of higher risk to patients; especially those of low weight, with liver impairment and those on multiple medicines. The aim is to raise awareness of the prescribing risks of Paracetamol and the relevance of patients' weight and other risk factors including liver function.

What are we going to do?

- Use improvement data to review current prescribing trends for paracetamol which will be used to test our improvement initiatives.
 - Raise awareness of the prescribing risks associated with Paracetamol and the relevance of patients' weight.
 - Develop educational materials and ensure all healthcare professionals involved in the prescribing, and administering of Paracetamol have the relevant training.
 - Education and feedback to be provided on wards for Healthcare Professionals and during pharmacy prescribing teaching sessions for doctors.
 - Ensure the new electronic prescribing system includes advice for oral Paracetamol prescribing that prompts weekly documentation of a patient's weight and consideration of the risk of liver toxicity when their weight is less than 50kg.
-

- Review available equipment on wards for weighing patients to ensure that accurate weights are obtained wherever possible.
- Review national guidance (and keep updated) for Paracetamol prescribing.
- Review prompts and alerts/ resources to support safer (electronic) prescribing.
- Review use of Paracetamol combination products (particularly at discharge) to reduce duplication of paracetamol dosing.

What will success look like?

- 100% of wards have the 'Medication Safety Bulletin' for Paracetamol on display across the trust.
- 100% of patients prescribed Paracetamol have their weight recorded to inform dosage.
- All wards will have appropriate scales/ weighing equipment for inpatients.
- Appropriate prescribing advice on EPMA including for low weight patients and those with liver impairment.
- Develop educational materials and ensure all Healthcare Professionals involved in the prescribing and administering of Paracetamol have the training.
- Education and feedback to be provided on wards for Healthcare Professionals and during pharmacy prescribing teaching sessions for doctors.
- Data to show improvement in prescribing paracetamol in low weight patients.

How will we monitor progress?

- Medication audit data
 - Ward visits/ spot checks
 - Data / Information from EPMA system
-



Clinical Effectiveness Priority

Reducing the number of rejected pathology samples

Why this has been chosen as a priority?

The Pathology department has sample rejection criteria for samples with the aim of ensuring patient safety by reducing the likelihood of incorrect or inaccurate results being released. Up to 5% of pathology requests have samples rejected due to avoidable circumstances including mismatched sample and form, unlabelled samples, or issues with the sample itself such as being haemolysed. This often leads to the sample needing to be retaken - causing an unnecessary invasive procedure. This in turn can result in delays to patient care, including longer wait times in Emergency department and delays to discharge. It also causes additional work for both the laboratory team and the requestor with regards to following up samples and raising and investigating incidents.

Work is currently ongoing to collect and analyse data regarding sample rejections in order to have a better understanding of how, why, and where this is occurring. The aim of this priority is to reduce the number of rejected samples thereby reducing the impact experienced by the patients affected, those requesting the samples, and the laboratory teams.

What are we going to do?

- A use of pathology services policy will be published alongside a campaign to ensure that all users are aware of the procedures for sending samples to pathology.
 - Targeted campaigns will be conducted to improve sample taking, recording, and requesting in areas where the issue is most prevalent. These will include written/visual information such as posters and outreach/education events.
 - Where a particular issue is identified in a specific area, we will work with those areas to identify any further preventative actions that can be taken.
 - Data will continue to be analysed to assess whether these actions result in improvements.
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What will success look like?

- A published use of pathology services policy
- A reduction in the number of rejected samples, reduction of Datix's, fewer patients having to be recalled to have samples retaken.

How will we monitor progress?

- Monitor overall numbers of samples rejected from a monthly audit of sample rejection codes.
- Monitor and trend rejections from specific areas where a particular issue has been identified.
- Trend Datix incidents regarding sample rejection issues





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

Reconditioning our patients

Why was this chosen as a priority?

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

Evidence suggests:

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

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

What did we do in 2023/24?

- Implementation of a FEDs (Frailty Early Discharge Scheme) on the Frailty unit at the EDGH
- A business case was developed; however it will be more cost efficient to review and introduce individual aspects of improvement in phases.
- Time to Move prompts have been introduced - Making Every Contact Count
- Additional ward leaders will join the Matrons for their 13-week checks – enabling new and fresh eyes from a different perspective.
- Working with Volunteer services - a volunteer retired from ASC (Adult Social Care) has started with reading and talking with one patient to organising and leading activities on one ward
- Working with the Dementia team - Limited availability currently but recruitment will take place soon
- Mobility Wars - 10m walk-way - how far can we collectively get?
- Communal eating – using patient bedside tables in the centre of the bay in the absence of a day room on most wards
- Staff dedicated to advising wards when procuring new chairs and other equipment to ensure a good selection of different chair availability on each ward
- Bitesize training available – revisit deconditioning, mobility and aides
- Identified reconditioning champions for each ward – supporting education of staff, championing mobility games.
- Successful charitable bid for activities with trolleys for each ward and activity suggestions

How have we done / How have we measured success?

- Spot checks around patients sitting out for meals, being dressed, communal eating to identify trends, ensure compliance to required standards of care and drive continuous improvement
- Consistently capturing patient feedback (Friends and Family Testing) – analysis, and acting upon results. Flagging any identified concerns to the leadership team.

Our plans for the future...

- Champions study day planned for June 2024
- Further bite size training for the wards to focus on therapies contribution, nutrition and hydration
- Ongoing Trust discharge training – every other month. Session on deconditioning and reconditioning.
- A deconditioning 3 minute video is being produced – this will be displayed on the trust website to support and remind patients to remain active.
- Working on information leaflets for patients and relatives
- Develop our own feedback forms and capture patient stories
- Looking at Bathrooms - More conducive to patients and independence with ADLs – Shelves, Plugs for sinks, mirrors, handles and rails, seats and stools.
- Look at different ways to capture Key Performance Indicators
- Further discussions with finance regarding development of a business case.



Part 2.3 – Statements of Assurance from the Board of Directors

During 2023/24 the trust provided and/or sub-contracted 88 NHS services.

The trust has reviewed all the data available to them on the quality of care in all 88 of these NHS services.

The income generated by the NHS services reviewed in 2023/24 represents 100% of the total income generated from the provision of NHS services by the trust 2023/24.

Participation in Clinical Audit and National Confidential Enquiries

Clinical audit is used within the trust to aid improvements in the delivery and quality of patient care and is viewed as a tool to facilitate continuous improvement. Clinical audit involves the review of clinical performance against agreed standards, and the refining of clinical practice as a result.

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

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

The national clinical audits and confidential enquiries that the trust was eligible to participate in during 2023/24 are detailed below.

National Audit and National Confidential Enquiries Programme

During 2023/24, 60 national clinical audits and five national confidential enquiries covered relevant health services that the trust provides.

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

Details of the national clinical audits and national confidential enquiries that the trust was eligible to participate in during 2023/24 can be found in Appendix 1.

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, and for which data collection was completed during 2023/24, are listed in Appendix 2, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.



National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)

NCEPOD issued three applicable reports in 2023/24:

- Transition from child into adult healthcare – The Inbetweeners - Published June 2023.
- Crohns Disease – Making the Cut – Published July 2023
- Community Acquired Pneumonia – Published December 2023

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

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

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

The Women and Children's division continues to report:

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

Terminations of pregnancy – All terminations from 22+0 weeks are notified and from 20 +0 weeks which resulted in a live birth ending in neonatal death should be notified.

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

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

UKOSS UK Obstetric Surveillance System

The UK Obstetric Surveillance System is a national system established to study a range of rare disorders of pregnancy, including severe ‘near-miss’ maternal morbidity. The Women & Children’s Division contributes, where cases meet the criteria, to these studies.

Reporting to UKOSS is undertaken by the divisional Governance Team.

The studies undertaken during the period 2023/24 include:

Study	Cases
Amniotic Fluid Embolism	0
New Therapies for Influenza	0 (closed 30/4/2023)
Previous cardiomyopathy	0
Thrombotic microangiopathy associated Acute Kidney Injury	Not participating as data unavailable
NEW: Biological agents in pregnancy	0
NEW: Severe Pyelonephritis in Pregnancy	0 (closed 30/9/2023)
NEW: Long-term non-invasive ventilation in pregnancy	Not participating as data unavailable

National Clinical Audit Reports in 2023/24

The reports of 22 national clinical audits were reviewed by the Trust in 2023/24. The Trust scrutinises each set of results to benchmark the quality of care provided, identify successes for celebration and / or identify any risks for mitigation. Recommendations for local improvement and change are considered and tracked via a central clinical audit action plan.

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

Full details of all mandated national clinical audits and Trust specific results are available online via: <https://www.hqip.org.uk/>



Society for Acute Medicine Benchmarking Audit (SAMBA) 2023

The Society for Acute Medicine Benchmarking Audit (SAMBA) 2023 provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 22nd June 2023.

Maintaining and improving the quality of care provided to our patients within acute medicine services is vital, but presents an ongoing challenge given the continual pressures felt across the urgent and emergency care system.

Overall message

Performance against all key clinical quality indicators was higher than SAMBA22 but remained lower than had seen previously. Acute care services face ongoing pressures, and careful consideration of how clinical quality and efficient patient pathways can be maintained is needed.

Emergency medicine remains the most common route of referral, with many units seeing a high proportion of their patients within the Emergency Department. However, the proportion of unplanned attendances who have their first clinical assessment in Same Day Emergency Care services has increased, reflecting increased use of these pathways, which achieve a higher performance against acute medicine clinical quality indicators.

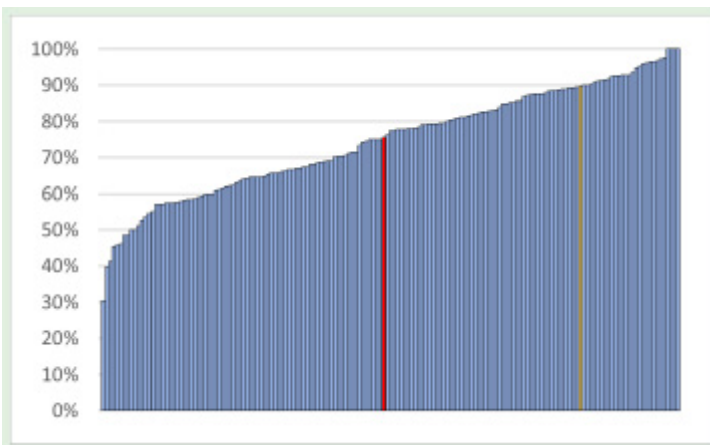
SAMBA23 local report - Eastbourne DGH

Key to Trust results

Trust site 

National Average 

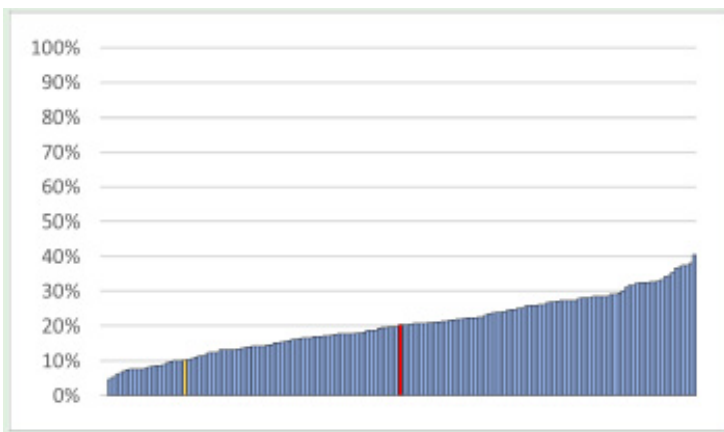
Early Warning Score



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

Median unit performance: 76%
EDGH: **90%** (2022 = 58%)

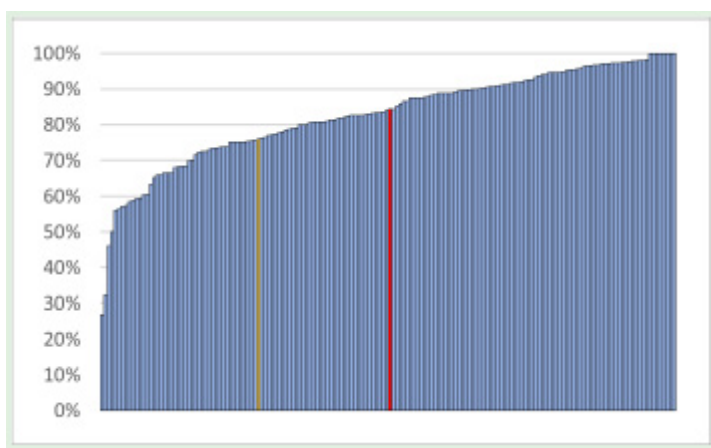
Unplanned admissions



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

Average: 20%
EDGH: **10%** (2022 = 19%)

First Clinician Review

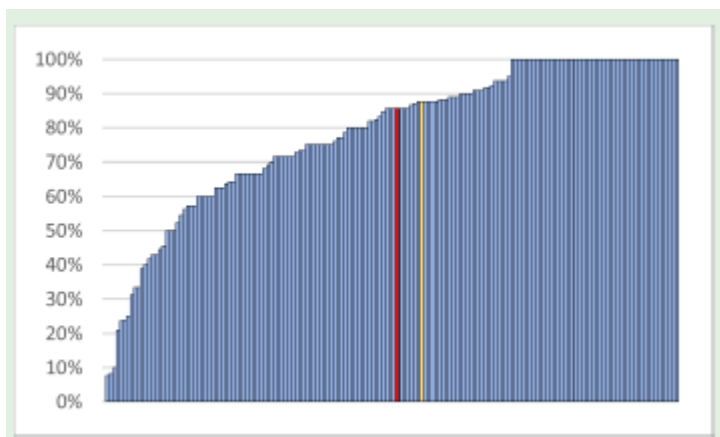


Percentage of unplanned admissions reviewed by a competent clinical decision maker within 4 hours of hospital arrival

Median unit performance: 84% (2022 = 82%)

EDGH: **89%** (2022 = 76%)

Out of Hours Consultant Review



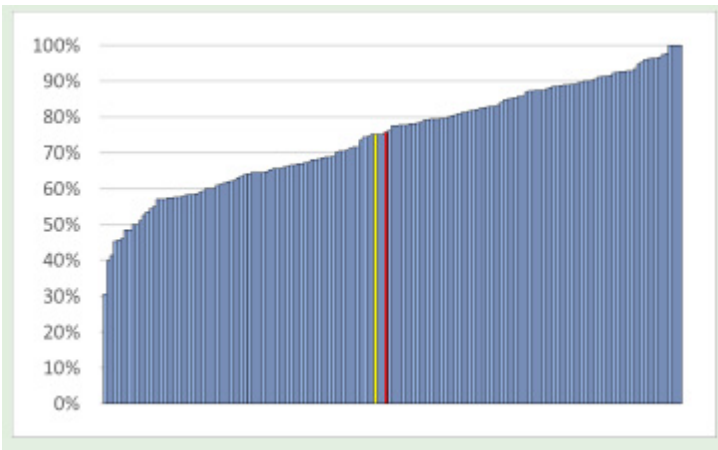
Percentage of unplanned admissions arriving overnight (20:00 – 08:00) with a consultant review within the target time (14 hours)

Median unit performance: 86%

EDGH: **88%** (2022 = 100%)

SAMBA23 local report - Conquest Hospital

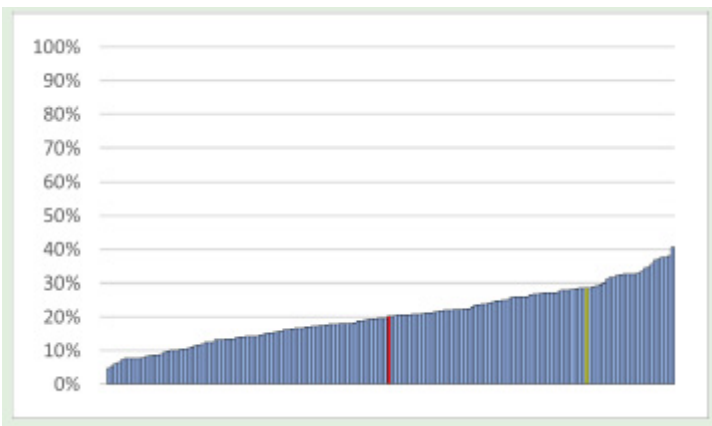
Early Warning Score



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

Median unit performance: 76%
CONQ: 75% (2022 = 68%)

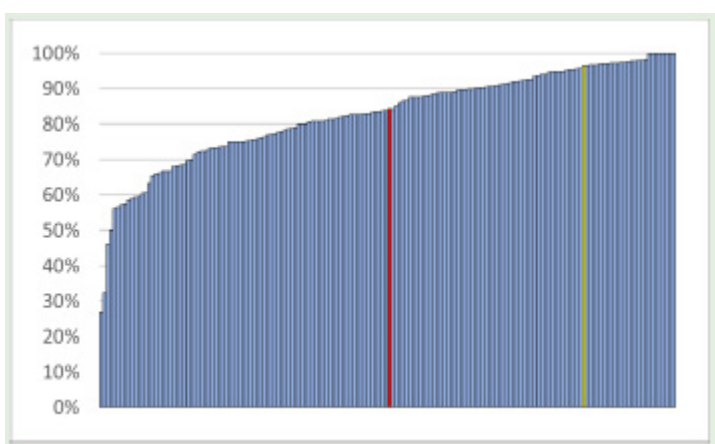
Unplanned admissions



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

Average: 20%
CONQ: 29% (2022 = 34%)

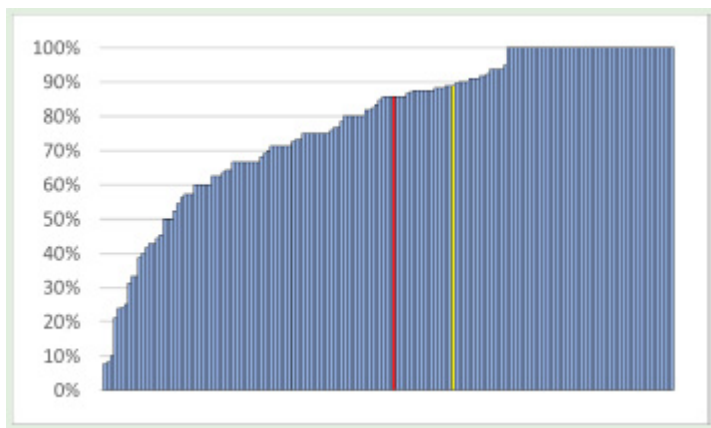
First Clinician Review



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

Median unit performance: 84%
CONQ: **96%** (2022 = 86%)

Out of Hours Consultant Review



Percentage of unplanned admissions arriving overnight (20:00 – 08:00) with a consultant review within the target time (14 hours)

Median unit performance: 86%
CONQ: **89%** (2022 = 100%)

Trust SAMBA Audit Action Plan

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

National Audit of Dementia – Round 5



The National Audit of Dementia care in general hospitals (NAD) examines aspects of care received by people with dementia in general hospitals in England and Wales. The audit is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England/NHS Improvement and the Welsh Government, as part of the National Clinical Audit Programme.

Data collection

Round 5 of NAD collected data between September 2022-January 2023. The audit was open to all general acute hospitals in England and Wales providing acute services on more than one ward which admits adults over the age of 65.

Key Findings

Delirium Screening

87% patients received an initial screen for delirium



Up from **58%** in previous round

Pain Assessment and Reassessment

61% patients only had questioning as a pain assessment



92% received any pain assessment

92% received a pain reassessment

Discharge

39% patients had a discharge plan initiated within 24 hours of admission

Median length of stay days **10**

Feedback from carers

Rating for overall quality of care decreased

Rating for quality of communication decreased



72% 2019 **66%** 2023

65% 2019 **60%** 2023

Positive responses **decreased** from previous round for **all questions**

Key Findings

Identifying People with Dementia

Unverifiable figures returned by hospitals for total number of patients with dementia identified per year, ranging from

33 – 29,769

with proportion of patients with dementia varying from

0% – 15%

Staff Expertise

20 hospitals reported having **no lead nurse** for dementia

Staff Training

Large variations of training reported, with

0% – 100%

hospital staff with **tier 1 training**

80% hospitals were able to provide figures for staff with **tier 1 training**

58% hospitals were able to provide figures for staff with **tier 2 training**

Dementia Friendly Environment Review

51% reviews taken place **throughout the hospital/all adult wards**

11% hospital review status' were **unknown or not taken place**

12% environmental review changes were **completed**

Personal Information Document

Proportion of patients with a personal information document decreased

59% 2019 **46%** 2023

Trust VS National result benchmarking

Key Metrics	National	EDGH	CONQ
% Delirium screen (inc. noted on admission)	87%	98%	90%
% Pain assessment	92%	87%	92%
% Pain reassessment	92%	74%	89%
% Pain tool – question only	61%	91%	94%
% Initiation of discharge plan in first 24 hours	45%	23%	18%
Carer rating overall care quality	66%	13%	100% (based on 1)
Carer rating communication	60%	0%	100% (based on 1)

Recommendation	SMART Action Plan	Action by deadline	Update on action
Carer rating overall care quality and communication	Discuss with the Dementia Champions to promote the completion of the carer questionnaires on the wards	31.07.2023	<p>17.01.2024 Action was discussed at the dementia care steering group. Dementia care leads confirmed this has been added to the dementia performance review for tracking. Dementia Champion involvement to promote completion of carer feedback questionnaires.</p> <p>22.04.2024 Team update - This is routinely done in the Dementia Champion catch up and training sessions.</p>

Summary Data	National	EDGH	CONQ
% People with dementia admitted to hospital over previous year	Range between 0.1% - 15% Median 3%	4%	4%
% People with personal information document at bedside	46%	10%	10%

Recommendation	SMART Action Plan	Action by deadline	Update on action
% People with personal information document at bedside	Promote via communications the Butterfly scheme and the use of the Reach out to Me document	31.07.2023	17.01.2024 Action was discussed at the dementia care steering group. Dementia care leads confirmed this has been added to the dementia performance review for tracking. Promotion of Reach Out to Me through deconditioning project and as part of NAD action plan 22.04.2024 Team update - In terms of the Butterfly scheme and person-centred document, Bev did suggest putting the Reach out to Me to the Matrons at their Safety huddles during Dementia Action Week which we thought a good idea. We plan to promote this once again on Comms during Dementia action week.
	Discuss with the Dementia Champions to promote the Butterfly scheme on the wards	31.07.2023	22.04.2024 Team update - In terms of the Butterfly scheme and person-centred document, Bev did suggest putting the Reach out to Me to the Matrons at their Safety huddles during Dementia Action Week which we thought a good idea. We plan to promote this once again on Comms during Dementia action week.
	Complete a QIP to improve the use of the Reach out to Me document	31.07.2023	30.01.2024 - Local Audit 1472 initially looked at how many patients had the bedside check. On evaluation of 32 patients with dementia admitted on the Frailty wards, only 5 had a REACH out to me document in their clinical case notes accounting to 15.6%. All 5 had up to date information provided (100%). Action plan identified conducting the QIP and sharing the findings. Leads to be identified for completion of the QIP.
	Consider adding a dementia dashboard on Nervecentre	31.07.2023	17.01.2024 Dementia dashboard test version is on nervecentre before it goes live. For already identified patients know to the dementia team.

Summary Data	National	EDGH	CONQ
Number of Lead Nurse for Dementia in post	Ranged between 0-6	1	1
% Staff with Tier 1 training	86%	R5 - unknown R6 – 30%	R5 - unknown R6 – 30%
% Staff with Tier 2 training	45%	R5 - unknown R6 – 31%	R5 - unknown R6 – 31%

Recommendation	SMART Action Plan	Action by deadline	Update on action
Carer rating overall care quality and communication	Discuss with learning and development and the Senior Management Team regarding T1 training being essential to complete	31.07.2023	17.01.2024 Dementia care leads met with the senior management team. Waiting for an update from learning and development regarding the training becoming mandatory. 22.04.2024 Team update - Awaiting feedback about a decision on Essential training. Our training figures have increased and we will again promote the Dementia training during National Dementia Action week.
	Request staff need to complete Tier 1 training before booking other dementia training	31.07.2023	22.04.2024 Team update – awaiting decision on whether this can become mandatory for Trust staff. All HCAs will now receive Tier 1. We have requested that Tier 1 is completed before booking on any other dementia care training.
% Staf with Tier 2 Training	Promote the training available for staff to complete. Ensure the number recorded for the ADS includes adult ward staff	31.07.2023	22.04.2024 Team update - we continue to be promote the training and this now incorporates CAIT. We would like to work with Comms to promote this, advising of the CAIT content. Numbers to the Tier 2 study days continue to be full. All training will be promoted again during National Dementia Action week and regularly at our Link meetings.



The National Joint Registry records, monitors, analyses and reports on performance outcomes in joint replacement surgery in a continuous drive to improve service quality and enable research, to ultimately improve patient outcomes.

Gold-level - NJR Quality Data Provider three-tier award scheme

The Conquest Hospital has been awarded as an NJR Quality Data Provider for 2023.

The 'NJR Quality Data Provider' scheme has been devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission quality audit process and by awarding certificates the scheme rewards those hospitals who have met the targets. From the 2022/23 audit year onwards, a new three-tier, gold, silver and bronze awarding system was applied to the scheme to further encourage all hospitals to strive to achieve the most excellent data quality standard.

The award targets are now awarded based on: audit compliance; the percentage of cases with no audit status; and the percentage of audit cases which have failed to be submitted. Hospitals are also required to have a minimum baseline compliance of 95% to qualify for an award. We know that meeting these NJR targets requires a strong departmental effort, and the award is also a way for all staff who have worked to achieve compliance targets during the 2022/23 data quality audit year to be thanked.

The hospital NJR Quality Data Provider Award 2023 certificate serves to recognise and reward the high standards and NJR targets being reached by hospitals. Hospitals who achieve NJR award status also have the relevant award emblem placed on their hospital dashboard page at www.surgeonprofile.

The hospital NJR Quality Data Provider Award 2023 certificate serves to recognise and reward the high standards and NJR targets being reached by hospitals. Hospitals who achieve NJR award status also have the relevant award emblem placed on their hospital dashboard page at www.surgeonprofile.njrcentre.org.uk - the NJR's Surgeon and Hospital Profile website.

The website displays orthopaedic volume data, which is published on an annual basis (refreshed in January each year) for joint replacement procedures in all the hospitals in the geographical locations where the NJR is operational.

Phillip Huggett-Robinson – National Registry Officer

Theatre Matron – Anna Lawrence

Mr Guy Selmon – Clinical Lead

Daiana Michnea – Quality and Improvement Coordinator Trauma and Orthopaedic Department





20th Anniversary
National Joint Registry
Working for patients, committed to excellence for 20 years

This is to certify that

Conquest Hospital

has achieved




Mr Derek Pegg
Chair, NJR Data Quality Committee


Mr Tim Wilton
Medical Director, NJR


Elaine Young
Director of Operations, NJR

EPILEPSY12

The Royal College of Paediatrics and Child Health (RCPC) are delivering the national clinical audit of seizures and epilepsies in children and young people, better known as:

Epilepsy12

This audit has been recommissioned by the Healthcare Quality Improvement Programme (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

East Sussex Healthcare NHS Trust has provisionally been identified as a positive outlier for Epilepsy Specialist Nurse Input in the 2022/2023 data analyses.

As part of its annual reporting process the Epilepsy12 audit has conducted Trust/Health Board outlier analysis on two audit measures for clinical cohort 5 data. The purpose of the outlier process is to identify and highlight variation, enable local review of the causes of that variation and stimulate quality improvement.

Metrics used for outlier definitions.

In our analysis, two metrics have been used to define outlier status within the Epilepsy12 audit:

1. Epilepsy Specialist Nurse (ESN) input – Percentage of children with epilepsy input by an epilepsy specialist nurse by first year.
 2. Tertiary input - Percentage of children meeting defined criteria for paediatric neurology referral, with input of tertiary care and/or CESS referral by first year.
- *Note that case ascertainment has been suspended from the outlier analyses due to methodological reasons.*

Information about how we calculate each measure can be found in our Round 4 [methodology overview](#). Epilepsy12 defines outlier status as being outside of 2 or 3 standard deviations from the national average). Depending on the measure, negative and positive outlier status can be defined. For negative outlier status 'alert' status is defined as outside 2 standard deviations from the performance mean and 'alarm' when outside of 3 standard deviations. For positive outlier status 'excellent' or 'outstanding' performance are defined respectively as 2 and 3 standard deviations above the average.

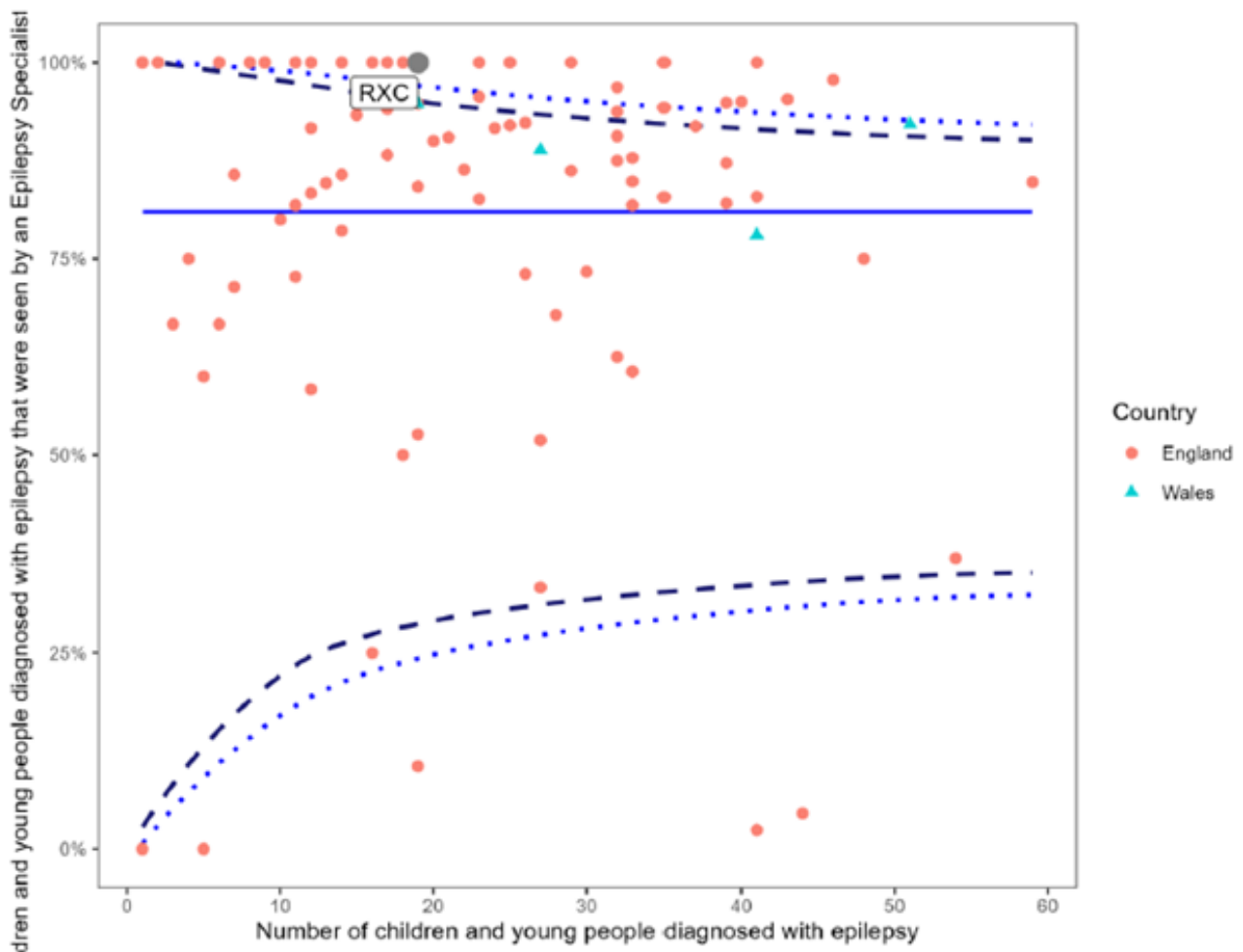


Figure 1 – Funnel plot for Epilepsy Specialist Nurse Input

We are pleased to confirm that East Sussex Healthcare NHS Trust has been identified as an **Outstanding** outlier for the audit measure Epilepsy Specialist Nurse Input.

Table 1 – Results table for Epilepsy Specialist Nurse Input input.

	Trust numerator	Trust Denominator	Trust Percentage	England/Wales Average
East Sussex Healthcare NHS Trust	19	19	100%	81%

Quality Reviews

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

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

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

Aims and objectives

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

Snapshot assessment of compliance with NICE QS152 – Liver Disease

This Quality Improvement Review was undertaken as part of the ongoing monitoring and review of NICE Guideline, QS152: Liver Disease - Gastroenterology had previously confirmed full compliance. This review covers Statements 1, 4 and 5 (Quality Statements 2 and 3 are currently in developmental stages)

Findings

19 patients had been coded with liver disease between 1st February 2023 and 30th April 2023:

Quality Statement 1 – People with non alcoholic fatty liver disease are given advice on physical activity, diet and alcohol

Three patients (16%) were found to have a fatty liver not related to alcohol. These three patients were all given advice on physical activity, diet and alcohol as per the guideline.

Diagnosis	Number of pts	Result
Fatty liver, no alcohol	3	100%

Quality Statement 4 – Surveillance for hepatocellular carcinoma

Adults with cirrhosis should be offered 6-monthly surveillance for hepatocellular carcinoma. Of the 19 patients reviewed, 10 patients who had cirrhosis were on appropriate 6-month surveillance. It should be noted, however, that 1 patient was non-compliant with appointments.

Diagnosis	Number of pts	Result
Cirrhosis of the liver	10	100%

Quality Statement 5: Prophylactic intravenous antibiotics for upper gastrointestinal bleeding

Diagnosis	Number of pts	Result
Prophylactic intravenous antibiotics	2	100%

It was necessary to provide prophylactic antibiotics in only 2 (10%) patients. The remaining 17 patients did not require antibiotics at this time.

Conclusion - This review has evidenced Trust is compliant with QS152: Liver Disease.

Assessing the effectiveness of ReSPECT documentation in the Early Care setting

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

This audit was assessing compliance for the completion of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms for patients:

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

An initial audit was undertaken in July 2021 (5074) because there were concerns regarding the discussions in detail about treatment recommendations and details of emergency contacts not always being recorded.

It had been two years since the ReSPECT forms had replaced the traditional DNAR forms in the trust, so the audit supported assessment of compliance and effectiveness of the form. The Resus Council UK and the trust guidelines were used as standards of care. Findings from the audit was published in the Physician Journal (op-17) 2021, Birmingham.

A re-audit was conducted in May 2022 (5239) to establish if the changes listed in the action plan following the baseline audit in July 2021 had led to improvements in the process of ReSPECT documentation in the elderly care setting at EDGH.

Clinical standard	1 st Audit	2 nd Audit
100% of all admitted patients with severe disabilities, irreversible conditions, deteriorating conditions or frailty should be considered for a ReSPECT form discussion.	46%	56%
100% of the filled forms should have clear and legible handwriting	68%	73%
100 % of the forms need to have patient's personal details mentioned including the preferred name and date of filing the form	20%	20%
100% of the forms need to mention the summary of relevant patient's information used to guide the decision-making including diagnosis and expected prognosis. Any special communication needs of the patient needs to be mentioned as well.	10%	39%
100 % of the filled forms need to mention patient's personal preferences and priorities for care, if they have the capacity to record these	78%	54%
100 % of the forms need to record clear clinical recommendations with the clinician's signature over the CPR decision	30%	51%
100% of the forms should mention if the patient has the capacity to contribute towards treatment recommendations and if not the details of the legal proxy has to be mentioned	78%	76%

Audit Action Plan - Assessment of completeness

Audit Recommendation	Action required	Process of review / Evidence found	Outcome
Patients and their families are not properly involved in the decision-making process.	Share findings at the Frailty Grand round and CG meeting. Look at what is missing in relation to shared decision making	Presented at the Geriatric Medicine Tutorial via Microsoft Teams Tuesday 12th July 2022 at 1pm -2pm. Presented at the Frailty CG meeting 28 th July 2022. Audit presented, findings presented and shared what elements were missing in the process	Full assurance
Clinical recommendations are sparse and mainly limited to ceilings of treatment and the form is still primarily utilized as a DNA CPR order	Share findings at the Frailty Grand round and CG meeting. Share the new ReSPECT forms are available	Presented at the Geriatric Medicine Tutorial via Microsoft Teams Tuesday 12th July 2022 at 1pm -2pm. Presented at the Frailty CG meeting 28 th July 2022. Information regarding the respect form and its use is available on the intranet.	Full assurance
The ReSPECT process still has a poor turnout in the Elderly medicine wards	Share findings at the Frailty Grand round and CG meeting. Gain feedback as to why not being completed	Presented at the Geriatric Medicine Tutorial via Microsoft Teams Tuesday 12th July 2022 at 1pm -2pm. Presented at the Frailty CG meeting 28 th July 2022. No documented evidence of why they are not being completed.	Partial assurance
There is less evidence of consultant participation in the ReSPECT process	Share findings at the Frailty Grand round and CG meeting. Discuss with consultants the findings	Presented at the Geriatric Medicine Tutorial via Microsoft Teams Tuesday 12th July 2022 at 1pm -2pm. Presented at the Frailty CG meeting 28 th July 2022. Discussed with all the consultants who realised the importance of participation in the ReSPECT discussion.	Full assurance
Re-audit to check compliance figures	Re-audit after 6 months of findings shared and implementation of actions	Audit 1147 currently underway. An additional audit is being conducted in AAU, Conquest Hospital following the same compliance (1193).	Full assurance

Identified risks or concerns

No recorded evidence as to why the form isn't being completed appropriately. Another cycle is underway, results will indicate if there have been any improvement made.

Recommendations

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) incorporating Decisions about Cardiopulmonary Resuscitation (CPR) - Policy and Procedure (September 2018).

Our trusts policy is now overdue for review and this should be undertaken as soon as possible.

Local Clinical Audit Reports in 2023/24

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

The reports of 75 local clinical audits were reviewed by the Trust in 2023/24. The Trust scrutinises each set of results to benchmark the quality of care provided, identify successes for celebration and / or identify any risks for mitigation. Recommendations for local improvement and change are considered and tracked via a central clinical audit action plan.

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

Compliance of Venous Thromboembolic Prophylaxis (VTE) assessment and prescription in Elderly patients

Rationale

Primary prophylaxis with an effective and safe intervention appears to be the best approach to venous thromboembolism (VTE) management in elderly medical patients, the most affected by VTE. With the increasing life expectancy, prevention of VTE, particularly in elderly patients, will become a significant public health problem. We have observed that compliance with VTE assessment has markedly improved after the ePMA system's introduction.

This audit will check compliance with standard pre - and post ePMA introduction.

The Acute Medical Unit (AMU) uses a paper-based system, we will therefore compare these results with patients in the elderly care department using the ePMA system to look at efficiency and compliance by comparing the two results.

The Acute Assessment Unit (AAU) is where medical patients are first assessed and treated when coming into Conquest hospital. It uses a paper-based system to prescribe medication, making it the most appropriate area of the hospital to conduct this study.

In terms of intervention, we are planning to do the following to improve the quality of care:

- Implementing the ePMA system in AAU to increase VTE assessment and prescription.
- Educating doctors on correct VTE dosage, based on Creatinine Clearance.
- Making sure correct thromboprophylaxis is prescribed correctly based on the VTE assessment

Clinical Standard	Expectations	Results
100% of adults who are admitted should be evaluated for VTE prophylaxis	None	<p>40 admissions in the AMU were reviewed with the following findings:</p> <ul style="list-style-type: none"> • 60% of the patients had VTE assessment. • 40% of patients were not evaluated for VTE assessment. • 100% of the patients who needed VTE prophylaxis had this prescribed. <p>40 patients in the elderly care ward were reviewed with the following findings:</p> <ul style="list-style-type: none"> • 72.5% of the patients had VTE assessments. • 27.5% of the patients were not evaluated for VTE assessment. • Out of all the patients who received VTE assessment, mechanical or chemical prophylaxis was prescribed to 100% of the patients who needed VTE prophylaxis.

Good practice identified:

All the patients who had the evaluation for VTE received either mechanical or chemical VTE prophylaxis.

Identified risks or concerns:

- VTE assessment is missed during clerking of the patients due to the dynamic nature of the AMU.
- Even though assessed, VTE prescription might not happen correctly.
- A significant number of patients do not get VTE prophylaxis prescribed.
- More could be done to explain the reasoning for withholding VTE prophylaxis. It is often not clearly explained in the patient plan or the prescription chart.

Conclusions

This audit has shown that although general compliance for VTE risk assessment and prophylaxis is poor across the Trust at present, there has been a significant improvement in compliance evidenced in the ePMA system compared to the paper-based system.

The most common barriers to compliance include lack of time, lack of reminders, lack of knowledge and difficulty to access the correct assessment tools. Despite measures of improvement, compliance amongst doctors to adhere to clinical guidelines for VTE risk assessment and prophylaxis is significantly low. This potentially puts patients at risks and future action plans should aim to increase awareness amongst doctors in the emergency department.

Lessons learnt:

This audit highlights the importance of VTE Risk Assessment and administering appropriate prophylaxis, which is an important learning point especially for junior doctors who are new to the department.

Recommendations:

- Implementing eMPA in the AMU will significantly improve VTE assessment.
- The reason behind suboptimal VTE assessment, even with eMPA should be investigated.
- Until the eMPA is implemented in the AMU, doctors should be encouraged to assess the patients for VTE prophylaxis.
- Regular, verbal reminders to staff of the importance of completing the VTE proformas should be implemented.
- A poster in the AAU and care of elderly department should be put up to highlight the necessity of VTE assessments.

Recommendation	SMART Action Point	Action by deadline	Comments / action status
Implementing ePMA will significantly improve VTE assessment.	Highlight the findings of this audit within the Acute and Frailty CG meetings and Medicine Governance meeting. Review how the ePMA can be implemented in the AMU	31 March 2023	Complete and discussed.
The reason behind suboptimal VTE assessment, even with ePMA, should be investigated.	Share the findings with the AMU and Frailty depts in their Grand rounds for discussion	31 March 2023	Complete and discussed.
Until the ePMA is implemented in AMU, doctors should be encouraged to assess the patients for VTE prophylaxis due to the significantly low number of VTE assessments done in the acute setting.	Share the findings with the AMU and Frailty depts in their Grand rounds for discussion	31 March 2023	Complete and discussed.
A poster should be in place in AAU and care of Elderly department to highlight the necessity of doing a VTE assessment and what considerations need to be made to ensure a safe prescription of thromboprophylaxis medication. This has proven to be effective in this QIP.	Create and display posters in the wards to remind staff	31 March 2023	Complete
We would recommend regular verbal reminders to the new and existing staff of the importance of completing the VTE proformas.	Highlight to ward staff to complete assessment of VTE for the ward patients. Liaise with Clinical Leads to ensure this is maintained.	31 March 2023	Confirmed completion, just after the audit was completed a discussion was held with the nurses and junior doctors.
Improving assessments in patients on ePMA system in the Trust	Reminder to doctors to complete VTE assessments and complete using ePMA system for all patients in care of the elderly. Liaise with Clinical Leads to ensure this is maintained.	31 March 2023	Complete Discussed and reminders set on ePMA
Reaudit to assess improvement once recommendations completed.	Reaudit	March 2025	

Analgesia management in surgical patients with rib fractures 1275

Rationale:

Rib fractures are a common reason for admission under General Surgery and can lead to significant morbidity and mortality. The effective management of pain plays an important role in the comprehensive care of patients afflicted with rib fractures and is important for preventing complications such as atelectasis and lower respiratory tract infections (LRTIs). In addition to this, effective pain management improves patient comfort and wellbeing, enhances rehabilitation by allowing earlier mobilisation, and improves patient satisfaction overall. Presently, the approach to analgesia management for these patients lacks standardized protocols, resulting in substantial heterogeneity across cases.

This audit was undertaken to understand current practices in analgesia management for patients admitted under General Surgery with rib fractures. Additionally, this audit seeks to discover areas of improvement in rib fracture analgesia practises.

Aims & Objectives:

The first aim of this audit aim is to compare analgesia prescription in rib fracture patients admitted under general surgery, with guidance set out by BJA (British Journal of Anaesthesia) Education and BMJ best practice. We also aimed to gain information on all methods of pain relief utilised for these patients during their inpatient stay.

The second aim was to find areas for improvement in analgesia prescription for these patients, to allow for targeted changes that would result in improved pain management overall.

Results:

A total of 34 patients were admitted under General Surgery with rib fractures between January and April 2023. Drug charts were available for 32 patients. The average patient in the dataset was 78 years old, sustained between 3-4 rib fractures, and had an average length of stay of 6.9 days.

Mild to moderate analgesics

100% of patients were prescribed regular paracetamol and received more than one mode of analgesia overall. Regular Non-steroidal anti-inflammatory drugs (NSAIDs) are suggested for use in patients without contraindication. Within our dataset 41% of patients were contraindicated for NSAID use, most commonly due to renal function, peptic ulcer disease, or concurrent use of Aspirin. However, of the eligible patients, only 32% (n=6) were prescribed a regular NSAID. Reluctance for NSAID use may be due to the advanced average age of the dataset, which was 78 years old.

Regular mild opioids (such as codeine or tramadol) were prescribed in only 16% of patients (n=5). On average, these were prescribed 1.8 days into the admission.

Topical analgesics

Lidocaine patches were prescribed for the majority of patients (81%), despite being absent from BMJ best practice guidelines, and being shown to be poorly effective in managing pain from multiple rib fractures. At least 50% of prescribed lidocaine patches were discontinued following review by the pain team .

Strong analgesics

100% of patients were prescribed a strong opioid for use as required, and this was prescribed from the 1st day of the admission for 94% of patients. Regular opioids were prescribed for 38% of rib fracture patients and commenced on the 3rd day of admission on average. 2 patients went on to receive a PCA while 8 patients required regional anaesthesia (blocks).

Clinical Standard	Exceptions	Result
All rib fracture patients should be started on oral analgesics such as paracetamol or an NSAID	Allergy	32/32 (100%)
All rib fracture patients should be prescribed: Regular paracetamol	Allergy	32/32 (100%)
All rib fracture patients should be prescribed: an NSAID if not contraindicated	NSAIDs contraindicated in patient / allergy	6/19 (31.5%)
All rib fracture patients should be prescribed: a weak opioid analgesic	Allergy	5/32 (15.6%)
All rib fracture patients should be prescribed: Strong opioid for breakthrough pain	Allergy	32/32 (100%)

Good Practice Identified:

All patients have regular paracetamol prescribed, as well as a strong opioid analgesic as required for breakthrough pain.

Identified Risks or Concerns:

Underutilisation of regular mild opioids such as codeine, which provide simple and effective analgesia prior to strong opioid use.

Underutilisation of NSAIDs, although the reluctance to prescribe NSAIDs may be explained by the advanced average age of the cohort.

Recommendations:

1. Create a poster guide for initial analgesia for rib fracture patients based on new trust guidelines, to be used by admitting doctors
2. Stickers with rib scores and reminders for Chest physio and Pain team referral in patient notes

Lessons learnt from this audit

- Overall, there is a good multimodal approach to rib fracture management in patients admitted under general surgery. Areas for improvement include encouraging use of regular weak opioids in analgesia regimens.
- The usage NSAID is quite low, even in those without contraindication. However, limited use may be due to the older average age of admitted patients.
- Lidocaine patches are very commonly prescribed despite lack of strong evidence for effectiveness and are often discontinued following pain team review.
- Presentation of these findings and new Trust guidelines for rib fracture management to the General Surgery team would be beneficial.

Recommendation	SMART Action Point	Action by deadline
Poster and sticker	Create a poster guide for initial analgesia for rib fracture patients based on new trust guidelines, to be used by admitting doctors. Stickers with rib scores and reminders for Chest physio and Pain team referral in patient notes	Nov 2023

Diagnostic Hearing Assessment Accuracy in Neonates and Young Children (<6 months of age)

Rationale:

The British Society of Audiology (BSA) guidelines provide clinicians who undertake diagnostic hearing assessments of babies and young children with the necessary guidance and protocols to ensure uniform testing and interpretation of results.

Due to the specialised nature of the testing, a peer review process is recommended to ensure these standards and protocols are adhered to and that the correct patient management is given. Suitably trained/experienced Audiologists at our trust, Sussex Community NHS Foundation Trust and University Hospitals Sussex NHS Foundation Trust have formed a peer review group so that all cases are externally reviewed, and feedback provided to clinicians.

This audit was undertaken to understand current practices in analgesia management for patients admitted under General Surgery with rib fractures. Additionally, this audit seeks to discover areas of improvement in rib fracture analgesia practises.

Aims & Objectives:

This audit aimed to provide confidence that the diagnostic hearing assessments of neonates and young babies (<6 months of age) provided by the Paediatric Audiology department met the national standards and protocols set by the BSA and the Newborn Hearing Screening Programme (NHSP).

A previous audit (5241) showed 98% of cases were sent for peer review. All results sent for review received feedback, though one set did not receive external feedback. All cases were agreed to be within +/-10dB of the reported results which is in line with national standards. In only one case, alternative patient management was considered, though this was based on a difference in the local management of babies with middle ear fluid.

Results:

All sets of results requiring peer review were sent and received feedback from at least one external reviewer.

100% of ABR results were agreed to be within 10dB of the original reported results.

In two cases, alternative management was considered, though patient care was not at compromise in either case.

Case 1: Whilst the child had met the NHSP discharge criteria of <30dB HL in both ears and there was no indication of middle ear fluid, as the left ear had a small wave V amplitude which was likely at threshold and the ABR test has the potential to underestimate behavioural hearing thresholds, the decision to arrange a precautionary review of the child's hearing behaviourally at 9 months of age was made. One external reviewer would have discharged this patient as the NHSP criteria had been met.

Case 2: Baby was found to have moderate conductive hearing loss bilaterally thought likely due to some middle ear fluid. The clinician had opted to review again at 9 months of age which had historically been standard practice, however locally we had started to move away from this and instead review again 8-12 weeks later as in many cases, resolution in middle ear function and hearing could be expected within that timeframe. Internal feedback was given as such.

Clinical Standard	Exceptions	Result
100% of neonates and young babies referred for diagnostic hearing assessment will have ABR test results within +/-10dB than those originally recorded.	None	100%
100% of neonates and young babies referred for diagnostic hearing assessment will have test results sent for peer review	None	100%
100% of neonates and young babies referred for diagnostic hearing assessment will have documented peer review feedback, including feedback from at least 1 external site.	None	100%
100% of neonates and young babies referred for diagnostic hearing assessment will have agreeable patient diagnosis.	None	100%
100% of neonates and young babies referred for diagnostic hearing assessment will have agreeable patient management.	None	96.5%

Good Practice Identified:

There is embedded good practice of sending results for peer review. The trust audiologists who partake in the assessment of neonates and young babies are adhering to national standards and protocols, achieving good quality test results, making correct diagnosis and patient management.

Identified risks or concerns:

No risks or concerns identified.

Recommendations:

Although this audit highlighted no areas of concern and the continuation of working in line with nation and local protocols, to ensure high standards remain, re-audit will continue on a timely basis.

Lessons learnt from this audit

Completing this audit highlights consistent good levels of practice and compliance.

Recommendation	SMART Action Point	Action by deadline	Comments / action status
Share audit with staff who partake in the testing of neonates and young babies.	Share findings via email with relevant team for learning.	Nov 23	Complete
Share audit with paediatric team via email.	Share findings via email with relevant team for learning.	Nov 23	Complete
Re-audit	Re-audit annually	Sept 24	

Participation Clinical Research

The Trust acts as a participating site for national and international research studies, recruiting patients to take part in novel treatments. All research in the NHS is approved centrally by the Health Research Authority. We deliver research recruitment to approximately 45 National Institute of Health Research (NIHR) portfolio academic and commercial studies. Since April 2023 research has become a Trust priority and the team has worked to ensure a wide portfolio of academic and commercial trials are available for our patient population to access as per table 1.



Project Short Title	Disease Area	Project Site Date Open to Recruitment	Planned Project Close Date	Principal Investigator
Add-Aspirin	Cancer	25/04/2016	01/04/2026	Dr A Soultati
ADDRESS 2 Type 1 diabetes	Diabetes	08/04/2013	31/07/2023	Dr Dashora
ADDAPT		15/05/2023	20/02/2024	Dr S Fong
AFTER – Ankle Fracture Treatment: Enhancing Rehabilitation trial	T&O	09/02/2023	14/06/2024	Mr B Rose
BADBIR previously recruited - re-opened 30.11.2023	Dermatology	27/07/2023	31/06/2026	Dr Alwash
Catheter ablation in symptomatic atrial fibrillation: a double blind randomised controlled trial SHAM AF	Cardiovascular	17/01/2020	31/12/2023	Dr Veasey
Clinical Characterisation Protocol for Severe Emerging Infection	Critical Care	12/03/2020	28/07/2027	SLEEPING
EPIC UKCLL	Cancer	20/04/2023	01/03/2026	T. Tsawayo
Enhanced Midwifery Continuity of Care (MCoc) - Case Study Site	Obstetrics	14/11/2023	31/05/2024	N/A
EXTEND (ABX Surgery)	Surgery	18/10/2022	30/06/2025	Mr El Dhuwaib/ Dr Mikail...
Foundation UK Follicular Lymphoma- observational	Cancer	26/07/2023	31/03/2025	T. Tsawayo
FOCUS 2 Fear of Pregnancy	Obstetrics	10/11/2023	01/05/2024	Dr S Lee
Fluids Exclusively Enteral from Day 1 (FEED1)	Obstetrics	24/08/2021	NK	Dr Kandasamy
Genetic and cellular analysis of malignant haematological samples	Cancer	04/08/2022	01/03/2037	Dr J Jones
GenOMICC	Critical Care	15/05/2020	28/02/2030	Dr Highgate
IMD BIO Resource	Rheumatology	02/03/2018	NK	Dr S Panthakalam
Improving pts Experience in Bowel Ca	Cancer	23/08/2023	31/07/2024	Dr I Masoodi
MIDI (MR Imaging abnormality Deep learning Identification)	Neurological	13/08/2021	31/03/2025	Dr D Sallomi
Minder CPMS 40872 Dementia	Dementia	16/01/2024	01/08/2025	Jo-Anne Taylor
MND Motor Neurone Disease Registry	Neurological	07/09/2023	20/11/2025	Simon Wilson
MYDRESS	Podiatry	27/06/2023	06/09/2024	Mika Dave
MyMelanoma Study	Dermatology	08/08/2023	31/08/2027	Nick Donald lead Derm CNS
Myeloma XIV (FITNESS)	Cancer	16/03/2022	14/02/2024	Dr N Sargent
OBS UK	Obstetrics	09/01/2024	31/07/2026	Dr Seema Pai
ONLINE PAWS B	Paediatrics	24/04/2023	31/12/2024	Dr G Gopalakrishnan
ORION-4	Cardiovascular	01/12/2018	31/07/2026	Dr Dickinson
PARTIAL Nephrectomy	Cancer	07/09/2023	31/12/2024	Mr K Spireti
POPPY	Critical Care	13/11/2023	09/02/2024	Dr J Highgate
PQUIP	Anaesthesia, Perioperative Medicine and Pain Management	25/02/2019	31/10/2023	Dr Bahool
PRIME 3 Ageing	Frailty	22/08/2023	30/04/2024	Dr H Alexander
RADAR	Cancer	04/12/2023	30/05/2024	Dr J Jones
RECOVERY - COVID	Respiratory	0/04/2020	SLEEPING	Dr O Kankam
REDUCE Carbon Inhalers	Respiratory	23/11/2023	04/01/2025	Dr James Wilkinson
Self-management in patients with adrenal insufficiency PIC	Diabetes	16/11/2023	30/03/2024	Dr David Till
SPIROMAC Asthma in Children	Paediatrics	23/10/2023	31/07/2025	Dr O Anton
Statins for Improving Organ Outcome in Transplantation (SIGNET)	Critical Care	01/02/2022	31/03/2026	Dr Bahool
Targeting Immune Pathways	Gastroenterology	11/04/2019	31/12/2025	J. Tidbury
TERN ACS	Cardiovascular	16/03/2023	23/04/2023	J. Sinclair
The impact of psychological stress on cancer burden and recurrence in ovarian cancer	Cancer	10/03/2023	10/03/2025	Dr K Lankester
Trimaximaize	Respiratory	11/04/2022	30/06/2024	Dr Kankam
UK Childhood ITP Registry	Cancer	NK	01/03/2024	Dr G Gopalakrishnan
UK MS Register	Neurology	01/04/2019	31/07/2027	J. Sinclair
WHITE 11- FRUITI	Musculoskeletal	05/11/2021	30/04/2029	Mr O. Keast-Butler
WHITE 12 - DUALITY	Musculoskeletal	02/12/2022	30/07/2024	Mr C. Buckell
ZODIAC ACS Cardiology Closed - recruited to target	Cardiovascular	26/04/2023	30/09/2024	Dr C Elorz

The number of patients receiving relevant health services provided or sub-contracted by the trust in 2023/24 that were recruited to participate in clinical trials approved by a research ethics committee was 1613 participants.

Commissioning for Quality and Innovation (CQUIN)

The Trust agreed 5 CQUINs with Sussex ICS for 2023/2024.

Where available, the table below shows performance for the year:

Ref	Scheme	Target	Detail	Reporting	Service	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CQUIN 1	Flu vaccinations for frontline healthcare workers	80%	80% uptake of flu vaccinations by frontline staff with patient contact or all staff offered vaccination	Monthly Sept - March	Occupational Health	N/A	N/A	100%	N/A
CQUIN 2	Supporting patients to Drink, Eat and mobilise (DrEaM) after surgery	80%	Ensuring surgical inpatients are supported to drink, eat and mobilise within 24 hrs of surgery	Quarterly	DAS	94.94%	93.64%	84.9%	90.1%
CQUIN 4	Compliance with timed diagnostic pathways for cancer services	55%	55% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer are meeting timed pathway milestones	Quarterly	Cancer	54.2%	54.6%	73%	62%
CQUIN 7	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	30%	30% of all unplanned critical care unit admissions from non-critical care wards having a NEWS2 score, escalation and response recorded.	Quarterly	ITU	71.42%	65.9%	82.6%	82.9%
CQUIN 13	Assessment, diagnosis and treatment of lower leg wounds	50%	Achieving 25-50% of patients with lower leg wounds receiving assessment, diagnosis and treatment in line with NICE guidance	Quarterly		43.8%	30.9%	66.7%	47.5%

Statements from the Care Quality Commission

The trust is registered with the Care Quality Commission (CQC) to carry out eight legally regulated activities from 17 registered locations with no conditions attached to the registration. No new locations were added in 2023/24.

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

The CQC continues to monitor and review information from all available sources and then have a conversation with us either online or by phone to discuss any issues identified. We have quarterly engagement meetings with them to discuss any current issues that may be impacting on the delivery and quality of our services.

During 2023-24 the CQC found no breaches that justified regulatory action, no requirement notices were issued, and no enforcement actions were taken. However, in February 2023 the trust received a fixed penalty notice for Failure to comply with Regulation 12(1) and 22(2)(b) Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 following a previously reported serious incident. The Trust was fined £4,000.

Data Quality

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

During 2024/245 we will support improvement in data quality by:

- Working collaboratively with divisions to identify areas for data quality improvement and determine actions to overcome long term data issues. Focus is on data capture via Improvement of clinical outcome forms for counting and coding.
- Patient Administration System (PAS) training continues to be reviewed to ensure new processes are captured. Refresher training will be moved to MyLearn to increase compliance and access for staff to refresh yearly on PAS. Nervecentre training is now being delivered as part of roll out of Digital improvement across wards.
- Continuing to validate correct attribution on the PAS of GP Practice through the national register (SPINE)
- Continuing to undertake regular audit of completeness of patients' NHS Numbers to ensure continued progress.
- A baseline measure of the Trust's ability to report against all protected characteristics has been conducted. Work has commenced to develop an improvement to focus on improved capture of three of those metrics over the next year on systems that can capture this information.
- Focus over the next two years will be on Electronic Patient Record (EPR) procurement and embedding data quality into the design and delivery of a new EPR. Within three years this will enable improvement in electronic data capture and health inequalities reporting.

NHS Number and General Medical Practice Code Validity

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

- 99.9% for admitted patient care
- 100% for outpatient care
- 99.3% for accident and emergency care

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

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

Data Security & Protection Toolkit attainment levels

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

All health and social organisations, including the trust, are mandated to carry out self- assessments of their compliance against the DSPT assertions. The Trust is required to evidence 34 assertions over the following ten standards:

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

The trust DSPT assessment score for 2022/23 was submitted with all standards graded as met. This is a self-assessment but is reviewed by our internal auditors to provide assurance of accuracy to the Trust. The Trust's auditors report gives a 'high' confidence level that the Trust's submission is robust for 2022/23. The deadline for the DSPT submission covering the 2023/24 period is due at the end of June 2024 and therefore has not yet been made. The trust are therefore still covered by the 2022/23 toolkit whilst continuing to work on the 2023/24 submission.

Clinical Coding Error Rate

The trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the accuracy rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 95.53%.

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

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

Results of the DSPT Audit

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

Levels of attainment – percentage accuracy targets for Acute Trust

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

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

Primary Diagnosis Correct	Secondary Diagnosis Correct	Primary Procedure Correct	Secondary Procedure Correct	Unsafe to Audit
93.50%	91.00 %	98.30%	97.10%	0

East Sussex Healthcare NHS Trust achieved an overall accuracy percentage of 95.53% highlighting 4.47% error rate.

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

- Relevant and mandatory secondary diagnoses and secondary procedures were omitted due to paying less attention and time pressures during data extraction.
- Some of the errors were due to inconsistencies in documentation and scanned record not available at the time of coding.
- Clinician awareness in coding terms and in recording co-morbidities is limited.

We will be taking the following actions to improve data quality:

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

Learning from Deaths

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

Most deaths are unavoidable and would be considered to be 'expected'. However, there will be cases where sub-optimal care in hospital may have contributed to the death or have occurred but has not contributed to or led to death. The Trust is keen to take every opportunity to learn lessons to improve the quality of care for our patients and families and is committed to fully implementing the national guidance on learning from deaths.

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

Number of patients who died

Between January 2023 and December 2023 2,068 patients died. The table below summarises the number of deaths which occurred in each quarter of that reporting period:

Number of deaths per quarter (January 2022 to December 2022)

Reporting period	Number of deaths
Q4 2022/23: January 2023 to March 2023	557
Q1 2022/23: April 2023 to June 2023	465
Q2 2022/23: July 2023 to September 2023	417
Q3 2022/23: October 2023 to December 2023	629
Total: January 2023 to December 2023	2032

Number of case record reviews or investigations

By 20/04/2024, 2,031 case record reviews and 85 investigations had been carried out in relation to the 2,068 deaths. In 85 cases, a death was subject to both a case record review and an investigation.

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

Reporting period	Number of case record reviews or investigations
Q4 2021/22: January 2023 to March 2023	548
Q1 2022/23: April 2023 to June 2023	465
Q2 2022/23: July 2023 to September 2023	412
Q3 2022/23: October 2023 to December 2023	552

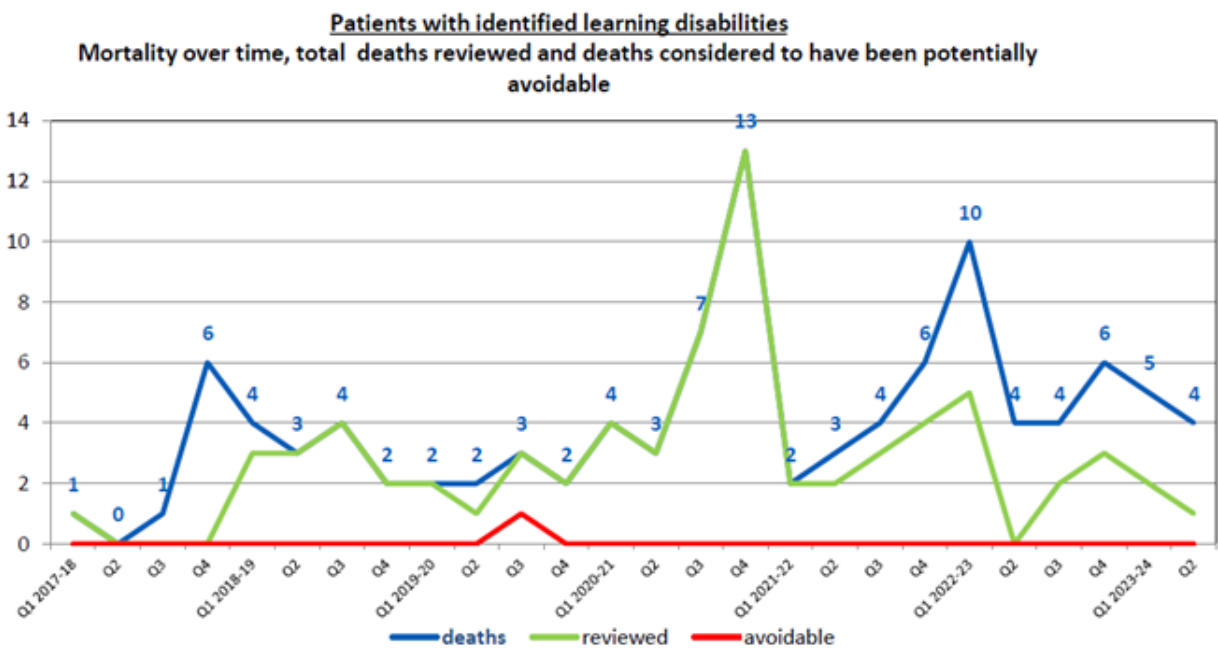
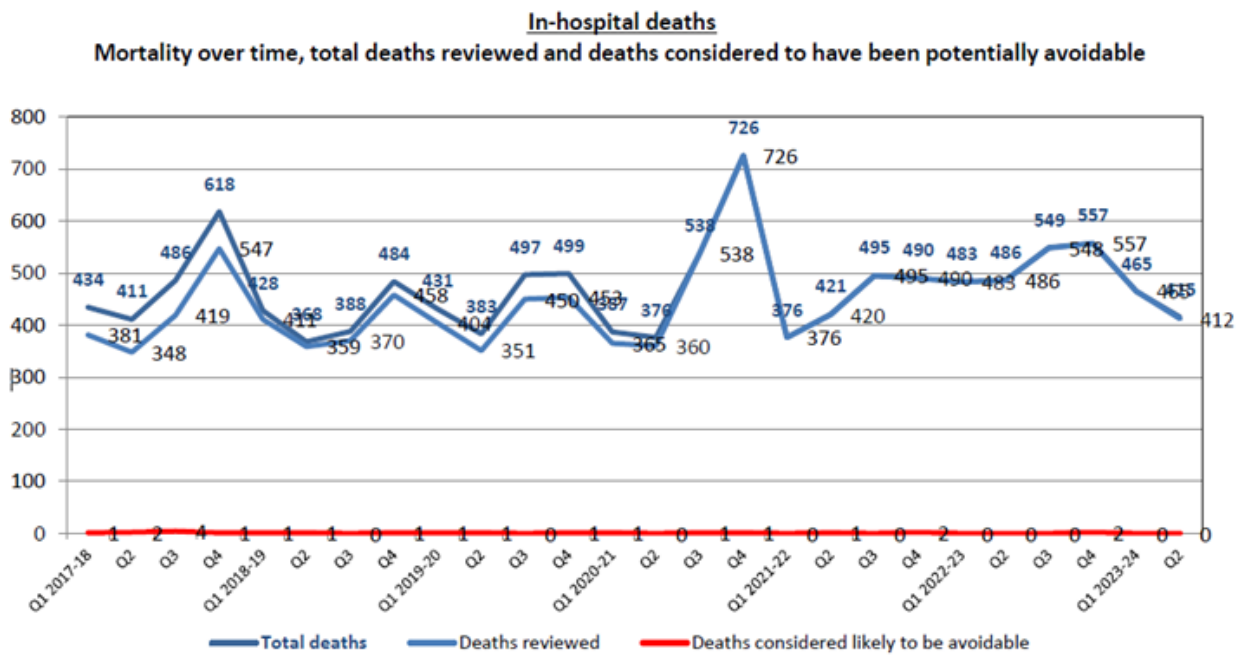
Two deaths, representing 0.098% of the patient deaths between January 2022 and December 2022, were judged to be more likely than not to have been due to problems in the care provided to the patient.

Estimated deaths per quarter considered likely to have been avoidable (January 2022 to December 2022)

Reporting period	Number of patient deaths considered likely to be avoidable	Percentage of the patient deaths considered likely to be avoidable
Q4 2021/22: January 2023 to March 2023	0	0%
Q1 2022/23: April 2023 to June 2023	2 / 557	0.35%
Q2 2022/23: July 2023 to September 2023	0 / 465	0%
Q3 2022/23: October 2022 to December 2023	1*	0%

*The Quarterly Mortality Review Audit for this period has not yet taken place, so this result may change.

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



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

Of the 3 cases identified (2 in Q1 and 1 in Q3) all of which were graded 3 (“probably avoidable: more than 50:50 likelihood of avoidability”) all were reviewed at the Trust quarterly review meeting. None of the patients had learning disability. There were no cases graded 1 or 2. The learning was as below:

1. In a patient with multiple organ co-morbidities and acute sepsis, there were delays in the recognition of the severity of a patient’s condition and uncertainty about ceiling of care in a patient that was unlikely to survive resuscitation. Prompt response to changes in a patient’s condition and good communication between admitting and ITU teams would have led to a clearer management plan. The importance of consultant-to-consultant communication, where there is uncertainty or disagreement about the best treatment approach was underlined. It is important that, if a care grading is changed, the specialty re-visits the care and the learning from it.
2. Lengthy admission with hospital-acquired pneumonia and subsequent Covid
3. More complicated surgery was performed on a patient than may have been needed.

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

- Extensive work throughout 2023, extending through 2024, on improving communication between departments involved in a patient’s hospital journey, improving discharge and transfer communication, and shortening length of stay and promoting safe earlier discharge.
- Strengthening the virtual ward provision enabling patients to continue treatment safely at home following discharge or avoid admission.
- Further refining infection control measures.
- Increasing the number of patients with ReSPECT documentation and the amount and quality of information in ReSPECT forms.

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

Improving patient flow and communication, with reducing length of stay and utilisation of out-of-hospital pathways, reduces the number of patients in additional clinical areas, improving the quality of their care and reducing risks of cross infection (e.g. Covid)

Rota Gaps

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

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

The aim of the GOSWH role is to provide assurance to doctors and employers that doctors are able to work within safe working hours. The GOSWH is there to champion and improve working lives for junior doctors to deliver this.

Where the system fails a set process allows early reporting (exception reporting) to occur which is aimed at giving doctors the confidence that improvements will be made. The GOSWHs provide quarterly and annual reports to the People and Organisational Development (POD) Committee and are also involved in the meetings in the table below.

Meetings attended by the GOSWH.

Group	Frequency
People and Organisation Development (POD) Group	Quarterly
Trust Local Faculty Group (LFG)	Every 4 months for each department
Oversight Group Meeting	Every 4 months (no longer happening)
Junior Doctors Forum	Quarterly
Junior Doctors Inductions	Three times a year
CEO Junior Doctors Forum	Every 4 months
Local Negotiating Committee	Monthly
GOSWH team meeting	Fortnightly

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

Staff to undertake two recently approved NHS roles (Doctor's Assistant and Physician Associate) have been appointed to and are now helping to cover ward areas and support the medical trainees.

Staff who speak up

The role of Freedom to Speak Up Guardians and the National Guardian for the NHS were established in 2016 following recommendations from Sir Robert Francis' Freedom to Speak Up Inquiry. Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, the issues they raise are responded to and that the person speaking up receives feedback on the actions taken. There is now a network of over 1,000 Freedom to Speak Up Guardians and over 100,000 cases have been reported to them since their establishment. Dominique Holliman and Ruth Agg are both employed as Guardians in the trust and abide by the guidance issued by the National Guardian's office.

It is essential to have a culture in which workers feel safe to speak up about anything that gets in the way of delivering safe, high-quality care. Embracing freedom to speak up by listening to and acting on the suggestions and concerns of workers is critical for learning and improvement.

Freedom to speak up Guardians undertake both reactive and proactive work to ensure that all colleagues, including students, temporary workforce and volunteers feel able to raise concerns and/or to make suggestions for improvement. Dominique and Ruth endeavour to ensure that the reach extends to minority groups and those that may face barriers to speaking up. Key progress has been made in increasing Guardian visibility, facilitating training, delivering bespoke speak up awareness and update sessions and supporting line managers to feel confident to receive concerns and to promote psychological safety. Guardians also work closely with key groups and networks to share anonymised intelligence and to scrutinise data and trends to inform proactive pieces of work and collaboration.

The Guardians are part of the south-east regional network and regularly meet with Guardian colleagues to share best practice and ensure that all reporting requirements to the National Office are being met. Progress and anonymised data is shared at the People and Organisational Development Committee every quarter and the Guardians report in person to the Trust Board every 6 months.

247 speak up concerns were brought to the trust Guardians between April 2023 and March 2024 with registered nursing and midwifery staff reporting the most concerns in each quarter. Key themes and reasons for speaking up are in line with national data submitted to the National Guardian Office from across the country.

Data sets from this year's staff survey show that our results were closely aligned with sector comparisons and 60.1% of trust substantive staff reported that they feel safe to speak up. This is a pleasing increase from the 58.5% reported in 2022. 47.3% reported confidence in their concern being addressed – a 2.4.% increase on last year. 92% of temporary workforce staff reported feeling secure to raise concerns about unsafe clinical practice.

Upon closure of a case, individuals are invited to submit anonymous feedback regarding their experience of using the Speak Up Guardian at the trust. Over the last year, 100% reported receiving a timely response from the Guardian, 97% felt supported by the Guardian and 97% of respondents stated that they would recommend the Speak Up Guardian and would use the service again.

Speak Up Issues by category and Quarter for 2023/24

Category	Q1	Q2	Q3	Q4	Category Totals
Behavioural / Relationship	1	0	0	0	1
Bullying / Harassment	1	7	2	4	14
Cultural	3	0	0	1	4
Discrimination Disability	1	0	0	2	3
Discrimination Racial	2	0	0	6	8
Discrimination Sexual	0	0	2	0	2
Leadership	0	2	0	3	5
Not Known	0	0	2	6	8
Other Inappropriate Attitudes or Behaviours	15	17	13	30	75
Patient Safety / Quality	7	6	6	11	30
Reprisal	1	0	0	1	2
Senior Management Issue	0	2	0	0	2
Staff Safety	0	1	0	0	1
System / Process	22	26	16	12	76
Violence and Aggression	0	1	1	1	3
Worker Safety or Wellbeing	3	7	3	0	13
Quarter Totals	56	69	45	77	247

Wellbeing of our People

Psychological wellbeing & safety

Dovetailed within a wider retention programme, several workstreams focusing on the psychological wellbeing & safety of our people have progressed throughout the past year.

Introduction of a new approach to the way in which teams report and assess work related stress has started with monthly sessions supporting managers on how best to facilitate and engage teams, whilst working with them in trying to find ways to mitigate and reduce work stress triggers. To date, 278 departments have completed a team stress questionnaire involving 2113 responses from our people.

TRiM, (Trauma Risk Management), has continued to be embedded within the Trust with 33 TRiM practitioners trained to date, 8 of which completed their training in the past year. Since April 2023 there have been 86 referrals for TRiM, 480 of our people have been offered TRiM, 72 people have had the initial TRiM assessment, 45 of our people have had the 1 month follow up and 5 of our people have had the 3 month follow up. In addition 25 supportive conversations have been held. Qualitative feedback from colleagues accessing TRiM, demonstrates that without this support their psychological wellbeing would have been significantly affected, increasing the risk of them developing PTSD which can lead to longer term challenges and difficulties.

Alongside this we have continued to offer teams and individuals specialist psychological support via our trauma therapists. Although demand from teams has decreased, the need for individual colleagues to access one to one support has increased with 58 colleagues engaging in this service over the past year.

Finally, we have introduced a training programme for Restorative Supervision, working in tandem with our Professional Nurse/Midwifery Advocates, in developing a sustainable, evidence based framework for supervision that is both effective and accessible. This work remains in its pilot stages but early indications show that it is being very well received and contributing to a wider scale culture shift within the organisation. 13 sessions of Restorative Supervision have taken place.

Retention

Over the past year there has been a dedicated focus on the Retention of our People with the development of an annual programme of work, based on priorities emerging from current exit data, engagement with leaders in areas of high turnover and intelligence from FSUGs and the wider HR division. Initially starting with 9 workstreams but quickly increasing to 12, a comprehensive range of elements are included. The trust has seen turnover continually reduce month on month with it currently standing at 9.9% for Feb 2024, the lowest since September 2021.

Priorities for 2024/25 have been drafted, building on existing workstreams but which also align with the trusts People Strategy and the NHS People Promise. The trust was successful in our submission to be part of the second wave of exemplar NHS sites for the People Promise and as a result a People Promise Manager will be recruited to the trust for 12 months to accelerate progress on retention and wellbeing workstreams, aligned with the People Promise, in order to optimise impact.

Wellbeing of our People

We continued to support the physical and emotional wellbeing of colleagues during the year by adapting the range of support that we offer to reflect the impact of ongoing pressures. We focused on the areas our people told us make the biggest difference following listening events.

We have also trained 216 of our people in the Mental Health First Aid qualification and a further 24 are due to be trained during 2024/25. We have increased our offer of Mental Health Aware Training, to date 52 of our people have been trained since this was introduced in 2023 and a further 108 places are available during 2024.

We have continued to support Wellbeing Conversations with colleagues in the trust. To date, 280 managers have attended Wellbeing Conversation training, supporting them to hold Wellbeing Conversations with their team members.

In 2023/24 We have delivered on our wellbeing menu of support, and have devised a Wellbeing Programme for our people for 2024. This programme includes increased support and focus on Mental & Physical Health, Mens health, Menopause, Maternity Support Groups, Self-Care, Understanding Compassion support sessions and External providers onsite promotional events, all of which our people have expressed are important to them following listening events, feedback and visits.

There has been a focus on Menopause support offered, quarterly Menopause Demystified' workshops have been delivered with 75% attendance, and Menopause related absence is now recorded on ESR, enabling us to support and signpost individuals where required.

We have promoted a Take-a-break campaign, Physical Health promotions including ; Couch to 5K, Park Run and Walking Groups and devised a Self-Care Resource page.

In conjunction with One You East Sussex we provided 119 health checks for colleagues aged between 40-74.

Our people have also been supported with their financial wellbeing, we have increased our signposting and offers of support services to all of our people and supported those in financial need. We have continued to work in partnership with WAVE who visited our sites to support our people, and we work with the local foodbank, enabling our wellbeing team to issue vouchers directly to those in need.

We have continued to offer bespoke wellbeing support and provided information and signposting for individuals, teams and managers.

In 2023/24 we visited over 155 teams and provided tailored support, provided 159 bespoke 1:1 calls to support our people, and delivered a variety of support sessions to our teams, of which, included: Self-care, and Understanding Compassion whilst working in collaboration with the chaplains.

Throughout the year we have been involved in events to thank and celebrate the achievements of our people, including working in collaboration with the wider Engagement and Wellbeing Team on the Trust Awards and the Festive Refreshments events in December 2023 where our executive team joined us in distributing refreshments and taking time to talk to and thank all colleagues.

Occupational Health

Within 2023, the Occupational health team have become SEQOHS Accredited, which was a significant piece of work. They received praise from inspectors for the work they had done to ensure that the support they offer is accessible and the concerted move towards more self-serve options. The occupational health team have based the improvement work on learning they had gained from the pandemic, such as electronic contact tracing following exposure to infectious disease enabling people within the organisation to receive OH support 24/7 and not just within opening hours.

Occupational Health have really become focused on how to improve taking the feedback of our service users as starting points for improvement, we measure across 4 core functions of OH;

- Management Referral Triage (5 Stars)
- Case Management, (5 Stars)
- Vaccination Clinic (4.5 Stars)
- Manager Support Feedback (4.5 Stars)

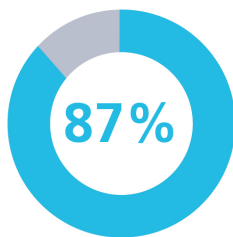
Into 2024, Occupational Health continue to be committed to providing the organisation with ever improving and accessible service. We have demonstrated our committed so far in 2024, with the introduction of new ways of working such as a revised management referral process, which has reduced the average waiting time for an appointment to less than 8 working days and by supporting managers with "OH Manager Bitesize" sessions; two of which have gone ahead with an average of 40 managers attending each session. We will continue to flex to the needs of the organisation whilst we continue to deliver our core and statutory care.

NHS Staff Survey 2023

This year nearly 50% of substantive staff took the time to complete the survey which was a 6% increase on the previous year and just above the national average response rate of 48%.

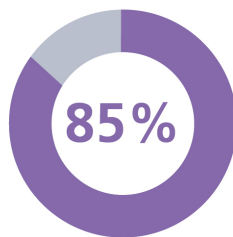
We have seen an improvement in each of the seven People Promise elements and in particular have seen a significant improvement in the 'We are always learning' element. Our colleagues also responded very positively that they feel valued by their teams and both Morale and Staff Engagement have improved slightly since 2022. 25 question level scores have improved significantly and just one has declined around colleagues experiencing discrimination.

Positive messages:



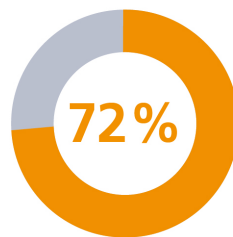
We are compassionate and inclusive

87% of our people feel their role makes a difference to patients and service users



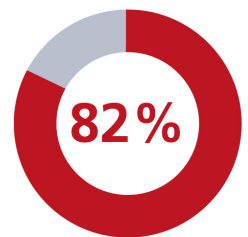
We are always learning

85% of us have had an appraisal in the last 12 months



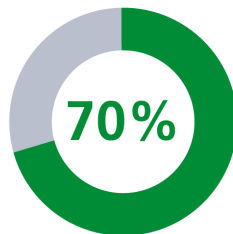
We are recognised and rewarded

72% of our people feel their immediate manager values our work



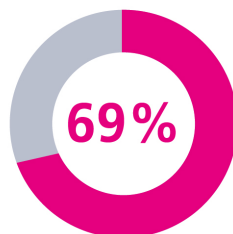
We are a team

82% of our people enjoy working with the colleagues in their team



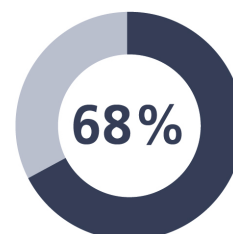
We each have a voice that counts (raising concerns)

70% of us feel secure in raising concerns about unsafe clinical practice and 90% of us feel trusted to do our job



We are safe and healthy

69% of our people say that they, or a colleague, reported when they experienced physical violence or harassment or bullying at work



We work flexibly

68% of us feel they can approach their immediate manager to talk openly about flexible working

We acknowledge that some scores relating to Staff Engagement are low although are improving. Colleagues have generally reported positively on the trust's action on health and wellbeing however we need to continue to ensure initiatives are well publicised to all our people, including our bank colleagues.

This year 35% of our bank colleagues completed the NHS Bank Staff Survey and the response rate was the second highest bank response nationally.

The results have shown that 86% of our bank people feel their role makes a difference to patients and service users and 92% of bank colleagues feel trusted to do their job. Results have also highlighted that we need to ensure that immediate managers actively listen to concerns raised by our bank people and explain the process of how their concern will be handled and treated seriously.

We know that some of our colleagues are more likely to experience discrimination and violence in the workplace and need to explore the number of our people who experience discrimination outside the traditional protected characteristics.

People Promise elements and themes: Overview

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



Your org	7.24	6.00	6.66	6.07	5.66	6.14	6.76	6.79	5.92
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	4042	4054	3988	3995	3816	4015	4032	4059	4050

Part 3 – Review of Quality Indicators and our Priorities for Improvement in 2023/24





Part 3.1 – Our Priorities for Improvement in 2023/24

The Trust identified three quality improvement priorities for 2023/24 to contribute towards the delivery of our Quality and Safety Strategy.

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

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

Implementing the Patient Safety Incident Response Framework (PSIRF)

Why was this chosen as a priority?

As part of the national Patient Safety Strategy that was introduced in 2019 (and updated in 2021), significant changes to the way in which patient safety incidents are responded to were outlined. One of the key changes included the implementation of PSIRF. PSIRF has multiple elements, and it is acknowledged nationally that it is likely to take time to implement. The trust will be continuously updating its PSIRF Plan and Policy over the next 18 months to ensure full clarity of systems and processes for staff. This was why this significant change to investigations/reviews of incidents/events was chosen as one of the priorities for 2023/2024.

What did we do in 2023/24?

The Patient Safety Team undertook training for Matrons/Senior Nurses and Managers from across all Divisions. We have encouraged and worked with the Trust's Learning and Development team to ensure appropriate access for all staff to undertake eLearning on MyLearn on patient safety level 1 and level 2 modules. The range of PSIRF templates were developed, as one or more can be used to review an incident/event to capture appropriately the learning and immediate and long-term actions/quality improvement for a service or services across the Trust.

A national learning tool has been introduced and will be utilised to capture the Trust's learning and how we are embedding this into the service/s across all Divisions and ensure a Just Culture and Learning ethos /culture at all times. The PSIRF Plan and Policy was completed and approved by the Quality & Safety Committee in September and the Trust Board in the October. The ICB gave their final approval to go live with PSIRF and cease to use the Serious Incident Framework 2015 on the 'go live' date for PSIRF.

The trust introduced PSIRF on the 20th November 2023. The PSIRF implementation plan phase 1 was completed and the second phase in implementing and embedding PSIRF has commenced.

The introduction and the embedding of PSIRF within the trust has started well. We are able to discuss 'teething' problems as they arise and ensure they are reviewed, and processes and systems strengthened accordingly. The development of a report that will reflect learning as captured on our learning tool is underway and we anticipate our first report by the end of April 2024. We have developed a master log for PSIRF so that we know where and by whom, which template is being used and to be completed by what date.

PSIRF is still at an early stage and will continue to be reviewed and developed over the next few months and years.

Our plan moving forward....

The trust Patient Safety Team will continue to embed PSIRF and work closely with all of the Divisions. We will monitor progress via the various PSIRF specific groups that are in place – namely the Weekly Patient Safety Summit, the PSIRF Review Group and the PSIRF Working Group. The PSIRF Plan, Policy, Implementation Plan phase 2 and review the completed PSIRF templates and the review and reporting of the learning tool that are in place. Patient safety reports will be further developed and produced monthly and quarterly for the learning, themes and trends and action/quality improvement work in place, underway or proposed. These reports will go for internal assurance to Trust Groups – Patient Safety and Quality group and Quality and safety Committee.

Monitoring discussions with the ICB will continue and work on areas that need wider collaboration will be shared at the ICB Sussex Patient Safety Specialist Forum. Eventually, with the recruitment of the trust Patient Safety Partners this will further support internal and external collaborative working and learning with other acute and community Trusts within the Sussex area and beyond across England.

Reducing insulin prescription and administration errors

Why was this chosen as a priority?

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

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

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

And the NaDIA Harms (2021) audit reported:

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

Our aims

- Explore in depth why this might be and propose (actions):
- Increase uptake of the essential to role safe use of insulin training and re-introduction of the competency assessment tool to be demonstrated three yearly to support revalidation for midwives and RNs, and one yearly for Community Support Workers (CSW).
- Propose that the Safe Use of Insulin Training becomes a mandatory training requirement for nurses, midwives and doctors and this should be completed every 2 years, yearly for Community Support Workers who had training and competency assessments completed and are tasked to administer insulin.
- Encourage uptake of regular training for doctors joining the trust to attend the regular training sessions provided by the Diabetes Team on safe use and prescription of insulin.
- Inclusion of the Datix reports on insulin errors and hypoglycaemia on the governance meetings.
- Active participation to the Medicines Safety meetings at the trust
- Inclusion of insulin treated patients and hypoglycaemia incidences on the huddles.
- Early referral to the diabetes team of patients requiring diabetes management review.
- Continued participation to the national awareness campaign on insulin safety and hypoglycaemia.

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

There are a wide range of errors that can occur in the process of prescription and administration of insulin, the diabetes team have included these subjects as critical elements of the training they provide.

These are:

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

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

What did we do in 2023/24?

- We have increased uptake of the essential to role safe use of insulin training and are planning on the re-introduction of the competency assessment tool to be demonstrated three yearly to support revalidation for midwives and RNs, and one yearly for Community Support Workers (CSW).
- We are restarted face to face safe use of insulin training, in addition to the virtual training we have been providing during the COVID period.
- In terms of staff attendance to the safe use of insulin training, for 2021-2022 there were 86 staff who completed the training. For 2022-2023 there were 115 staff, and 2023-2024 there were 90 staff.
- The proposal for the Safe Use of Insulin Training in becoming a mandatory training requirement for nurses, midwives and doctors (completed every 2 years, yearly for Community Support Workers who had training and competency assessments completed and are tasked to administer insulin) has been included on the agenda for the trusts Education Steering Group meeting to be held on the 29th April 2024.
- We are still an essential part of the regular training for doctors joining the Trust. We have also been providing regular training/teaching sessions to staff in admissions unit including the Emergency Department, SDEC, AAU/AMU and SAU.
- We have been discussing the Datix reports on insulin errors and hypoglycaemia on the governance meetings.
- For Datix incidents, there has been a downward trend year on year, but a noticeable increase during the months of August and September, which coincides with the arrival of new medical staff- highlighting the importance of providing the training on safe insulin use as an essential, even mandatory part of their induction.
- We are also trying to understand where the incidents were happening and the emerging themes, so we can develop action plans to address these.
- We are trying to have active participation to the Medicines Safety meetings at the trust. This has been difficult due to already established clinical work clashing with the dates of the meetings, but this is being reviewed.
- We have been offering and providing ward based training for various departments/wards in the Trust (cross site)
- We have successfully revived the diabetes link nurse system, both for acute staff and community staff.
- Continued participation to the national awareness campaign on insulin safety and hypoglycaemia.

Our plan moving forward....

- We will continue to work very hard to ensure that effective strategies we utilised continue to become embedded in practice
- We will continue to gather feedback to improve the training we provide to the staff at the trust on the safe use of insulin to reduce further the incidents of insulin prescription and administration errors

End of Life Care

Why was this chosen as priority?

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

The National Audit of Care at the End of Life (NACEL) focussed on the quality and outcomes of care experienced by dying patients and those closest to them during their last hospital admission throughout England and Wales. The trust participates annually in this audit, which monitored progress against NICE Quality Standard 144, including recognising that a person is nearing the end of their life, person centred communication and assessment of their needs and the needs of those closest to them. The four NACEL audits (2018 – 2022) has shown that often we recognise that a person is dying very late and that our staff do not feel confident in initiating open and honest conversations about death and dying. The overarching themes of EoLC complaints relate not to care, but to poor communication about deteriorating conditions, uncertainty around recovery, dying and death; and often the wishes of patients and those closest to them are not listened to.

Our aims

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

How have we done?

National Audit of Care at End of Life (NACEL)

The trust has participated in four rounds of NACEL and our results are improving with the last round of NACEL seeing us scoring higher than the national average in most measures. While this is positive it is important to understand how we have performed and compare our own audit results over the years.

Areas of improvement have been:

- Recognising dying
- Discussing side effects of anticipatory medicines with families
- Assessment of hydration and nutrition
- Discussion of risks and benefits of hydration and nutrition, especially with family members
- Assessment of personal care needs
- Assessment of symptoms

But there continue to be areas requiring improvement:

- Starting an individualised care plan (NICE guidance)
- Regularly reviewing the individualised care plan because it was started too late
- Spiritual assessment
- Documenting preferred place of care / death
- Documentation of discussions with families about anticipatory prescribing
- Families feeling supported and being given all of the information they need

Anticipated deaths with an individualised care plan and ReSPECT

	Jan-24	Feb-24	Mar-24
Number of ESHT in-hospital deaths	183	197	168
Number of anticipated deaths (as recorded on the verification of death form)	146	164	134
% of in-hospital deaths that were anticipated	80%	83%	80%
Number of anticipated deaths on 'Last Days of Life Careplan'.	116	143	109
% of anticipated deaths on 'Last Days of Life Careplan'	79%	87%	81%
Number of anticipated paediatric deaths (as recorded on the verification of death form)	0	0	0
Number of deaths with a RESPECT form	168	188	155

While NACEL demonstrates that there has been an improvement in recognising that a person is dying, figures exploring the percentage of anticipated deaths and the percentage of anticipated deaths on an individualised care plan remains lower than expected. As a minimum we would want 85% of deaths to be anticipated and 85% of these anticipated deaths to be on an individualised care plan. The number of anticipated deaths was not achieved this quarter, and the expected number of anticipated deaths on an individualised care plan was only achieved in February.

Not all patients who die have a ReSPECT form but we would expect all patients we anticipate as dying to have one, from the above figures it is impossible to determine if all anticipated deaths had a ReSPECT form in place.

Audit of Quality of ReSPECT forms

A clinical audit of the quality of ReSPECT forms was repeated in October 2023. The audit data suggests that ReSPECT Forms (RFs) in the trust are primarily being used to document DNACPR decisions and consequently RFs are not being used to their full potential in guiding personalised care.

In terms of compliance to national standards, the trust is good at completing the basics of a RF: adequate legibility, complete patient demographics, health summary, clinical recommendations, DNACPR decisions, and the details of clinician who wrote the form. However, although these sections are being completed, there is room to improve the quality of information included.

For example, whilst 98% of the RFs had something written in the summary of information section, almost a third (32%) of this information was regarded as poor. This was because clinicians simply listed medical conditions (not all of them relevant) and used acronyms that other members of the health multidisciplinary team may be unfamiliar with. Only 12% of RFs met the criteria for an excellent summary of information, making this is a clear area for improvement.

The same picture is reflected in the clinical recommendation section of the RF. Whilst 93% of clinicians are writing a clinical recommendation, 13% of these recommendations were judged poor and only 28% excellent. Furthermore, only 48% of RFs had recommendations that would be useful to a community practitioner if the patient was discharged from hospital. The RF is meant to be a tool for patient care across all areas of healthcare, not just hospital treatment.

There were some outstanding RFs which had clearly involved the patient and attempted to make truly personalised plans. However, these were the exceptions. This is well illustrated by the fact only 28% of RFs listed the patients preferred name: indicating that patients had not been fully engaged with the ReSPECT discussion. Indeed, it was felt that less than half (48%) of RFs had any evidence of patient involvement in the RF process – despite the fact 61% of RFs said patients had capacity to be involved with the process.

A major area for improvement is the emergency contact section of the form. Only 33% of forms had the full details of an emergency contact. In cases where patients lack capacity, only 33% of RFs had evidence an emergency contact was involved in planning. This is particularly worrying as when patients lack capacity, those closest to them should be consulted to get a sense of what mattered most to a patient. In such situations it is also important to inform the family about clinical decisions made about the relative, as per past legal precedent.

An action plan is now being developed to improve completion of RFs.

Learning from Complaints and Incidents

There have been three complaints related to EOLC all are currently being investigated. The first complaint is from a family raising multiple concerns about the care the patient received, poor communication with family and aggressive discharge planning. The second complaint relates to the identified cause of death of a patient; the family feel he died as a result of head injury following an unwitnessed fall, rather than his chronic medical condition. The final complaint is from a family who have raised a concern that their relative was not properly laid out when they attended the ward after death.

There have been 49 incidents reported related to EOLC, 70% of these related to pressure sores developed either in the patient's own home or during a hospital admission. Patients at end of life are particularly vulnerable to skin breakdown for reasons including frailty, reduced mobility and reduced or poor nutrition. 12% of incidents were related to medication errors, these included prescribing errors, lack of anticipatory prescribing, medication miscounts and lack of stock in patients homes. The remaining incidents were related to other incidents including falls, poor discharge information, inappropriate use of an ambulance and poor communication. All have been investigated and lessons learnt have been shared with the divisions the incident occurred in.

Feedback from bereaved families

Bereavement surveys are no longer sent out but following each death the medical examiner contacts family members to discuss the death and provide an opportunity for expression of any worries or concerns. It is hoped in the future that feedback from these discussions can be collated.

Bereaved families have commented that the open and honest conversations with the Medical Examiner team as well as an increased level of transparency following a death has been welcomed. It has allowed them to ask questions to a single point of contact.

The Trust participates every year in the National Audit of Care at End of Life (NACEL) as part of this bereaved relatives are encouraged to complete a 'quality survey' about their experiences of their loved ones dying in the acute hospital setting. This survey runs for the whole calendar year. There were no responses received in Q4.



Part 3.2 – Review of our Quality Indicators

Amended regulations from NHS England require trusts to include a core set of quality indicators in the Quality Account.

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

Patient Safety Indicators

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

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

The percentage of patients aged 16 and over admitted in the year who were assessed for risk of VTE on admission to hospital 2023/24 the trust achieved 88% compliance.

Rate of C. Difficile Infection

Mandatory surveillance of healthcare associated infection

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

The NHS Standard Contract 2023/24 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of both Clostridioides difficile (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England.

Trust thresholds

Trusts are required under the NHS Standard Contract 2023/24 to minimise rates of both *C. difficile* and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England.

***Clostridioides difficile* Infection**

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

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

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

Gram-negative bloodstream infections

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

Table 2: The five prior healthcare exposure groups for Gram-negative bloodstream infections

Prior healthcare exposure group	Definition
Hospital-onset healthcare associated (HOHA)	Specimen date is ≥ 3 days after the current admission date (where day of admission is day 1)
Community-onset healthcare associated (COHA)	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
Community-onset, community associated (COCA)	Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)
Unknown	The reporting trust answered 'Don't know' to the question regarding previous discharge in the month prior to the case
No information	The reporting trust did not provide any answers to questions on prior admission

Baseline period

All thresholds are derived from a baseline of the 12 months ending November 2021 or November 2022 and the final threshold selected is the lowest of the two.

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

Performance

East Sussex Healthcare NHS Trust	Case thresholds for 2023/24	Actual Cases reported for 2023/24		
Organism		Total	HOHA	COHA
C. difficile (CDI)	57	69	41	28
E. coli	77	113	53	60
Pseudomonas	12	20	12	8
Klebsiella sp.	35	49	23	26

Source: The trust 23/24 data is from the UKHSA Healthcare Acquired Infections (HCAI) Data Capture System. All other data is from NHS Digital. At the time of writing this report the annual 23/24 surveillance report had not been published.

The annual surveillance report for 2023/24 has yet to be published so the 2023/24 data has been taken from the data capture system and is subject to slight variation.

A total of 69 cases of CDI were attributed to the trust for 2023/24 which is higher than the threshold. For 2023/24 we have reported 69 cases against a limit of 57. 41 hospital onset healthcare associated (from 41 patients) and 28 community onset healthcare associated infections (from 24 patients).

UKHSA commentary for 2022-2023 noted a 10year high in reported CDI of 27.6 per 100,000 bed days, and that "increases are driven by both hospital and community-onset cases, though the trend appears notably steeper in the hospital-onset category". The trust reported 93 cases of CDI for 2022-23 and has since focused on a recovery plan aimed at changing antimicrobial prescribing practice on the wards with higher CDI risk. In real terms there has been a significant reduction in hospital onset cases in the past year from 74 in 2022-23 to 41 in 2023-24 and it appears we are returning to similar number of cases seen in previous years.

Rapid post infection review as part of implementing PSIRF, has been undertaken on the hospital onset cases and we have sought collaboration with the ICB to understand COHA cases. All cases have been sent for ribotyping to assist with detecting outbreak and there is one case that may be a result of cross infection.

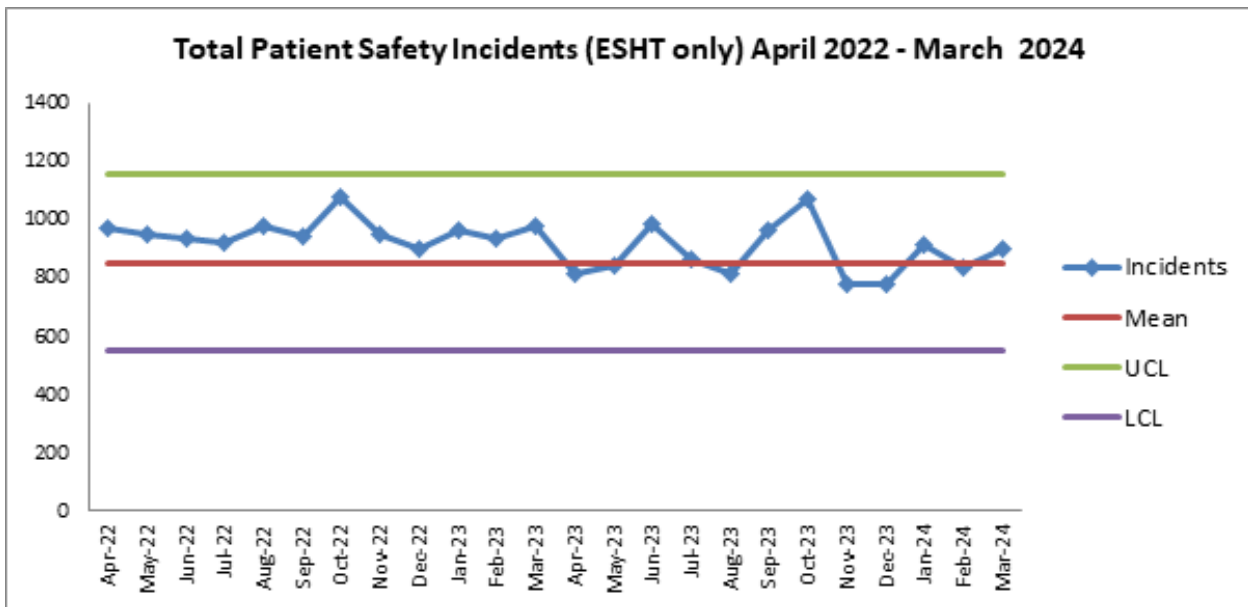
Further work is needed to positively influence antimicrobial prescribing and gain insight into how increased frailty and deconditioning impacts on healthcare associated infection. Since the reporting algorithm has changed to include a prior healthcare exposure element for community onset cases it has been much more challenging to reduce infection cases. Infections of CDI and gram negative bacteraemias diagnosed within 48hrs of admission (community onset infections) are now attributed to the acute trust and classed as community onset healthcare associated (COHA); if the patient has been coded as an inpatient in the previous 4 weeks. Prior healthcare exposure now includes attendance for planned day case care and attendance at emergency assessment units – (even if this is a few hours). In future, care provided in virtual wards will also be considered part of the acute trust.

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

The National Reporting and Learning System (NRLS) ceased to function in the summer of 2023. Learning from Patient Safety Events (LfPSE) is currently being introduced across the NHS and is a new national service for the recording and analysis of patient safety events that occur in healthcare.

The trust reporting of incidents with no harm/near miss is 71% or higher consistently month on month. The percentage achieved remains on par with the national rate of 71%. This percentage does highlight a Trust that is demonstrating a good and consistent reporting culture.

Table 1 - Total Incidents only from April 2022 - March 2024

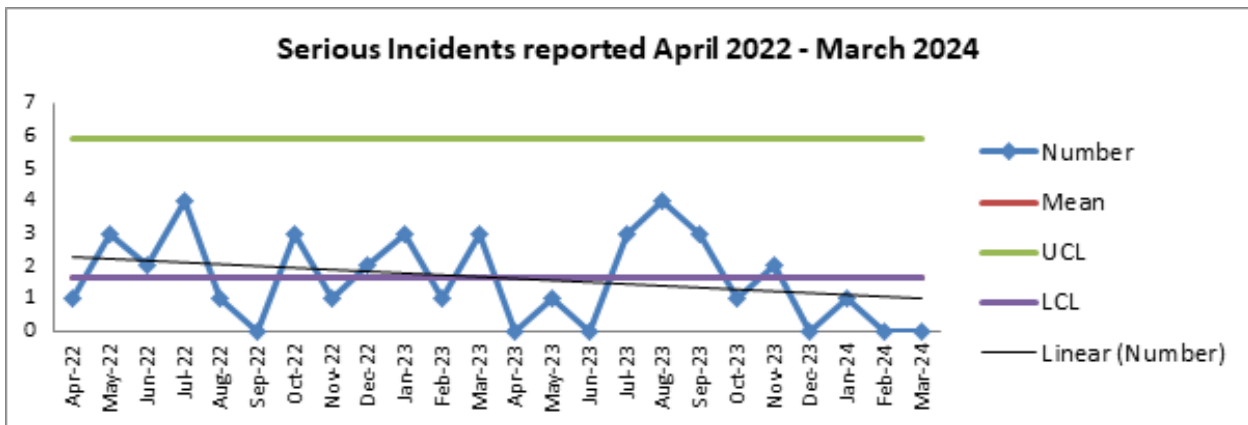


The graph indicates a series of months where the incident totals are above previous months. This is due to the increased reporting and activity following the Covid-19 pandemic and has now returned to a level similar to pre-pandemic.

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

- The management of investigation of incidents/events is centralised and is embedded in the Trust with an ongoing improvement in the quality of investigations, reviews, learning and quality improvement.
- The introduction and embedding of the new Patient Safety Incident Framework (PSIRF) are all managed in accordance with national legislation timescales.
- Progress of any incidents/events utilising the new PSIRF templates is monitored by the Trust Patient Safety Team, the Weekly Patient Safety Summit and the PSIRF Review Group.
- Actions resulting from PSIRF templates are monitored with updates on the number of outstanding provided to the Patient Safety and Quality Group monthly. All outstanding Ambers and SI actions are also being monitored until completion.
- In November 2023 the Serious Incident Framework (SIF) was stopped and the new framework, PSIRF was commenced on the 20th November 2023 whereby no further SIs or Amber Reports were reported. PSII's, Thematic Reviews and other PSIRF compliant templates have started to be used for Patient Safety Events.

Table 2 – Serious Incidents



The graph shows a decline in the number of severity 4 and 5 incidents reported. This is due to reduction in Covid-19 cases and the number of serious incidents is now similar to pre-pandemic levels. In November 2023, PSRIF was introduced, and no SIs have been reported. The graph above does show that in January, 2 SIs were raised, but these are maternity incidents and are currently being investigated by the MNSI (formerly HSIB).

Clinical Effectiveness Quality Indicators

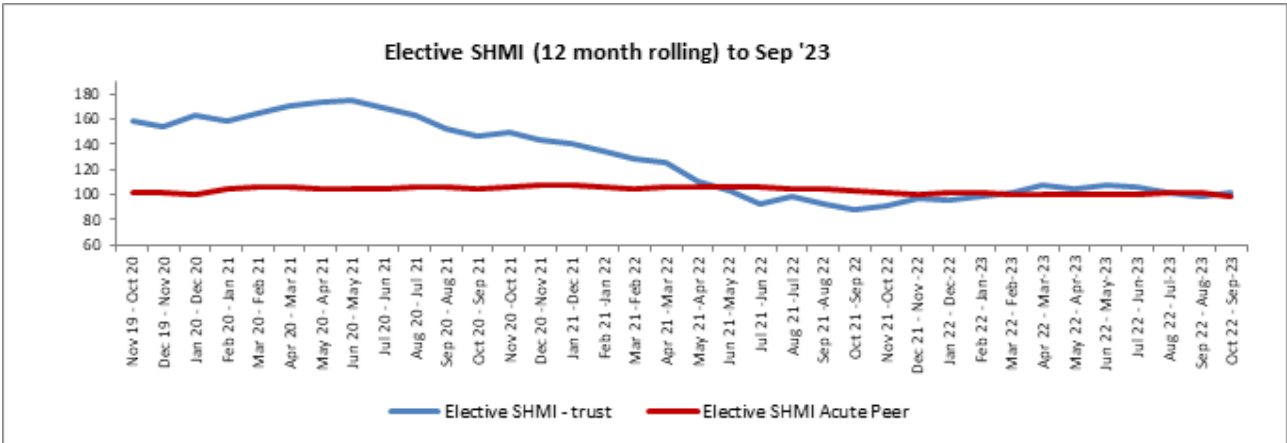
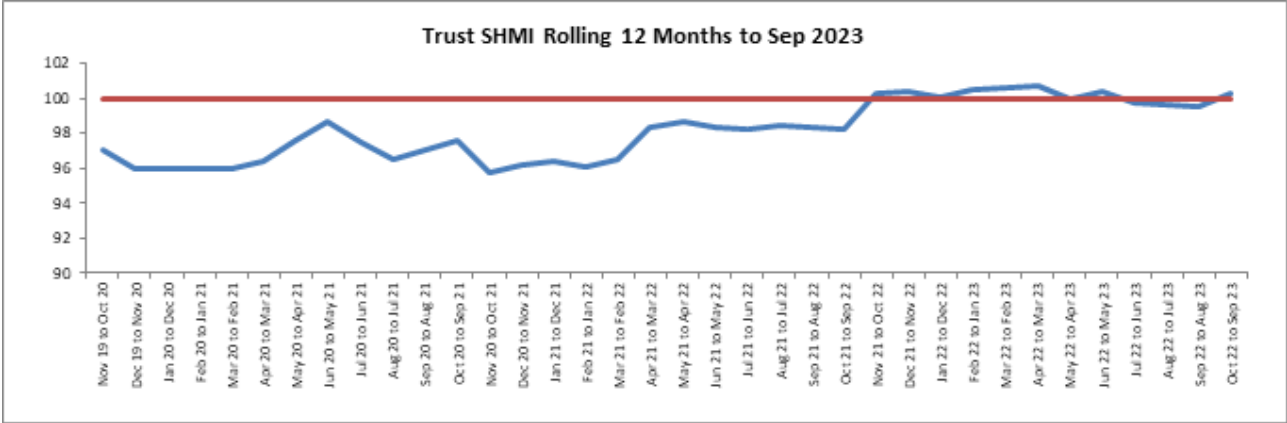
Summary Hospital-level Mortality Indicator (SHMI) Risk Adjusted Mortality Index (RAMI)

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

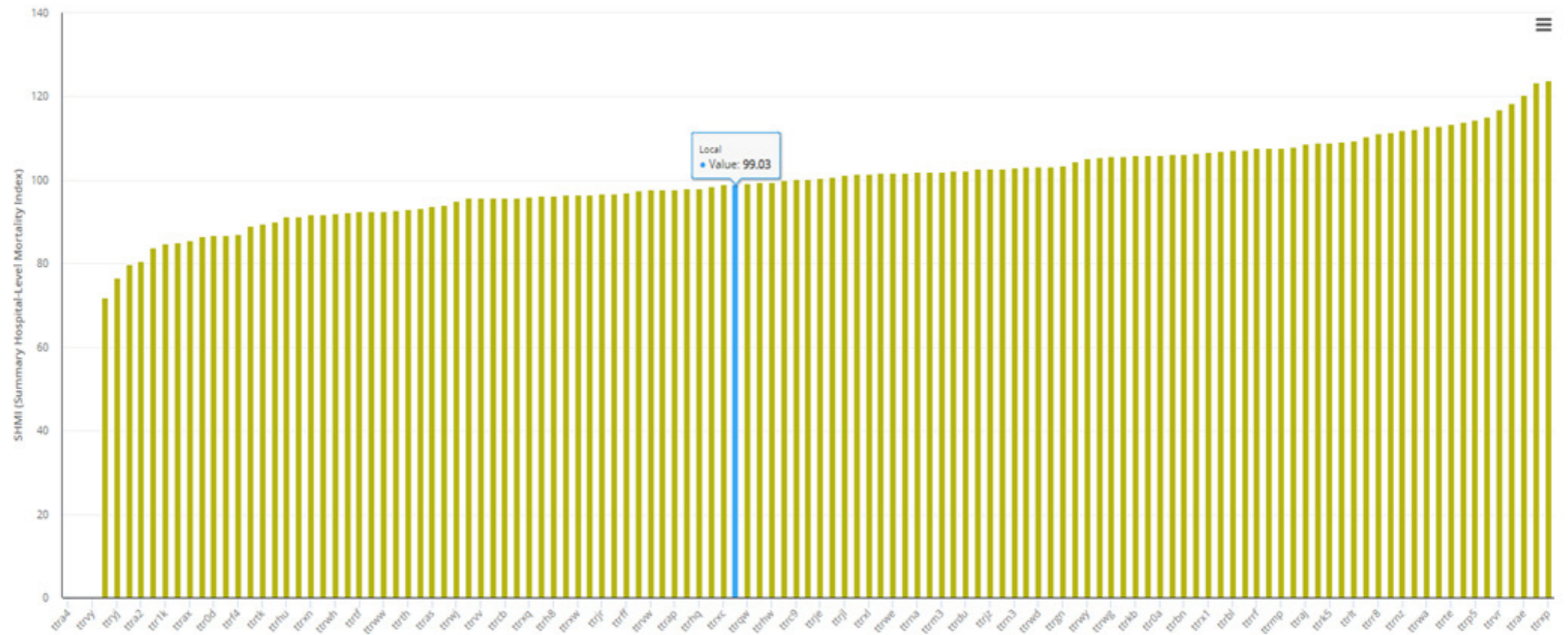
SHMI is one of several statistical mortality indicators used to monitor the quality of care provided by the Trust. We also look at the Hospital Standardised Mortality Ratio (HSMR) and the Risk Adjusted Mortality Indicator (RAMI), as well as crude death rates and associated local metrics.

Indicator	ESHT Jan 17 - Dec 17	ESHT Jan 18 - Dec 18	ESHT Jan 19 - Dec 19	ESHT Jan 20 - Dec 20	ESHT Jan 21 - Dec 21	ESHT Dec 21-Nov 22	ESHT Dec 22-Nov 23
SHMI value	1.04	0.97	0.97	0.96	0.96	1.00	0.99
Banding	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)
% of patient deaths with palliative care coding	22.7	32	35	38	42	42	46

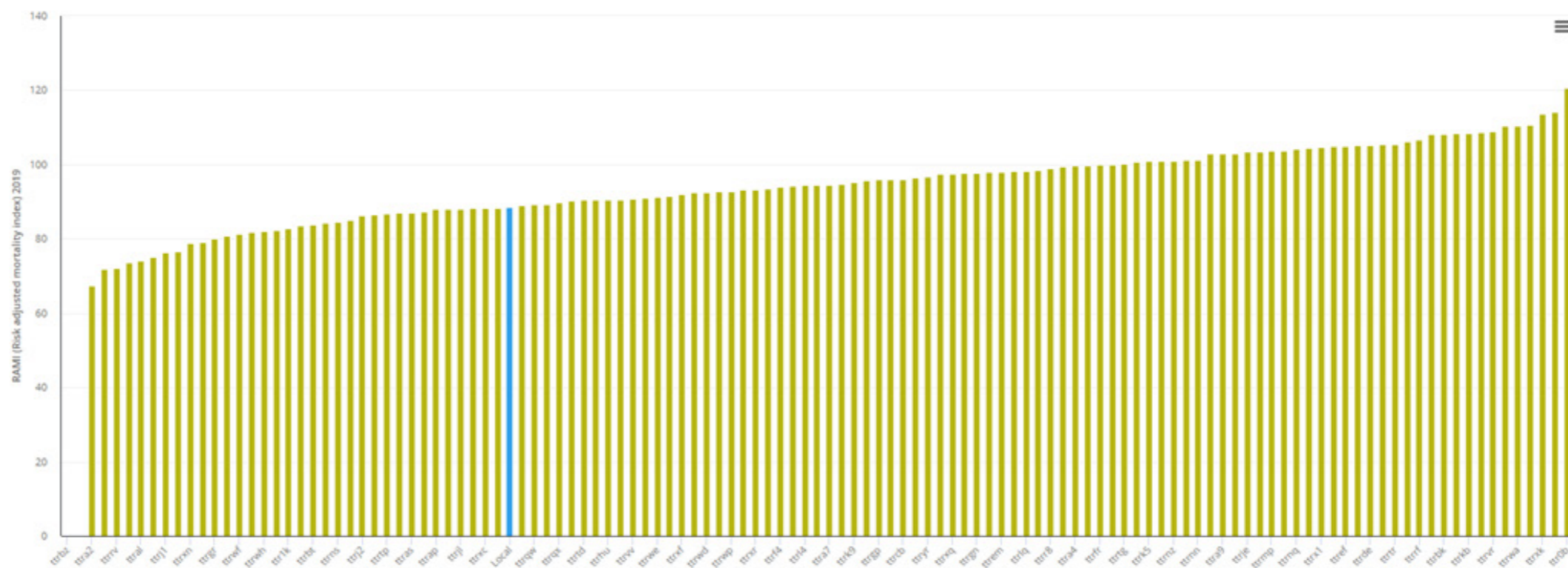
Source: NHS Digital

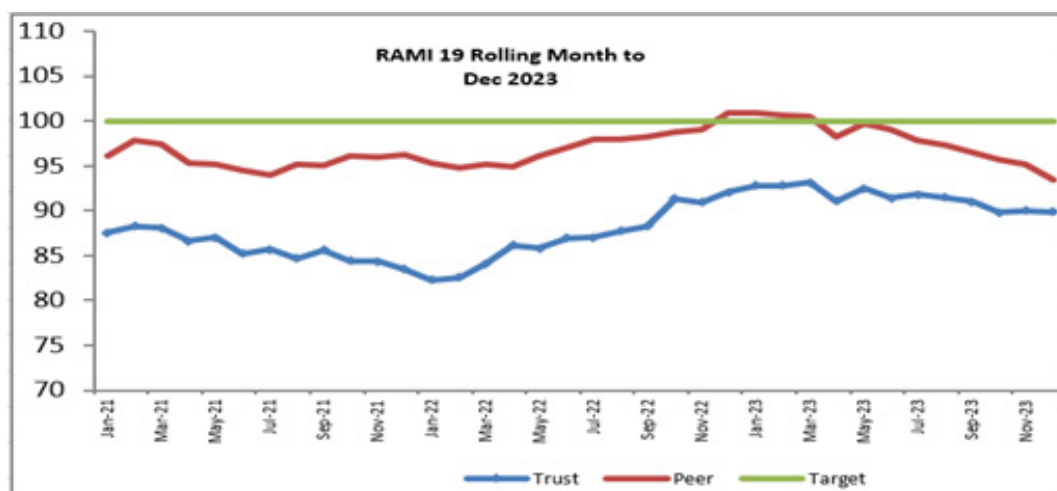


SHMI in comparison with other Trusts



RAMI in comparison with other Trusts





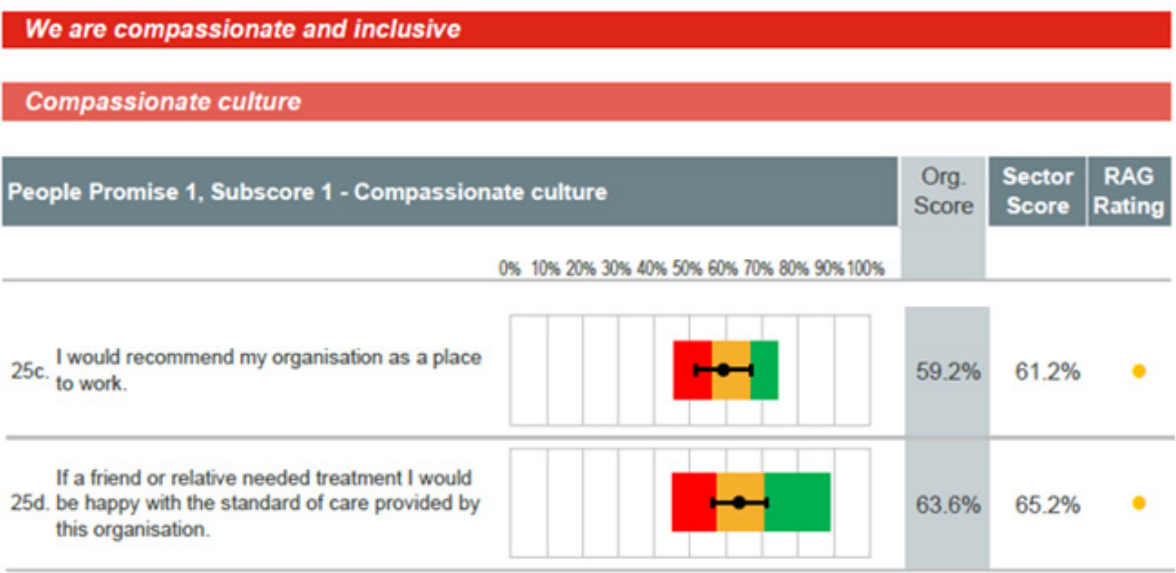
The trust has taken the following actions during 2023-24, to improve mortality and the quality of its services:

- Improved consultant staffing in our emergency units and acute medicine departments so we can provide optimum care when patients are acutely ill, with consultant presence on Medical Assessment Units (AAU, AMU) every day for around 12 hours.
- Produced standards of care for assessment and treatment of acute admissions, to improve patient safety, timely diagnosis, effective streaming to appropriate specialties.
- Increased the number of doctors resident at night.
- Strengthened provision of Same Day Emergency care (SDEC), with units open on both sites, 7 days a week, taking patients from Emergency Department and allowing more rapid senior input throughout the week.
- Maintained focus on the recognition and rapid treatment of Sepsis and Acute Kidney injury (AKI).
- Provided timely senior decision making at ward level through multi-disciplinary daily board rounds, led by the consultants.
- Improved handover for acute teams using NerveCentre for handover, task allocation, and patient tracking.
- Extended the use of NerveCentre, incorporating more parameters, to identify patients whose observations are deteriorating. The system is used to record and share the information ensuring clinicians have full visibility of a patient's observations and can respond at the earliest opportunity.
- Rockwood frailty scoring is now standard in the adult gateway areas and is incorporated in NerveCentre and the paper admission notes (IPD).

- Further rolled out Electronic Prescribing (EPMA) across the acute hospital inpatient wards, along with an accompanying training programme. This increases the accuracy and safety of medication prescribing and administration.
- Overview of Trust mortality indicators is provided by the monthly Mortality Review Group, reporting to the Clinical Outcome Group (COG) which is chaired by the Chief Medical Officer. The group also drives improvement in a number of workstreams to improve outcomes for patients.
- The quality of mortality reviews is monitored monthly.
- The programme of specialty mortality and morbidity (M&M) meetings has been strengthened, following a period, during the main waves of covid-19, in which these were somewhat less regular.
- In depth reviews are carried out, using the Structured Judgement Review methodology (recommended by the Royal College of Physicians) in cases referred to the Coroner, and for deaths in patients with learning disability, to support the regional Learning Disability Mortality Review Programme (LeDeR) review system.
- Deep dives into mortality associated with elective admissions and into post-operative infections, stroke and MI mortality.
- A weekly Patient Safety Forum, chaired by the Medical Director and Chief Nurse, reviews incidents reported on the Datix clinical incident system, determining the level of investigation, to maximise learning from these.
- Learning from deaths and from clinical incidents is shared across Divisions, specialties, and wards.
- Wards hold regular safety huddles, promoting awareness of patient safety issues and disseminating learning.
- An additional quarterly review group (Mortality Review Audit Group) reviews the case notes of all deaths graded by Medical Examiners as having poor quality of care, deaths involving serious clinical incidents, complaints, and people with learning disability.
- The independent Medical Examiner system is now well established, providing independent review of all deaths.
- The Trust Board is sighted on our mortality performance with formal quarterly reporting of "Learning from Deaths", which includes the number of avoidable deaths and regular updates on indices such as SHMI, RAMI and HSMR.
- Work is ongoing improving clinical coding of patient information to ensure mortality indicators are based on accurate clinical information.

Staff and Patient Experience Indicators

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



25c. I would recommend my organisation as a place to work.

	2022		2023		Comparator	
Strongly disagree	207	6.1%	169	4.2%	12,378	4.8%
Disagree	366	10.8%	369	9.2%	24,335	9.4%
Neither agree nor disagree	954	28.0%	1,102	27.5%	63,916	24.6%
Agree	1,469	43.2%	1,782	44.4%	114,257	44.1%
Strongly agree	408	12.0%	592	14.7%	44,453	17.1%
Missing	49		57		2,378	
Positive Score		55.1%		59.1%		61.2%
Negative Score		16.8%		13.4%		14.2%
Base	3,404		4,014		259,339	

25d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

	2022		2023		Comparator	
Strongly disagree	114	3.4%	104	2.6%	8,671	3.3%
Disagree	332	9.8%	342	8.5%	20,836	8.0%
Neither agree nor disagree	934	27.5%	1,018	25.4%	60,640	23.4%
Agree	1,622	47.8%	1,964	49.0%	124,375	48.0%
Strongly agree	392	11.5%	584	14.6%	44,571	17.2%
Missing	59		59		2,624	
Positive Score		59.3%		63.5%		65.2%
Negative Score		13.1%		11.1%		11.4%
Base	3,394		4,012		259,093	

- Created an accountability framework for divisions to utilise in order to ensure that their staff survey action plans remain focused, relevant and on track.
- Planned focused groups led by the engagement team in June and July 2023 with representatives from divisions where hot spot areas had been identified.
- Continue to use the People Pulse results as a source of intelligence and temperature test to inform and signpost to areas for improvement in staff working life, wellbeing, conditions, and work environment.
- Retention annual programme of work developed with 12 workstreams, informed by exit data, feedback from areas of high turnover and a trust wide retention survey.
- Continue to focus on the elements of NHS People Promise and the Trust's People strategy, incorporating Wellbeing and Retention strategic objectives.
- The organisation development team have been working with forty bespoke team interventions.
- In addition to the base load programme of strategic work and leadership courses that are offered on an ongoing basis, sixteen civility sessions have been facilitated and eight new coaching clients have been added to the current coaching and mentoring service.
- There has also been support for three cultural reviews for major services across the organisation.
- Wellbeing team have achieved Bronze accreditation with ESCC Wellbeing at work.
- Wellbeing programme developed with self-care resources, informed by wellbeing listening events held throughout the year.
- Occupational Health attained national SEQOHS accreditation (Safe Effective Quality Occupational Health Service)
- Partnership Forum and Forum Partners pivotal in developing new trust values.
- New Trust Values agreed following widespread consultation with our people. Launched in April 2024.
- Development of people metrics for corporate IPR with contributions from People Engagement & Wellbeing Team, Organisational Development and Culture and wider specialist HR services.

Responsiveness to inpatients' personal needs

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

Indicator	ESHT 2021	ESHT 2022
"care and treatment"	7.9	8.3

*CQC National Inpatient survey was published in September 2023.

This survey is comparable with previous surveys as the questions remained the same. Eligibility to take part in the survey was if the patient stayed in hospital for at least one night during November 2022 and were aged 16 years or over at the time of their stay.

The trusts response rate for this survey was 43%, an increase of 1% vs. the 2021 Adult Inpatient Survey.

Change since 2021

Average score: 75.1% (decrease of 0.5% from 2021).

When comparing results, there is a reduction in 10 questions scoring worse by 5% in 2022.

	2021	2022
Better by 5% or more	2 questions	0 questions
Less than 5% change	40 questions	49 questions
Worse by 5% or more	12 questions	2 questions
Better by 5% or more	2 questions	0 questions

The two questions which scored worse by 5% or more when compared with the 2021 survey were (both questions featured in the bottom 20% of Trusts in the national comparison):

- Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital? (2021 score= 81.4%, 2022 score=67.5%)
- Q34. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital? (2021 score = 71.7%, 2022 score= 58.3%)

National Comparisons

Each Trust is assigned one of five bands according to their overall performance across the survey: The trust is “middle 60%”.

The table below categorises the number of questions which scored in the top 20%, middle 60% and bottom 20% of Trusts. When comparing the trust results nationally, there is an increase of five questions that feature in the top 20% of Trusts and a reduction in 12 questions that feature in the bottom 20% of Trusts.

	2021	2022
Top 20% of Trusts	2 questions	7 questions
Middle 60% of Trusts	26 questions	39 questions
Bottom 20% of Trusts	19 questions	7 questions

Themes of the questions which featured in the top 20% of Trusts (2022) were:

- Food (assistance with meals and availability)
- Privacy when being treated
- Staff availability to meet patient needs
- Staff asked about additional equipment needed when leaving hospital
- Patients were asked to give their view on the quality of care

Seven questions which scored in the bottom 20% of Trusts (2022) were:

- Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?
- Q18. When doctors spoke about your care in front of you, were you included in the conversation?
- Q25. How much information about your condition or treatment was given to you?
- Q31. Beforehand, how well did hospital staff answer your questions about the operation or procedure?
- Q32. After the operation or procedure, how well did hospital staff explain how the operation or procedure had gone?

- Q34. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?
- Q46. Thinking about any medicine you were to take at home, were you given any of the following:
I was given medicine but no information

Overall, this report is positive with fewer questions scoring worse by 5% or more and in the bottom 20% of Trusts.

Patient feedback and performance against standards are monitored and reported on through divisional Integrated Performance Reviews, such as communication, discharge and waiting times (against standards and themes of complaints/ concerns).

There are still areas for improvements with the questions which scored in the bottom 20% of Trusts (this includes the two questions which scored worse by 5%). The Trust's Head of Patient Experience has created an action plan to address these questions.

The Inpatient survey is a Trust wide survey, we are not able to identify areas where responses came from; this action plan will be shared with operational leads and there will be shared ownership for completion and themes arising from patient feedback will be monitored.

This report has been shared widely throughout the trust.

Annexes

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

Statement from Commissioners

Thank you for giving NHS Sussex ICB the opportunity to comment on your Quality Account for 2023/24. We appreciate the ongoing collaborative working and open communication with the Trust, in particular with the Trust's senior clinicians at the quarterly Quality Review Meetings and internal ESHT quality meetings which NHS Sussex are invited to attend.



NHS Sussex has reviewed the Quality Account for 2023/24 and consider it to be a fair and accurate reflection of the Trust's performance during the year. NHS Sussex acknowledge the continued improvement in key areas in 2023/24, notably:

- Continued focus on safe insulin administration with improved uptake of the Safe Use of Insulin training (which includes regular training for doctors joining the Trust and regular sessions for staff in admissions units.) It is positive to see that related incidents reported on Datix have shown a downward trend year on year. NHS Sussex acknowledge there is an increase of incidents noted in the months of August and September 2023, coinciding with the arrival of new medical staff, which the regular training targeted at this cohort aims to improve.
- Participation in four rounds of National Audit of Care at End of Life (NACEL) demonstrating the Trust's results are improving. The most recent round of NACEL identified that ESHT is scoring higher than the national average in most measures.
- Implementation of the Patient Safety Incident Response Framework (PSRIF) and plans to update the Trust's PSIRF Plan and Policy over the next 18 months ensuring there is clarity of systems and processes.

NHS Sussex is supportive of your three strategic improvement priorities, noting the range of wider improvement projects planned during the 2024/25 year, including:

- Safe administration/prescribing of Paracetamol
- Reducing the number of rejected pathology samples
- Improving the quality of decision making for people who lack capacity.

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

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

Yours sincerely,

Allison Cannon
Chief Nursing Officer
On behalf of NHS Sussex

Statement from Healthwatch East Sussex

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



East Sussex Healthcare NHS Trust (ESHT) is responsible for the Conquest Hospital and the Eastbourne District General Hospital (EDGH). It is also responsible for three community hospitals in Bexhill, Rye and Uckfield. In addition, it delivers services in the community focussing on people with long term conditions.

Healthwatch East Sussex has reviewed the performance of ESHT over the last 12 months based on its Quality Account. We have done this through a 'patient lens', focusing on user experience, safety and performance.

As has been well documented, the NHS faced significant pressures during the last financial year. Despite this, the Trust highlights achievements, including:

- Progress made on the construction of the Sussex Surgical Centre at EDGH and notes that it is due to open in 2025.
- The opening of a new Community Diagnostic Centre at Bexhill. Healthwatch visited the centre and sought feedback from patients all of which was generally positive.
- The opening of a refurbished cardiac catheterisation lab at EDGH thanks to a donation of £400,000 from the Friends of EDGH.
- The harnessing of information technology, in particular with provision of a virtual ward, the digitalisation of the Trust's pathology service, offering 3-D tours of the Trust's Special Care Baby Unit to support parents, and participation in the MIDI national research programme to develop AI to identify brain abnormalities and injuries.
- Reducing nearly to zero the number of patients waiting over 65 weeks for planned care interventions.
- Progress made in improving the speed of access to urgent care – meeting the 76% target set by NHS England in March 2024.

We welcome the Trust's commitment to collaborating with others to provide better services for people, whether through Provider Collaboratives or Integrated Community Teams. Similarly, the Trust's Partnership Forum which draws together staff from across the Trust in order to improve care is a positive initiative.

Healthwatch East Sussex notes the progress made in relation to the three priorities for improvement for 2023/24 and the commitment to carry on work to improve in these areas.

It was concerning to read the overall message in relation to the SAMBA 2023 audit that provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24 hour period – namely that performance against all key quality indicators whilst higher than for SAMBA 2022 remained lower than that seen previously. Acute care services face on-going pressures, and careful consideration of how clinical quality and efficient patient pathways can be maintained is needed. It was also disappointing to see that whilst some progress has been made in relation to the effectiveness of ReSPECT documentation in the Early Care setting, much more progress is needed in order to meet the clinical standard. It is also note that the Trust is not meeting the clinical standard for Venous Thromboembolic Prophylaxis.

It will be re-assuring to patients and local people that throughout 2023-24:

- the independent regulator of health and social care (the Care Quality Commission or CQC) has taken no enforcement action against ESHT, although in February 2023 the Trust was fined £4,000 for a breach following a previously reported serious incident.
- The CQC ratings for all services in 2020 were Good or Outstanding. Following an inspection of maternity services by CQC in October 2022 an action plan was put in place and actions have been progressing positively.
- the Trust met all standards of the Data Security and Protection Toolkit for 2022/23. The next deadline for submitting data is June 2024.

Healthwatch East Sussex welcomes the three priorities for improvement in 2024/25 namely the safe administration of paracetamol, reducing the number of rejected pathology samples and improving the quality of decision making for people who lack capacity. However, we note the description given by ESHT of the challenges faced by the Trust – “people are waiting too long to get necessary or effective interventions – this is probably the biggest detriment to quality of care in our system alongside people spending too long in hospital beds when having support at home would be much better and prevent deterioration”. It is not clear how the priorities identified by ESHT will address this challenge.

Over the next 12 months we will seek to maintain a constructive, and critical friend relationship with the Trust, in particular in relation to patient experience of using virtual wards; the accessibility and patient wait times across its service portfolio; and looked after children’s experience of the Annual Health Assessment with the Specialist Nurse Service.

Riona Doidge
Head of Volunteering and Engagement

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

Thank you for providing the East Sussex Health Overview and Scrutiny Committee (HOSC) with the opportunity to comment on your Trust's draft Quality Report 2023/24.



The HOSC recognises much of the Trust's efforts over the past year will have been focussed on maintaining its high standards of care whilst dealing with pressures in the healthcare system, workforce issues and the recent industrial action. The Committee, therefore, welcomes the success ESHT has achieved in 2023/24, despite the considerable pressures placed on it.

In particular, the Committee is pleased to hear of successful recruitment work and is reassured to see the reduction in the staff vacancy rate from 9% in February 2023 to 4.5% in February 2024. Dedicated work in retention has resulted in a continuous fall in staff turnover, so that in February 2024 it stood at its lowest level since September 2021, and the HOSC also notes the continued positive work on staff support programmes. While these are positive developments, the Committee would hope that recruitment and retention remain a priority for the Trust in the coming year, noting that staffing challenges led to the closure of the Eastbourne Midwifery Unit earlier this year.

HOSC has invited ESHT to attend all its meetings over the past year to look at various issues, including changes made to paediatric services at Eastbourne District General Hospital (EDGH), the Building for our Future programme, and the healthcare system's winter plan. The Committee thanks those Trust officers and clinicians who gave their time to attend.

The changes to paediatric services at EDGH were scrutinised by a HOSC review board, whose findings and recommendations were reported to the HOSC in March 2024 following the initial implementation of some of the changes in January 2024. The Committee thanks the Trust for its response to the recommendations of the review board and looks forward to continued engagement on the issue as the impact of the changes are monitored and the Trust works to ensure the new service model can be sustainably staffed. Having early engagement with the Trust on future service changes also remains important to the Committee's positive progress.

Quality Priorities

The 2023/24 priorities for improvement focussed on implementing the Patient Safety Incident Response Framework, reducing insulin prescription and administration errors and End of Life Care. The Committee is pleased to see that progress has been made in each of these areas and that the Trust is working to embed those changes. In particular, HOSC welcomes the continued work on End of Life Care as it is an important and sensitive area of care. The HOSC welcomes the Trust's high levels of the participation in national clinical audits (98%) and national confidential enquiries (100%). The Committee also notes the Trust's participation in 45 clinical studies and is pleased to see that engagement with research has become a Trust priority as it has the potential to benefit patient care. Progress made against the action plan developed in response to the CQC inspection of Maternity Services in October 2022 is welcome, although the HOSC considers that the Quality Account would benefit from having more detail on this positive progress.

The HOSC notes that at the time of writing the draft Quality Account does not contain information about Learning from Deaths and this is to follow. The Committee would wish to see the inclusion of this information and the actions to be taken going forward in the final version of the Quality Account report.

The Committee notes the Priorities for Improvement in 2024/25 and is supportive of the Trust's patient centred approach to improving services in chosen priority areas.

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

Councillor Christine Robinson
Vice Chair
Health Overview and Scrutiny Committee

Annex 2: Statement of Directors' responsibilities in respect of the Quality Accounts

The Directors are required, under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

- In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:
- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable; conforms to specified data quality standards and prescribed definitions; is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Joe Chadwick-Bell Chief Executive



Date 27/06/2024

Steve Phoenix Chairman



Date 27/06/2024

Appendix 1 – National Clinical Audit and National Confidential Enquiries Programme

National clinical audits and national confidential enquiries we were eligible to participate in during 2023/24.

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

National Confidential Enquiries	ESHT Eligible	ESHT Participation
Maternal, newborn and infant and perinatal mortality (MBRRACE- UK) (and all applicable studies)	Y	Y
Child Health Clinical Outcome Review Programme (and all applicable studies) and Mortality Database	Y	Y
NCEPOD – Juvenile Idiopathic Arthritis	Y	Y
NCEPOD - Testicular torsion	Y	Y
NCEPOD – Community Acquired Pneumonia	Y	Y
NCEPOD – Crohns Disease	Y	Y
NCEPOD – End of Life Care	Y	Y
NCEPOD – Endometriosis	Y	Y
NCEPOD – Epilepsy	Y	Y
NCEPOD – Rehabilitation following critical illness	Y	Y
National Clinical Audit	ESHT Eligible	ESHT Participation
National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standard QS138	Y	Y
National Comparative Audit of Blood Transfusion – Bedside Transfusion Audit	Y	Y
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y	Y
National Audit of Seizures and Epilepsies in Children & Young People (Epilepsy 12)	Y	Y
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Y	Y
National Maternity and Perinatal Audit (NMPA)	Y	Y
Neonatal Intensive and Special Care (NNAP)	Y	Y
Adult Critical Care Audit (Case mix programme - ICNARC)	Y	Y
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	Y	Y

FFFAP – Inpatient Falls	Y	Y
FFFAP – National Hip Fracture Database	Y	Y
National Joint Registry (NJR)	Y	Y
National Gastrointestinal Cancer Audit Programme – Bowel Cancer	Y	Y
National Gastrointestinal Cancer Audit Programme – Oesophago Gastric Cancer	Y	Y
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Y	Y
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Y	Y
National Prostate Cancer Audit	Y	Y
National Lung Cancer Audit (NLCA)	Y	Y
Major Trauma (TARN)	Y	Y
National Audit of Coronary Angioplasty / PCI	Y	Y
Cardiac Rhythm Management (CRM)	Y	Y
National Joint Registry (NJR)	Y	Y
National Gastrointestinal Cancer Audit Programme – Bowel Cancer	Y	Y
National Gastrointestinal Cancer Audit Programme – Oesophago Gastric Cancer	Y	Y
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Y	Y
National Heart Failure Audit	Y	Y
Acute Coronary Syndrome / Acute MI Audit (MINAP)	Y	Y
National Audit of Cardiac Rehabilitation	Y	Y
National Cardiac Arrest Audit (NCAA)	Y	Y
National Inflammatory Bowel Disease Programme*	Y	N
National Emergency Laparotomy Audit (NELA)	Y	Y
Elective Surgery (National PROMs Programme)	Y	Y
National Paediatric Diabetes Audit (NPDA)	Y	Y
National Pregnancy in Diabetes (NPID) Audit	Y	Y
National Diabetes Inpatient Safety Audit	Y	Y
National Diabetes Foot Care Audit (NDFCA)	Y	Y
National Diabetes Adult Audit	Y	Y
National Diabetes Audit Integrated Specialist Survey	Y	Y
National Ophthalmology Database (Adult Cataract Audit)	Y	Y
Perioperative Quality Improvement Programme	Y	Y
Stroke National Audit (SSNAP)	Y	Y
Learning Disability Mortality Review Programme (LEDER)	Y	Y
Adult Respiratory Support Audit	Y	Y

National COPD Audit Programme - Pulmonary Rehabilitation	Y	Y
National COPD Audit Programme – COPD in Secondary Care	Y	Y
National COPD Audit Programme – Adult Asthma	Y	Y
National COPD Audit Programme – Paediatric Asthma	Y	Y
Society for Acute Medicine’s Benchmarking Audit (SAMBA)	Y	Y
Care of Older People	Y	Y
Mental Health and Self Harm	Y	Y
National Audit of Dementia (NAD) - Care in general hospitals	Y	Y
National Audit of Care at the End of Life (NACEL)	Y	Y
BAUS Nephrostomy Audit	Y	Y
British Hernia Society Registry	Y	Y
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Y	Y

Appendix 2 – Participation in Mandatory Clinical Audits

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, and for which data collection was completed during 2023/24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Number of Cases submitted	% Submitted of those required
National Audit of Dementia (NAD) - Care in general hospitals	EDGH – 40 CONQUEST - 40	100% (all required data submitted)
National Adult Diabetes Audit	Trust - 16850	100% (all required data submitted)
National Pregnancy in Diabetes Audit	EDGH – 9 CONQUEST - 14	100% (all required data submitted)
National Paediatric Diabetes Audit	Trust - 196	100% (all required data submitted)
National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standard QS138	EDGH – 20 CONQUEST - 26	100% (all required data submitted)
Adult Respiratory Support Audit	EDGH – 0 CONQUEST - 6	100% (all required data submitted)
Society for Acute Medicine's Benchmarking Audit (SAMBA)	EDGH - 56 CONQUEST - 42	100% (all required data submitted)
Winter Society for Acute Medicine Benchmarking Audit (SAMBA)	EDGH - 64 CONQUEST - 42	100% (all required data submitted)
BAUS Nephrostomy Audit	Trust – 18	100% (all required data submitted)
Testicular Torsion (NCEPOD)	6 x Clinical Questionnaires 6 x Case notes 2 x Organisational Questionnaires	100% (all required data submitted)
End of Life Care (NCEPOD)	12 x Clinical Questionnaires 12 x Case notes	100% (all required data submitted)
Juvenile Idiopathic Arthritis (NCEPOD)	12 x Clinical Questionnaires 12 x Case notes 2 x Organisational Questionnaires	100% (all required data submitted)

Glossary

Acute Kidney Injury

Acute Kidney Injury (AKI) is sudden damage to the kidneys that causes them to not work properly. It can range from minor loss of kidney function to complete kidney failure.

Aerosol Generating Procedures

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

Ambulatory Emergency Care

Ambulatory Emergency Care (AEC) is the provision of same-day emergency care for patients who would otherwise be considered for emergency admission.

Amniotic Fluid Embolism

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

Anti-thrombin in Pregnancy

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

After Action Reviews (AARs)

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

BAME

Umbrella term used to describe non-white ethnicities

Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations.

Visit: www.cqc.org.uk

Centor Criteria

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

CHKS

CHKS is a provider of healthcare intelligence and quality improvement services. This includes hospital benchmarking and performance information to support decision making and improvement.

Cirrhosis in Pregnancy

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

Clinical Audit

Clinical Audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clostridium difficile or C. difficile / C.diff

Clostridium difficile (also known as 'C. difficile' or 'C. diff') is a gram-positive bacteria causing diarrhoea and other intestinal disease when competing bacteria in a patient or person's gut are wiped out by antibiotics.

C. difficile infection can range in severity from asymptomatic to severe and life-threatening, especially among the elderly.

Commissioning for Quality and Innovation (CQUIN)

High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Computerised Tomography (CT) scan

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

COVID-19

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

Culture

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

Data Quality

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

Data Security and Protection Toolkit (DSPT)

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

Datix/DatixWeb

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

Department of Health (DOH)

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

Deteriorating patient

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

Diabetic Ketoacidosis in Pregnancy

This is an infrequent complication of pre-gestational or gestational diabetes mellitus during pregnancy (high blood sugar levels that develops during pregnancy).

Discharge

The point at which a patient leaves hospital to return home or be transferred to another service or, the formal conclusion of a service provided to a person who uses services.

Division

A group of clinical specialties managed within a management structure. Each has a clinical lead, nursing lead and general manager.

Duty of Candour (DoC)

Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory duty of candour be introduced for health and care providers. This is further to the contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. In interpreting the regulation on the duty of candour we use the definitions of openness, transparency and candour used by Robert Francis in his report:

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it

DOLS (Deprivation of Liberty Safeguards)

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

Excellence in Care (EIC)

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

Electronic Prescribing and Medicines Administration (ePMA)

ePMA is a web-based system which will replace the traditional paper medication charts

eTriage System

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

FeverPAIN criteria

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

Fontan

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

Friends and Family Test (FFT)

The NHS Friends and Family Test (FFT)

were created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give their views after receiving care or treatment.

General Medical Council (GMC)

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

Glasgow Coma Scale

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

Guardians of Safe Working Hours (GOSWH)

GOSWHs champion safe working hours for junior doctors. The roles are independent from the Trust management structure and are supported by the British Medical Association (BMA) to:

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

Healthwatch

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

Hospital Episode Statistics

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

Hospital Standardised Mortality Ratio (HSMR)

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

Integrated Performance Review (IPR)

Meeting attended by members of Trust board, senior leads from the division, Finance, HR, Knowledge Management

ICNARC

The Intensive Care National Audit and Research Centre.

Integrated Care Board (ICB)

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

Key Performance Indicators (KPIs)

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

Lumbar Puncture

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

Methicillin Resistant Staphylococcus Aureus (MRSA)

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

Methicillin Sensitive Staphylococcus Aureus (MSSA)

MSSA is a type of bacteria that is not resistant to antibiotics.

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

The Confidential Enquiry into Maternal Deaths is a national programme investigating maternal deaths in the UK and Ireland. Since June 2012, the CEMD has been carried out by the MBRRACE-UK collaboration, commissioned by the Healthcare Quality Improvement Partnership.

Multidisciplinary

Multidisciplinary describes something that combines multiple medical disciplines. For example, a 'Multidisciplinary Team' is a group of professionals from one or more clinical disciplines who together make decisions regarding the recommended treatment of individual patients.

National Audit of Dementia

The National Audit of Dementia is commissioned on behalf of NHS England and the Welsh Government. They measure the performance of general hospitals against standards relating to delivery of care which are known to impact people with dementia while in hospital. The standards are from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals charter and reports from the Alzheimer's Society, Age Concern and Royal Colleges. National Clinical Audit Patient Outcomes Programme (NCAPOP) Set of national clinical audits, registries and confidential enquiries which measure healthcare practice on specific conditions against accepted standards. These projects give healthcare providers' benchmarked reports on their performance, with the aim of improving the care provided.

National Confidential Enquiry into Patient Outcome and Death – NCEPOD

reviews clinical practice and identifies potentially remediable factors in the practice of anaesthesia and surgical and medical treatment. Its purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public. It does this by reviewing the management of patients and undertaking confidential surveys and research, the results of which are published. Trust clinicians participate in national enquiries and review the published reports to make sure any recommendations are put in place.

National Institute for Health and Clinical excellence (NICE)

The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk

NerveCentre

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

NHS Digital

Formerly the Health and Social Care Information Centre (HSCIC), NHS Digital is the national provider of information, data, IT infrastructure and systems to the health and social care system.

NHS England (NHSE) and NHS Improvement (NHSI)

From 1st April 2019 NHS England and NHS Improvement began working together as a single organisation, designed to better support the NHS to deliver improved care for patients and support delivery of the NHS Long Term Plan.

Ofsted

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

Patient Reported Outcome Measures (PROMs)

All NHS patients having hip or knee replacement, varicose vein surgery or groin hernia surgery are invited to fill in a PROMS questionnaire. The questionnaire's aim is to find out about the patients' health and quality of life, before and after the operation. This enables hospitals to measure their success and make improvements supported by feedback from patients on the reported outcomes of their surgical intervention and compare themselves to other Trusts nationally.

Peripartum Hyponatraemia

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

Personal Protective Equipment (PPE)

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

Polymerase Chain Reaction (PCR)

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

Pressure ulcers

Pressure ulcers develop when a large amount of pressure is applied to an area of skin over a short period of time, or they can occur when less force is applied but over a longer period of time.

Protein C Deficiency in pregnancy

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

Providers

Providers are the organisations that provide NHS services, e.g. NHS trusts and their private or voluntary sector equivalents.

Public Health England (PHE)

Public Health England (PHE) is an executive agency of the Department of Health and Social Care. PHE provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific expertise and support.

Perinatal Mortality Review Tool (PMRT)

A collaboration led by MBRRACE-UK has been appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'.

The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

PSIRF Patient Safety Incident Response Framework

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

Research

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

Risk Adjusted Mortality Indicator (RAMI)

The Risk Adjusted Mortality Indicator (RAMI) is a mortality rate that is adjusted for predicted risk of death. It is usually used to observe and/or compare the performance of certain institution(s) or person(s), e.g. hospitals or surgeons.

Root Cause Analysis (RCA)

RCA is a method of problem solving that tries to identify the root causes of faults or problems that cause operating events. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing correction on root causes, problem recurrence can be prevented.

Rupture of Membranes

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

ReSPECT

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

Rockwood score

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

Schwartz Round

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

Secondary Uses Service (SUS)

The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support NHS in the delivery of healthcare services.

Sepsis

The body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure and death.

Serious Incident (SI)

A Serious Incident is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where healthcare is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern.

Speak Up Guardian

A person who supports staff to raise concerns.

SPINE

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

StEIS

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

Strategy

A high-level plan of action designed to achieve long term or overall aims.

Summary Hospital-level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation is in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust (where 1.0 represents the national average). Depending on the SMHI value, Trusts are banded between 1 and 3 to indicate whether their SMI is low (3), average (2) or high (1) compare to other Trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.

Surgical Site Infection

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

Surgical Site Infection Surveillance Service (SSISS)

The Surgical Site Infection Surveillance Service (SSISS) helps hospitals across England record and follow-up incidents of infection after surgery, and use these results to benchmark, review and change practice as necessary.

Supportive and Palliative Care Indicators Tool (SPICT)

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

Treatment Escalation Plan (TEP)

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

Trust Board

The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance, and helping to promote links between the Trust and the community.

Trauma Risk Management (TRiM)

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

UK Obstetric Surveillance System (UKOSS)

The UK Obstetric Surveillance System is a national system established to study a range of rare disorders of pregnancy, including severe near-miss maternal morbidity.

Venous Thromboembolism (VTE)

Blood has a mechanism that normally forms a 'plug' or clot to stop the bleeding when an injury has occurred, for example, a cut to the skin. Sometimes the blood's clotting mechanism goes wrong and forms a blood clot when there has been no injury. When this happens inside a blood vessel, the blood clot is called a thrombus. When the blood clot is deep inside one of the veins in the body, most commonly in the leg, it is called deep vein thrombosis (DVT). If the blood clot comes loose it can travel through the bloodstream to the lungs. This is called pulmonary embolism and it can be fatal. DVT and pulmonary embolism together are known as venous thromboembolism.

VitalPAC

Is a mobile clinical system that monitors and analyses patients' vital signs to identify deteriorating conditions and provide risk scores to trigger the need for further necessary care. It removes the need for paper charts and manages scheduled observations based on clinical need.

Virtual Wards

Virtual wards allow patients who are acutely unwell to get the care they need at home safely and conveniently, rather than being in hospital.

In a virtual ward, new technology such as wearable devices, oxygen and blood pressure monitors along with apps, are available where necessary to provide real-time information on people's vital signs

VOICE

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



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