East Sussex Healthcare
NHS Trust

QUALITY ACCOUNT

2024/25

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

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Part 1 - Introduction

Social Media

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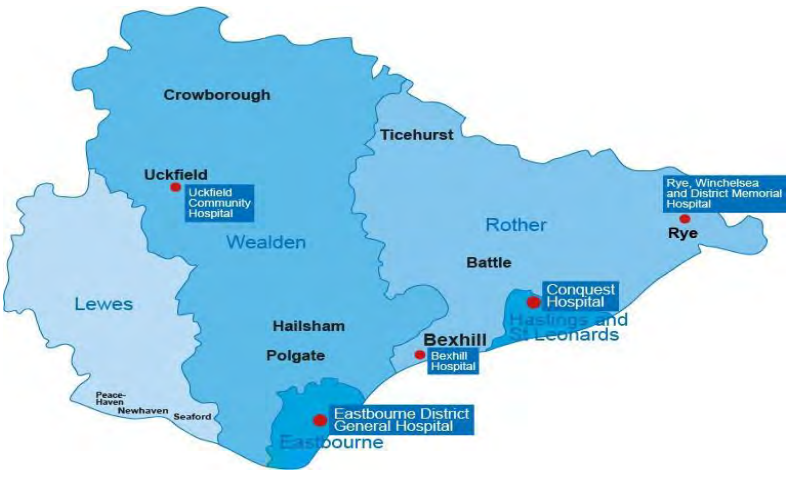
About the Trust

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 £720 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. Conquest Hospital and our Community** Services were rated **'Outstanding'** and Eastbourne District General Hospital 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 trauma services and obstetrics is at Conquest Hospital while our centre for urology and stroke services is at Eastbourne DGH.



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

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

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

Statement of Quality from the Chief Executive

As the new Chief Executive of East Sussex Healthcare Trust, I am delighted to present our Quality Account for the year 2024/25.

This report is a summary of our unwavering commitment to delivering safe, effective and compassionate care to every patient, every day.

Over the past year, our teams have continued to demonstrate extraordinary dedication and resilience in the face of ongoing challenges across the healthcare system. Despite pressures on capacity and workforce, we have made significant strides in improving patient outcomes, enhancing safety, and listening more closely to the voices of those we serve.

Chief Executive
Jayne Black

Our key achievements include:

- Improving patient safety by recording patients' weights more accurately, which helped to ensure that the correct dose of paracetamol was given in nearly all cases.
- Enhancing clinical effectiveness by reviewing processes and providing further staff training, which has led to fewer rejected lab samples over the past year, especially in our Emergency departments.
- Strengthening patient experience by identifying inconsistencies in how consent decisions were recorded for patients who lack capacity.
- We are now planning a more in-depth training schedule and developing clearer documentation to address this issue.
- A 100% participation rate in eligible national clinical audits and confidential enquiries; receiving a Gold Award in the National Joint Registry (NJR) as a recognition of our excellent data quality.

- Improvement in our incident reporting culture, evidence of our high level of safety consciousness.
- Improvement in data capture for protected characteristics and patient safety.
- Introducing several wellbeing initiatives for staff including enhanced men's health and menopause support, and the achievement of the Silver Wellbeing at work award.

We remain committed to continuous improvement and delivering high-quality care across East Sussex.

We look ahead to the coming year with a strong focus on integrated care, improving mental ill health awareness and support for our patients, and shining a dedicated spotlight on safer care for our patients and staff wellbeing, as outlined in our quality priorities for 2025/26.

Thank you all for your ongoing support.

Jayne Black
Chief Executive

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 the 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

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Part 2.1 - Priorities for Improvement in 2025/26

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 2025/26

- Patient Experience – Community intermediate care rehabilitation model
- Patient Safety - Improving the care of patients with mental ill health
- Clinical Effectiveness - Increasing the quality of WHO Safety Checklist compliance across the Trust

Patient Experience Priority

Community Intermediate Care Rehabilitation Model

Why this has been chosen as a priority for our Quality Account?

This is an opportunity to improve patient experience of care with a single community or 'step-down' offer from hospital.

Patients do not need to be on one waiting list or another to get the support that they need to go home, and this could be avoided with a 'one team' approach with the patient at the Centre, with the planning based on patient needs.

This one-team approach would improve the clarity of the delivery model (not multiple different service criteria), it would reduce duplication of referrals and wait times and should release capacity in community services. There would also be a reduction in community deconditioning and increased risk that is evident in long waits to access community services, which then impacts on risks of readmission or secondary complications.

What are we going to do?

Development of a single integrated Intermediate Care service (including our community beds and wider community services) with a single point of access to ensure that we match the right clinical and care skills to support patients to get home. This would be an integrated approach with Urgent Community Response, Virtual Wards, community therapy including Stroke and our Uni-Disciplinary services (Speech and Language, Dietetics and Podiatry services). There would also be an opportunity to include Adult Social Care and Reablement services as well as our Community Voluntary sector partners. The integrated Intermediate Care service could also support both in-reach and out-reach care to best meet patient needs.

What will success look like?

Success will be a streamlined and simplified integrated care approach through one pathway to support patients in going home after hospital (currently there are at least five access routes), which would be able to provide:

- A reduction in the need to understand and identify specific separate services to support patients.
- Improved equitability of access to responsive and intensive community home based therapy (currently this is only offered in the Stroke early supported discharge pathway).
- A broader range of skill sets to meet patient needs, reducing referrals and hand-offs and hidden waits.
- Improved clinical decision making with a cohesive, Multidisciplinary Team (MDT) approach.
- A reduction in the risk of deconditioning for people who have long waits to access community therapy.
- A reduction in the number of people needing long term care placement, due to responsive rehabilitation and reablement.
- A reduction in the length of stay across both acute and community beds.
- Reduced duplication of referrals for the same patient and better integration between health and care.

From the NHSE Intermediate care Framework Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge:

Implementation of step-down intermediate care as outlined here is expected to result in improved outcomes, experiences and independence of people discharged, reduced avoidable hospital readmissions, and reduced avoidable/premature long term care provision.

Further expected benefits include improved flow and discharge from acute and community hospitals, freeing up NHS hospital capacity for those who need it most.

How will we monitor progress?

- Audit against the Intermediate care framework using the Intermediate care maturity self-assessment NHS England » Integrated urgent and emergency care pathway maturity self-assessment
- Audit against the Community Rehabilitation Alliance standards - self-assessment for all community therapy services to be launched soon in Sussex.
- We will also review our operational metrics including length of stay, delays in discharge and community waiting times.

Patient Safety Priority

Improving the care of people with mental ill health

Why has this been put forward as a priority option for our Quality Account?

There has been an increase in people with mental ill health attending acute care settings over the last three years - between December 2022 and December 2024, ESHT saw 11,447 Mental Health (MH) attendances across Conquest and EDGH.

Length of stay (LOS) for these patients has increased as the availability of MH beds has fallen, necessitating the admission of patients whose sole reason for attending is an MH disorder into acute beds. Not only does this reduce the availability of beds for medically unwell patients, but it also places additional pressure on ward staff who often must manage challenging behaviour, not infrequently associated with violence and aggression.

This has also necessitated an increase in security staffing and an additional temporary staffing cost as a result.

The current situation is suboptimal for all involved - clinical staff not specifically trained in meeting MH patients' needs are increasingly being asked to do so, and this is not only challenging for the staff but is also less than ideal for patients who often may receive care that is more focused on behavioural management and control rather than on therapeutic interactions.

This is compounded in cases where security staff are involved. Although the team does excellent work in treating MH patients with respect and compassion, they are not clinical staff and as such are naturally focused on controlling the situation. It has also been anecdotally reported that some MH patients find their presence intimidating, due to their Police-like appearance. Other patients and members of the public are also at times adversely affected by the presence of patients with mental ill health in acute care areas.

Overall, this presents a risk to the organisation that care may be sub optimal, and a subsequent risk that there may be a deterioration in the behaviour and wellbeing of MH patients in our care at ESHT whilst awaiting MH beds.

What are we planning to do?

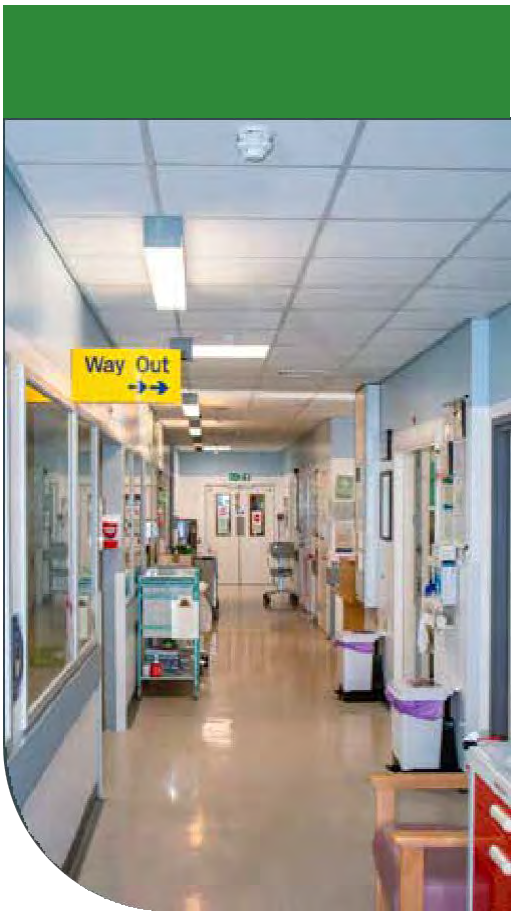
Improvements to this area of care will require a multi-faceted approach, these will be delivered in stages…

Collaboration with the wards, local Mental Health Trust, Local Authority, **voluntary, community and social enterprises (VCSEs) and other arm's** length providers -

Continue to liaise with and work with MH Trust colleagues through a defined Service Level Agreement (SLA) and joint operational policies to achieve optimal provision of care for the patients, including bed escalations and alternatives to admission. Link with wards and the Mental Health Liaison Team (MHLT) to ensure holistic care of patients using available resources:

- Clear referral pathway.
- Removal of unnecessary steps to referrals and creating more accessible forms of referral other than telephones.
- Bleeps issued to both teams – mental health liaison team and mental health outreach team.

Development of a hospital Mental Health Outreach Team (MHOT) to provide enhanced therapeutic observations of care (ETOC):



Recruit and train specialised mental health professionals.

- The post of MH lead nurse was created in early 2024 and the new appointee began work in January 2025. This post holder will provide expert guidance to colleagues, facilitate early and continual review of the complex needs of MH patients and liaise with external MH colleagues. They will also provide leadership to the newly formed Mental Health Outreach team (MHOT).

- Development of a Mental Health Outreach Team for the provision of ETOC for patients who present with mental health crises in an acute hospital. This is aimed at significantly improving the quality of care provided, improving patient outcomes, and contributing to the efficient and effective operation of patient care, treatment & flow across all areas.

- The pilot team at the EDGH will consist of x 10.0 WTE MH Clinical Support Workers (CSWs) at Band 3 and x 1.0 WTE Band 6 Registered Mental Health Nurse (RMN).

- Parallel Assessment in the Emergency Department/ wards - MHOT RMN will conduct parallel assessments to safely expedite the flow of mental health patients through the Emergency Department (ED), make early referrals to the Liaison Psychiatry service for patients with physical and mental health needs. Joint or parallel assessment can facilitate earlier mental health assessment and decision-making and consequently expedite discharge planning. The notion of 'not being medically fit for assessment' will be addressed so that patients can be seen according to all their needs, both physical and psychological.

The pilot will be evaluated and will inform the delivery of future service across both acute hospital sites.

Improved Patient Outcomes:

'Front of **House'** triage and initial risk assessment of people with mental ill health in the Emergency Department (ED) - this is aimed at delivering parity of esteem between MH patients and others who attend the ED.

It will facilitate early therapeutic engagement and reduce the referral time to MHLT and the Length of Stay in the hospital. There is hope that this will enhance patient's adherence to treatment, reduce complications and support emotional wellbeing of the patients/staff.

The Mental Health Outreach Team (where appropriate) will provide specialised and focused care, leading to better mental health outcomes for patients. This includes quicker assessment, timely interventions, and individualized treatment plans as identified by the enhanced clinical framework. This intervention will lead to better overall outcomes for all.

Regulatory Compliance:

The importance of providing quality mental health care within acute hospital settings has been emphasised by the national and regional healthcare regulatory bodies. Support for the concept of enhanced care teams in the UK can be found in various healthcare policy documents, professional organisations (CQC reports, NICE guidelines, NHS Long-term Plan, Royal College of Psychiatry and so on).

Stigma Reduction:

The integration of mental ill health provision within acute hospitals helps reduce the stigma associated with mental ill health disorders. Patients will be provided with personalised care plans jointly developed with the local MH Trust and this will create a supportive stigma-free environment, leading to improvement in patients' satisfaction and outcome.

Enhance Staff Competency:

Devise care protocols in line with the enhanced therapeutic observations care framework. Offer ongoing training and professional development opportunities for healthcare staff across the Trust, to improve their mental health care skills. This will be achieved through the enhanced clinical framework for mental health.

Rolling Mental Health Training:

Liaise with Sussex Partnership Foundation Trust (SPFT) to deliver rolling MH training for all staff across ESHT as part of the Psychiatry Liaison Network best practice standards (PLAN). This will provide learning across Children, Adults, Older Adults, Neurodiversity and Learning Disabilities services.

Mental Health E-Learning:

Providing additional training to acute care staff via The Maudsley Hospital learning model in de-escalation techniques and therapeutic interaction with MH patients.

Infrastructure:

Designated fit for purpose triage room within the ED at the EDGH for the registered mental health nurse to assess patients.

The long-term projection beyond 2025/26 is to work with the estates team and relevant authority to allocate space and resources for the MHOT.

Consideration for a Transfer and Assessment Facility (TAF) that will cohort suitable patients, accommodate the MHOT and MHLT to deliver safe and effective care as well as free up medical beds.

Shared IT interface -

Clinical noting facility for MHLT and relevant ESHT staff to ensure seamless handover and updating of clinical information to expedite patient care, for example: updating risk assessments and access to historical risks when considering care /safety formulations.

Reduction in incidents of violence and aggression:

With timely therapeutic engagements with patients, it is envisaged that the visibility of security personnel in clinical environments to manage disturbed patients' behaviours will be reduced and only deployed as last resort and reviewed accordingly. This will in turn lead to:

- Prevention of Escalation:

Through the provision of early risk assessments, interventions (medication) and close monitoring, it is hoped that MHOT can prevent the escalation of mental health crises, reducing the need for emergency interventions or intensive care.

- Reduced Hospital Length of Stay:

Timely and specialised care can potentially reduce the length of hospital stay for mental ill health patients, freeing up hospital resources and minimizing disruptions in patients' lives.

- Staff Safety / Satisfaction:

Through the above provision, there will be support throughout the MH journeys of patients in ESHT, creating the added benefits of a reduction in burn-out, sickness and creating staff satisfaction. We are also offering career advancement opportunities to mitigate some of the challenges associated with staff retention.

- Staff Safety and Wellbeing:

It is proposed that the MHOT will be provided with personal alarms to provide extra security when lone working. This will enhance the ability to seek timely help where appropriate.

What will success look like?

Ultimately the hope remains that systems and processes will be developed that will reduce the delay for patients that require admission to specialist MH beds, and ESHT will continue to work with their MH partners to facilitate this as much as possible.

However, in the context of extremely challenged MH bed availability, locally and nationally, success at ESHT may be measured as:

- Earlier referral and earlier appropriate intervention for MH patients by application of the fit to assess model. To be monitored including the response time by MHLT (within one hour).
- Better quality care for MH patients in terms of therapeutic interactions and patient experience.
- A reduction in the use of security staff to monitor or control behaviours of MH patients.
- A reduction in incidents related to violence and aggression, specific to MH patients, but also risk of harm to the MH patients themselves.
- Evidence of qualitative feedback from MH patients and staff being used to develop our services.
- Improved Patient Care and Treatment: Enhanced care by specialised staff enhances treatment adherence, reduces complications, and supports patients' emotional well-being, and reduce stressors as patients are managed safely as they wait for their MH inpatient admissions. There are soft therapies and activity planning with patients to actively engage with them, thereby reducing complications like challenging behaviours to communicate unmet needs.

Enhanced Reputation:

Offering high-quality mental health care can improve the hospital's reputation and attract more patients. Providing parity of esteem for the management of patients with mental ill health concerns helps deal with stigma and enhances hospital reputation.

Staff Satisfaction and wellbeing:

Feedback from and involvement in the development of the service. Monitoring of retention rates and leavers. There is mental health training for staff on the Mylearn system and opportunities for de-brief provided. Bespoke mental health training for specialist areas are also being considered.

Financial efficiencies:

By preventing complications and potentially reducing the length of stay, MHOT can help reduce the financial burden on the healthcare system, it will also assist in reducing the agency spend of providing enhanced care for mental ill health patients.

How will we monitor progress?

Implementation of the new Mental Health Task Force and Strategy Group. Routine quarterly reporting into the Quality and Safety Committee.

Outcome measures

The Mental Health Outreach Team's quality will be monitored and evaluated, including:

- Key Performance Indicators (KPIs), benchmarks, and continuous improvement strategies.

We aim to implement a robust monitoring and evaluation system to assess patient outcomes and Teams performance. For example, the referrer satisfaction scale for the Mental Health Liaison Team through evidence-based outcome measures like:

- Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP)

And other frameworks such as:

- PREMs (Patient Reported Experience Measures)
- PROMs (Patient Reported Outcome Measures)
- FFTs (Friends and Family Test)
- Incident reporting
- KPIs (Key Performance Indicators)
- Benchmarks
- Continuous improvement strategies

Clinical Effectiveness Priority

Increasing the quality of WHO Safety Checklist compliance across the Trust

Why this has been chosen as a priority for our Quality Account?

The World Health Organisation has undertaken several global and regional initiatives to address surgical safety including the introduction of the Safe Surgery Checklist. The checklist identifies the three phases of an operation, each corresponding to a specific period in the normal flow of work:

- Sign In — Before the Induction of anaesthesia
- Time Out — Before the incision of the skin
- Sign Out — Before the patient leaves the operating room.
- PACU — Signed by PACU at handover of patient

In each phase a checklist coordinator must confirm that the surgery team has completed the listed tasks before the operation begins.

The National Patient Safety Agency introduced the World Health Organisation (WHO) surgical checklist as an alert in February 2009.

Monthly spot check audits have been carried out since June 2011 to assess compliance with a random five patients undergoing a procedure in areas such theatre, endoscopy, cardiology and radiology (a total of 41 areas are assessed).

The use of the surgical safety checklist has been implemented to enhance patient safety and reduce the risks of clinical incidents. The completion of the checklist as part of a quality monitoring system provides assurance to the organisation that patients are being safely prepared and cared for during operative/invasive procedures.

The best national practice standard is for all spot check audits to achieve 100% compliance with completion i.e. each section of the checklist is fully completed, and if not, action is taken immediately at a local level to address the areas of non / poor compliance.

Following this, an exception report is produced to explain the results and highlight the necessary steps that are now being taken to reduce the risk of non / poor compliance happening again.

There is concern that these audits have become a 'tick box' exercise. To this end areas are encouraged to undertake a live observational study of the WHO checklist, noting areas where there are discrepancies, producing short tracking reports for review across divisional and Trust wide meetings as appropriate.

These live audits should be conducted by each clinical area at least once (ideally twice) a year – low data submission for the live audits has been noted, therefore a Trust wide picture of annual compliance cannot currently be accurately determined.

What are we planning to do?

Cross area review and auditing - staff that undertake the live audits do so outside of their usual clinical area. For example, a Radiology staff member may attend Theatre to look at the WHO checklist practice outside of their normal area of work, and vice versa. This is considered best practice as issues can be identified with fresh eyes, issues that perhaps weren't seen or realized before.

We plan to look at the live auditing requirements in more detail, to understand why these aren't being completed as required – reviewing identified constraints and reasons for any lack of engagement with this process.

An auditing rota may be implemented to monitor compliance and completion across clinical areas.

The current audit tool will also be reviewed to ensure this is as simple (and quick) for staff to complete as possible, ensuring information can be collected easily for addition to the annual report.

What will success look like?

Each area conducts a minimum of two live audits per year, ensuring compliance with best practice national standards. The live audits will enable real time identification of any areas of concern which can be dealt with promptly, any risks will be mitigated, lessons learnt can be shared and areas of good practice highlighted.

How will we monitor progress?

Progress will be monitored at the bimonthly WHO meeting, and through the Trust's reporting structure as necessary – trends will be tracked and any concerns flagged, reviewed and acted upon as necessary. All results will be presented in the annual WHO report.

Part 2.2 - Statements of Assurance from the Board of Directors

Social Media

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During 2024/25 the Trust provided and/or sub-contracted 83 NHS services.

The Trust has reviewed all the data available to them on the quality of care in all 83 of these NHS services.

The income generated by the NHS services reviewed in 2024/25 represents 100% of the total income generated from the provision of NHS services by the Trust 2024/25.

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 2024/25 are detailed below...

National Audit and National Confidential Enquiries Programme

During 2024/25, 70 national clinical audits and five national confidential enquiries covered relevant health services that the Trust provides.

During that period, the Trust participated in 100% 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 2024/25 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 2024/25, 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 2024/25:

- Juvenile Idiopathic Arthritis – Joint Care? - 2025
- End of Life Care – Planning for the End - 2024
- Endometriosis – A long and Painful Road – 2024

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 – Any registered stillbirth (from 24 completed weeks gestation) or neonatal death (from 20 completed weeks gestation) resulting from a termination of pregnancy should be notified. However, only initial notification is required not full surveillance.

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 and 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 2024/25 include:

Study	Cases
Amniotic Fluid Embolism	0
NEW: Long-term non-invasive ventilation in pregnancy	Unable to obtain data (finished March 2025)
Severe respiratory Virus infection in pregnancy and participating in the RECOVERY trial	ESHT not participating in trial
Transabdominal cerclage (TAC)	0
Peripartum Hysterectomy	0
Haemophagocytic Lymphohistiocytosis (HLH)	0

National Clinical Audit Reports in 2024/25

The reports of 11 national clinical audits were reviewed by the Trust in 2024/25. 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 national audits are detailed below with the associated actions that the Trust intends to take (if required) to improve the quality of healthcare provided.

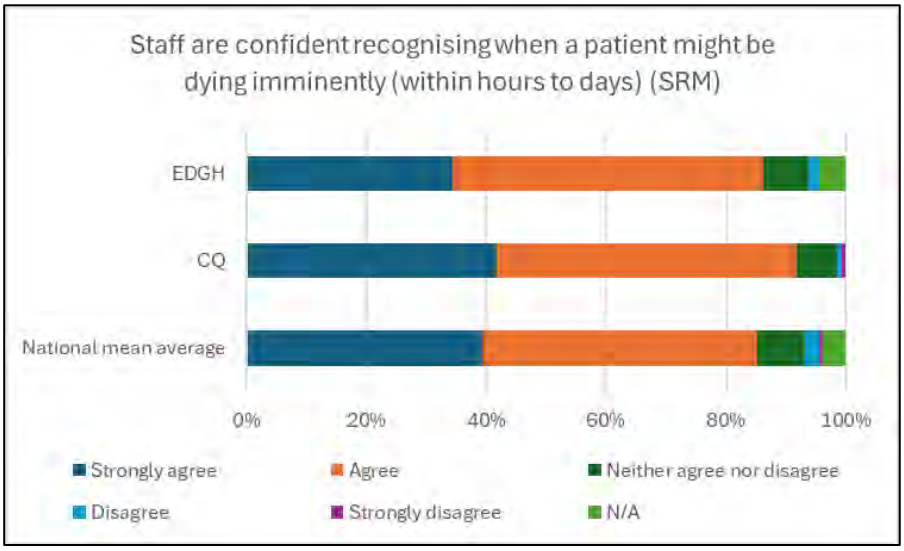
Full details of all mandated national clinical audits and Trust specific results are available online via: www.hqip.org.uk/

The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person (aged 18 and over) and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental ill health inpatient providers in England and Wales.

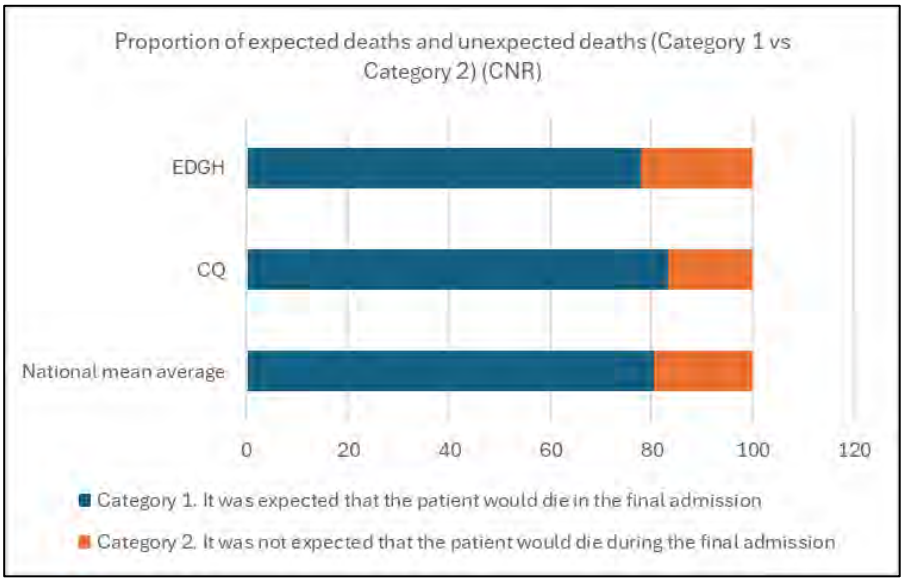
Key Trust results from the 2024 audit

Previous audits demonstrate difficulties in recognising dying and even when recognised, it is often in the final hours before death. The staff reported measure shows that staff generally feel confident in recognising the dying patient, but this is not always reflected in practice.

There are several factors which might influence why dying isn't recognised including parent team / ward changes, family not accepting and conflict with other targets / pathways.



Recognition of dying is clearly documented:

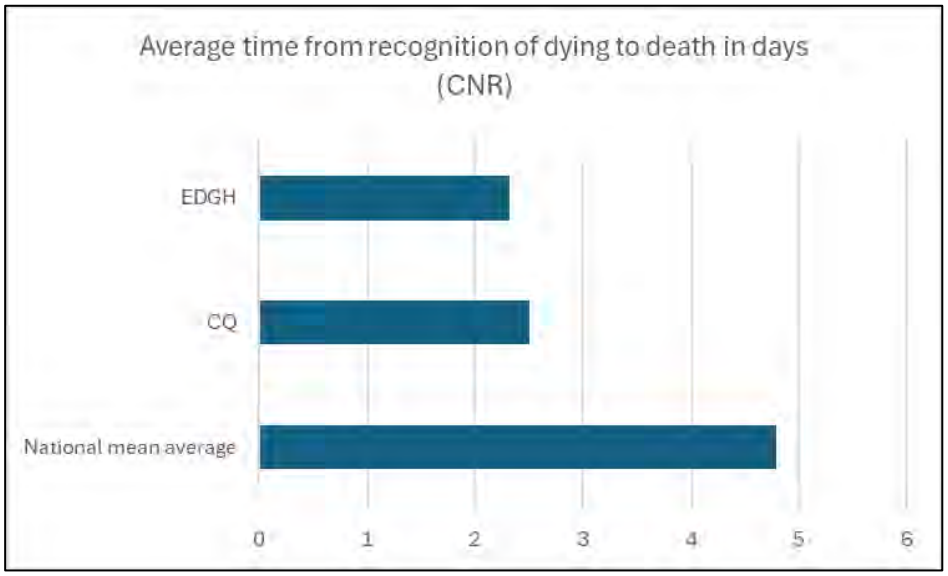


The ESHT End of Life Care improvement group set a target that 90% of deaths would be anticipated / expected, this audit has shown that we have not reached this target, although there has been some improvement as the year progressed. This is particularly the case for Conquest, where 83% of deaths were anticipated and is above the national mean average of 80%.

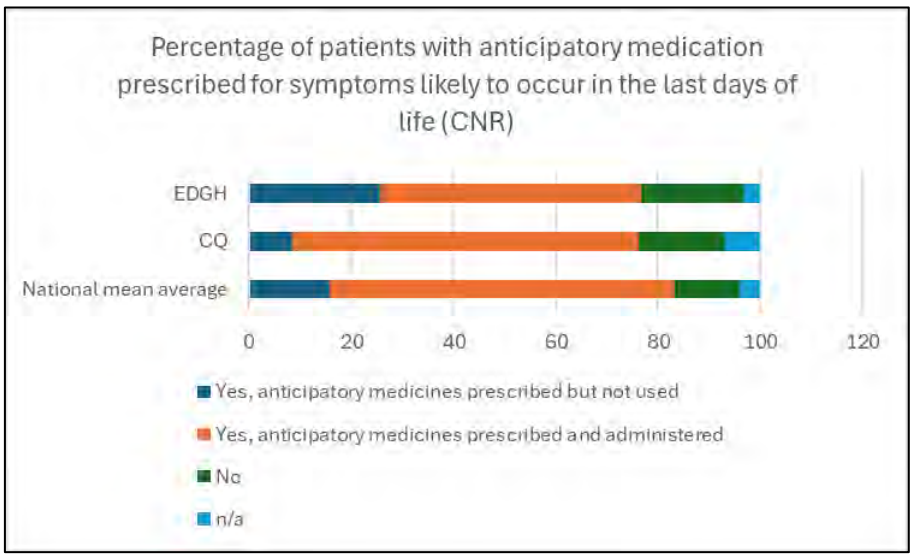
Recognition was lower at Eastbourne Hospital with 78% of deaths anticipated. On reviewing the notes, it often was clear that the patient was deteriorating and were 'sick enough to die' much earlier in their admission but was not formally recognised.

Of those patients whose death was not expected, we also didn't always recognise that they were 'sick enough to die'. Being 'sick enough to die' is when a patient is deteriorating, clinically unstable with limited reversibility and at risk of dying during the episode of care despite treatment. For the audit this would include documentation that the patient may not survive this admission.

Previous audits have consistently demonstrated that dying is recognised very late with little time to prepare patients and those closest to them. There was an average of 2.5 days at CQ and 2.32 days at Eastbourne DGH from documented recognition of dying to death, compared to 4.79 days national sample. But the timeframe ranged from less than an hour to 7 days.



Anticipatory medication is reasoned, prescribed and reviewed regularly

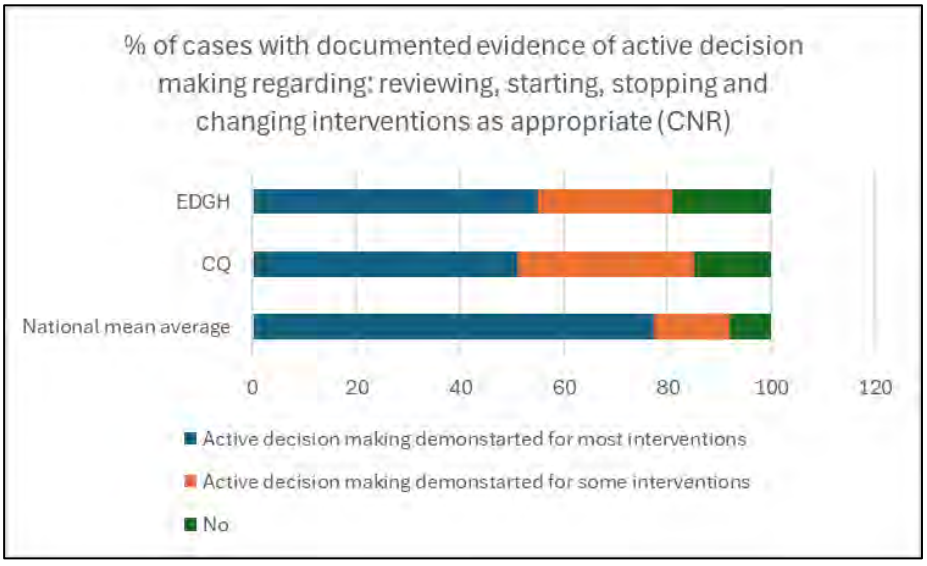


Anticipatory medication is prescribed in anticipation of the common symptoms experienced in the dying person, this includes medication for pain, breathlessness, agitation, retained secretions and nausea.

Prescription of anticipatory medications for the dying person is generally done well as demonstrated in previous audits. If a patient is identified as 'sick enough to die' we would encourage the prescription of anticipatory medicines in case of further deterioration.

Evidence of active decision-making regarding reviewing, starting, stopping and changing interventions as appropriate

When it is recognised that a person is dying there should be a review and clear documentation of which interventions should stop or continue. There is a specific section within the Integrated Care Plan (ICP) for this. Any intervention can continue with a clear rationale, and palliative care will encourage starting the ICP while for example, IV antibiotics continue for another 24 hours.



The Trust remains below the national average with active decision making demonstrated for most interventions.

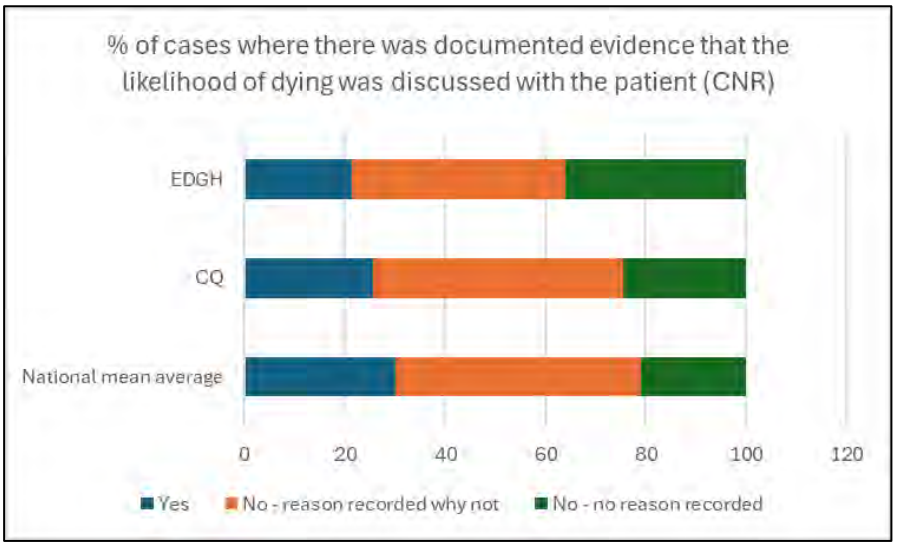
Evidence that staff sought to determine the needs (communication, psychological, spiritual, cultural (including dignity), practical and social) and goals of care of the patient AND evidence that the team tried to address these

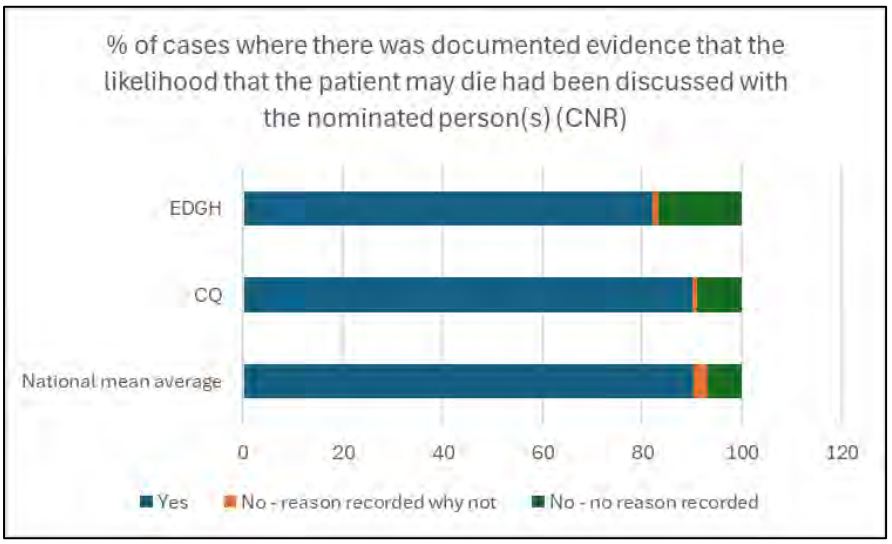
Previous audits, including Excellence in Care, have shown poor results in spiritual needs assessment, with this section of the Integrated Care Plan (ICP) left blank or just showing a record of a visit from chaplaincy, often chaplaincy visits were the only element documented.

Previous audits have demonstrated that there is poor documentation about how we support those closest to the dying person. This is the first time this has been broken down into individual assessments and documentation has remained poor.

Our current ICP does not prompt for specific assessments of those closest to the dying person, which may be why documentation was so poor in this area. But staff report that they are confident in responding to the needs of those important to the dying person including after death. Previous quality audits have shown that family members do feel supported by ward staff.

Communication about dying - The likelihood that the person is sick enough to die is discussed with them and those important to them in an individualised timely way and as appropriate



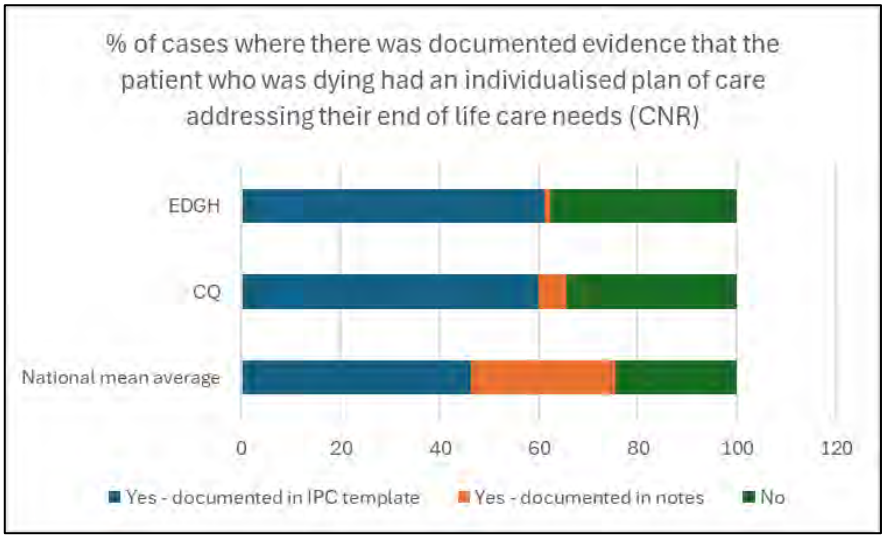


Overall, there is very little documented evidence that discussions are held with the patient that they are likely to die during this admission. Introducing the phrase 'sick enough to die' might help. Using the word 'die' when patients are acutely unwell might help patients and those closest to them to have a warning of how unwell the patient is and may help with decision making about what is most important to the patient. There is usually clear documentation of the discussion with the nominated person about the likelihood of dying, the ICP is usually started following these discussions.

Staff have the knowledge, skills and experience to communicate sensitively and appropriately with the person who is sick enough to die and those important to them, including re-engaging in discussions as appropriate. This includes communication after a patient has died.

Personalised care and support planning

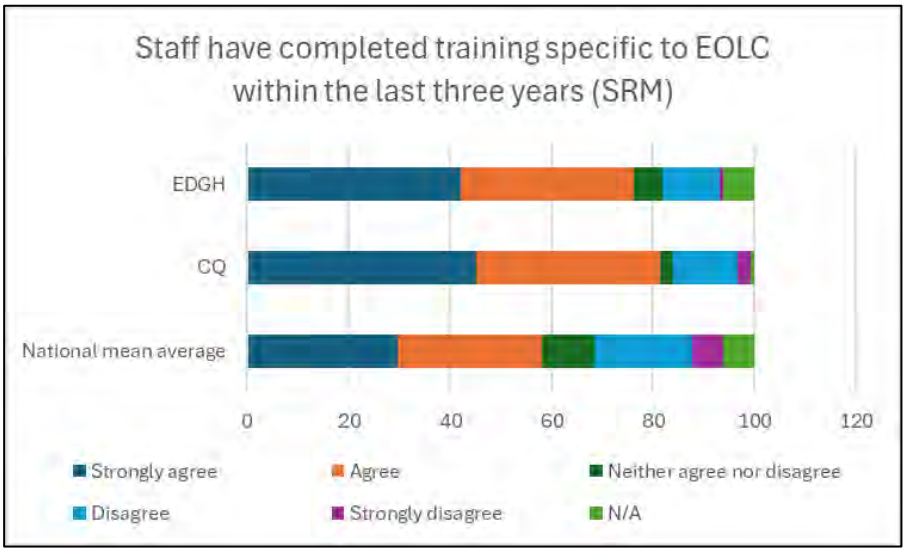
The End-of-Life Care improvement group set a goal of 85% of dying patients having an ICP, unfortunately this was not achieved on either site. Anecdotally this was often due to late recognition of dying, leaving no time to start the ICP.



Advance Care Planning (ACP) conversations generally involved having a completed ReSPECT form, which ideally should be a summary of other types of ACP. Occasionally other forms of ACP were present, usually Lasting Power of Attorney or Preferred place of death. It is currently difficult to find out of ACP has taken place in the community, due to a variety of IT systems in place.

Workforce supported, equipped and engaged to provide end of life care

Staff have 3 yearly training specific to end of life care



EOLC training is mandatory for all staff currently except our senior doctors and includes either face-to-face teaching or reading a leaflet depending on staff role.

Audit recommendations for ESHT:

- Quality Improvement work for 2025/2026 – several projects are now underway to support improvement in this area.
- There are several changes that need to be made to the Trust's Integrated Care Plan (Last days of Life Personalised Care Plan) to include specific prompts around family need assessment and assessments of hydration and nutrition; this will only happen once the new EPR has been agreed, and an End of Life (EOLC) template has been developed. The EOLC mandatory training is used to highlight gaps in assessment and link nurses have also been asked to prompt their colleagues.
- Ongoing work is needed to improve recognition of dying and increasing the use of 'sick enough to die'. This should include training for senior doctors to help with decision making and communication skills around EOLC.
- Increased focus on symptom control on wards, for ward staff of all grades, this is currently being offered by SPCT on an adhoc basis. Referrals to SPCT are being made to help support even minimal symptoms. Formal symptom control teaching sessions will be delivered from April 25.
- Relaunch of the Supportive and Palliative Care team with referral guidelines and referral form planned for April 2025.
- Explore ways to increase participation in the quality survey.

The NACEL will be repeated in 2025, following the same format, but excluding the staff reported measure.

The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement procedures to support work to improve the clinical outcomes for the benefit of patients, but also to provide feedback on surgical performance to orthopaedic clinicians and joint replacement implant manufacturers. The registry collects high quality orthopaedic data to support patient safety, standards in quality of care, and overall value in joint replacement surgery. The 'NJR Quality Data Provider' certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety and to reward those who have met the registry's high targets in the achievement of the quality of the data collected.

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

Conquest Hospital has been awarded as an NJR Quality Data Provider for 2024.

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. Our three-tier: gold, silver and bronze award levels have again been applied to our scheme to encourage all hospitals to achieve the most excellent data quality standard.

The award targets are 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 this award is also a way for us to thank all staff who have worked to achieve compliance targets during the 2023/24 data quality audit year.

The hospital NJR Quality Data Provider Award 2024 certificate serves to recognise and reward the high standards and NJR targets being reached by hospitals.


NJR
National Joint Registry
Working for patients, committed to excellence
This is to certify that
Conquest Hospital
has achieved
NJR
Quality Data Provider Award 2024
Gold
for commitment to patient safety through the registry
CERTIFICATION FOR DATA SUBMISSION & QUALITY
Mr Derek Pegg
Chair, NJR Data Quality Committee
Mr Tim Wilton
Medical Director, NJR
Elaine Young
Director of Operations, NJR

SSNAP | Sentinel Stroke National Audit Programme

The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme. We measure how well stroke care is being delivered in the NHS in England, Wales and Northern Ireland. We provide timely information to clinicians, commissioners, patients and the public so it can be used to improve the quality of care that is provided to patients.

Key Trust results from the 2024 audit

Access to Initial brain imaging Within 1 hour of arrival:

National average = 61.9%

EDGH = 89%

Median time taken from clock start to scan:

Nationally = 00:39 minutes

EDGH = 00:17

Thrombolysis rates

The Eastbourne DGH was selected as one of six hospitals across the UK to participate in the TASC (Thrombolysis in Acute Stroke Collaborative). The projects primary aim was to increase our rate of thrombolysis from 8% to 20% but with a realistic standard aim of 15%...

National average = 12.3%

EDGH = 20.7%

Assessment by Stroke Clinician within 24 hours

National average = 85%

EDGH = 87.7%

Assessment by Stroke Specialist Nurse within 24 hours

90.5% nationally

EDGH = 95.6%

Specialist Pathway - access to a stroke unit within 4 hours of arrival

Standard = 90% stay on a Stroke Unit

National average = 77.8%

EDGH = 89.5%

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.

National Early Inflammatory Arthritis Internal Audit Review

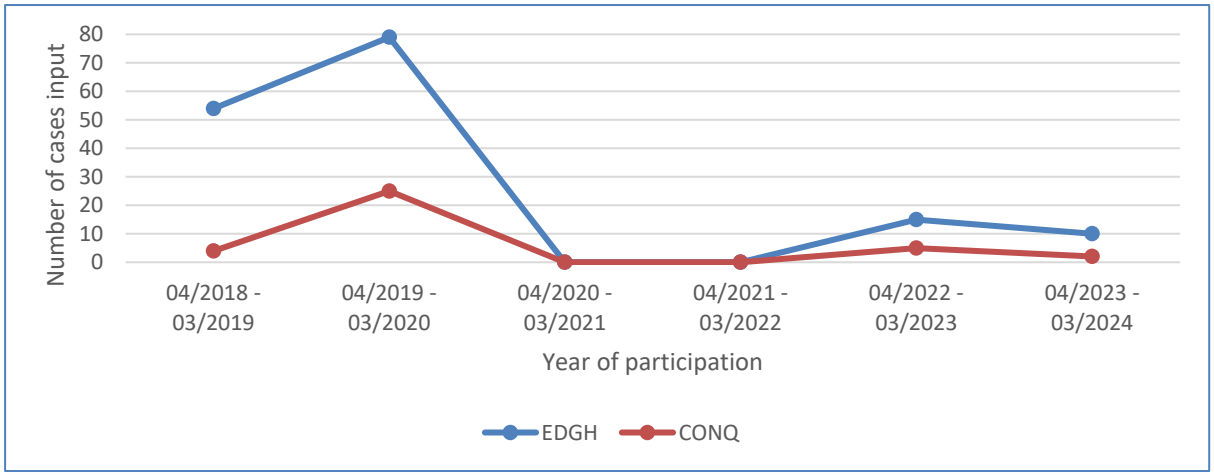
The National Early Inflammatory Arthritis Audit (NEIAA) has been running for 5 years since May 2018. NEIAA recognises that it "has been instrumental in ensuring that people with inflammatory arthritis receive timely diagnosis and treatment through the commitment of professionals and patients across the rheumatology community, NEIAA is the largest outpatient audit in the UK" Changes to The National Early Inflammatory Arthritis Audit (rheumatology.org.uk) capturing information on all new patients over the age of 16 years seen in specialist rheumatology departments with confirmed early inflammatory arthritis, Connective Tissue Disease (CTD) and Systemic Vasculitis in England and Wales.

NEIAA measures the quality of care against NICE Quality Standard 33 **'Rheumatoid Arthritis in over 16s'**

- Adults with suspected persistent synovitis affecting the small joints of the hands or feet, or more than one joint, should be referred to a rheumatology service within 3 working days of presenting in primary care.
- Adults with active rheumatoid arthritis start conventional disease-modifying anti-rheumatic drug (cDMARD) monotherapy within 6 weeks of referral, with monthly monitoring until their treatment target is met.
- Adults with rheumatoid arthritis are given opportunities throughout the course of their disease to take part in educational activities that support self-management.
- Adults with rheumatoid arthritis and disease flares or possible treatment-related related side effects receive advice within 1 working day of contacting the rheumatology service.
- Adults with rheumatoid arthritis should receive a comprehensive annual review that is coordinated by the rheumatology service.

Participation in the National audit is mandatory, since registering the Trust has input a total of 381 cases. The audit requires clinicians to input all cases where the patient (over the age of 16) has had an outpatient appointment, where a new diagnosis of early inflammatory arthritis or suspected early inflammatory arthritis has been made.

Participation in the National audit across the Trust has decreased over the years, in part due to the COVID-19 pandemic. An internal review was conducted in early 2024, at the time of review, the Conquest Hospital had entered a total of 36 cases and the Eastbourne DGH 158 cases to the national audit since participation began in 2018.



Local audit

A local audit was undertaken to quality assess the data being submitted. Patients attending Rheumatology outpatient appointments from the 1st April - 30th November 2023 were requested via our Trust Information Management system.

A total of 181 patients were seen in clinic with a condition relating to arthritis, only 12 of these patients had been entered into the national audit.

50 patients were randomly selected from the population list (not including the 12 patients already entered). Clinic letters were reviewed for newly diagnosed patients.

Results and Conclusion

Out of the 50 patients selected, 34 met the criteria of a newly diagnosed condition and therefore should have been included in the audit. The findings were discussed widely across the Division, and an agreement was made to retrospectively add these missing patients to the audit and devise a plan moving forward to support the department to meaningfully participate in the national study.

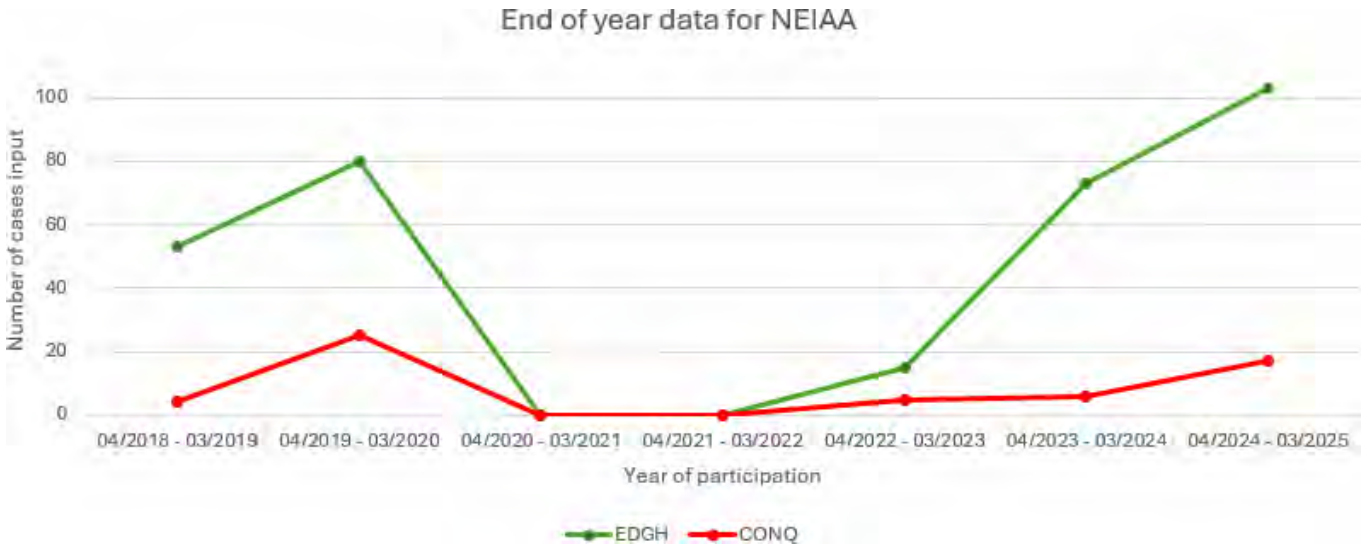
Current Trust status following the Review - March 2025

Significant progress and improved clinical engagement has been evidenced over the past six months, with thanks to the focused efforts of the Medicine Governance Team, Clinical Leads and the Trust's Medicine Audit Facilitator.

Data submission has now increased (progress is tracked monthly). Both sites have achieved the minimum submission requirement), dedicated support continues to be provided to the specialty for this study which is being closely monitored.

The Trust has requested for data submission to be reported as a single Trust wide figure due to lower clinical case load at the Conquest Hospital, however the national audit team has denied this request.

The audit is now no longer flagging as a concern for the Trust - huge congratulations to the team and all involved!



Local Clinical Audit Reports in 2024/25

Local clinical audits and quality improvement projects 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 58 local clinical audits / quality improvement projects were reviewed by the Trust in 2024/25. The Trust scrutinises each set of results to benchmark the quality of care provided, identify successes for celebration and / or identify any risks for mitigation. Recommendations for local improvement and change are considered and tracked via a central clinical audit action plan.

Two of these locally completed clinical audits / quality improvement projects are detailed below with the associated actions that the Trust intends to take (if required).

Reducing Waiting Times for Test Results by Use of a Virtual Clinic Format (1689)

Rationale

One of the major challenges the National Health Service and East Sussex Community Health NHS Trust faces today is managing the number of patients who are waiting for appointments. Current wait times for appointments in urology are between 45-50 weeks for routine and 34-39 weeks for urgent appointments. Urology currently has 2030 patients waiting for appointments. Subsequently what clinical capacity we have must be utilised with care. It is potentially wasteful to use our limited availability to make appointments in order to give results of investigations when this could be done virtually.

Aim of the Project and Planned Intervention

The aim of this quality improvement project is to primarily quantify and demonstrate the reduced waiting times for patients to receive their test results through the use of virtual clinics.

The secondary aim is to increase appointment slots per session of work by a minimum of 20%. A normal face-to-face or telephone clinic will have between 8-12 patient slots (average 10) pending 'did not attends' (DNAs) or 'unable to attends' (UTAs).
The virtual clinic is a session of work where a clinician reviews a list of patients and their investigations in the absence of the patient. It is intended for reviewing negative or minor investigations, surveillance blood tests or other investigations that would not justify generating a face-to-face or telephone appointment to discuss the results.

The patients who fill these clinics are pulled from various sources: new referrals, follow- up appointments or from on call duties.

Baseline Measurement

For the primary outcome, a mean time of 46 weeks (322 days) was used as a reference for the waiting time between an investigation being reported and a clinic being generated. This figure was taken from the Department of Anaesthesia and Surgery waiting times list dated December 2024.

Methodology

The data collection was contemporaneously compiled along with the virtual clinics on Microsoft Excel. The analysis was performed retrospectively again in Excel. No statistical analysis was required given the low numbers.

Timeline

The data collection period was between July to October 2024. Analysis and write up has taken until January 2025.

Results

During the study period a total of three virtual clinics were assessed, these had a total of 42 patients:

- 42 patients were seen in three sessions. Assuming an average of 10 patient slots per clinic, the virtual clinic allowed a 40% increase in the number of appointment slots per session.
- The mean duration between having an investigation and a letter being written was 39 days, which is a marked reduction from the mean time of 46 weeks (322 days) to wait for an appointment.
- A third of patients in the virtual clinics were discharged. 45% required virtual follow up, 12% a face-to-face appointment, and 5% required Patient-
- Initiated Follow Up (PIFU) or upgrading to the Faster Diagnosis Pathway (FDP) respectively.
- The FDP is a new national standard in the UK. It ensures that any patient referred to secondary care under the suspicion of cancer undergoes all necessary diagnostic tests and receives communication ruling out or confirming a cancer diagnosis within 28 days.
- Around a quarter of patients (23.81%; n = 10) did not have the required investigation. Nine of these were blood tests that had been requested by a clinician that the patient did not manage to have taken. The remaining patient did not have his MRI scan booked.

Problems Identified

Two patients (4.76%) were found to have concerning findings and were upgraded to the FDP. Should these patients have had to wait for an appointment, any underlying pathology may have progressed in that time.
A relatively high level of non-compliance with suggested investigations and plans was observed with 23.81% of patients (10/ 42) not having had the requested investigations.

Unfortunately, this is not a rare occurrence with both virtual or face-to-face clinic appointments and is unlikely to be more prevalent in virtual clinics.

Virtual clinics do not allow for any interaction between the patients and their clinicians and should patients have questions or need further explanation of their test results, this may still generate further clinic slots.

Strategy for Sustained Improvement

Where appropriate, the use of virtual clinic format should be encouraged. Prospective data collection and review should be done alongside virtual clinics to ensure their efficiency.

Conclusion

The virtual clinic format is a helpful tool in the context of an overburdened NHS for the dissemination of less significant results such as surveillance of routine blood tests or negative/non-cancer investigations.

The main benefits are twofold, firstly 40% more patients are reviewed in a virtual clinic than in the standard format and secondly, results of investigations reach patients much quicker than if further clinics are requested to discuss them. This allows for both faster movement through diagnostic pathways for patients and less anxiety waiting for results.

Patients should be well counselled regarding virtual follow up as this does not allow for interaction between the patients and clinicians. In well-triaged patients, virtual clinics are an efficient and effective means of reviewing a patient's investigations and management plans.

A Touch of Gentleness in Critical Care Hand Massages for Critically Ill Patients in ITU - Evolving Critical Care Post-Pandemic

Background

The COVID-19 pandemic has dramatically reshaped critical care practices worldwide. In Intensive Treatment Unit (ITU), the pandemic highlighted not only the importance of advanced medical interventions but also the critical need for holistic patient care. As we evolve beyond the acute phase of the pandemic, there's a growing recognition of the psychological toll on critically ill patients, particularly due to isolation, reduced physical contact, and the stress of critical illness. This quality improvement project aims to address these challenges by introducing hand massages as a complementary therapy, representing a key evolution in critical care practices post-pandemic.

Critical Care Hand Massage

The hand massages also provided complimentary inventions in the unit addressing Pain, Comforting Agitation and Delirium, Complimentary therapy to hand immobility and promoting better sleep hygiene.

March of 2023, the Trust's Critical Care Senior Sister saw an opportunity joining a community non-profit organisation - "A Touch of Gentleness".

This organisation provides community support by providing hand massages and gentleness support to local families and communities.

Primary Objective

To implement a structured hand massage program in the ITU that reduces patient-reported stress and anxiety levels, better sleep and control of pain within 3 months of implementation.

Secondary Objectives

1. PADIS Management: To improve the management of Pain, Agitation, Delirium, Immobility, and Sleep (PADIS) in ITU patients through the implementation of the hand massage program:

a. Pain: Reduce patient-reported pain scores by 20% within 3 months of implementation, as measured by a standardised pain scale (e.g., Numerical Rating Scale or Critical-Care Pain Observation Tool).
b. Agitation: Decrease the incidence of agitation episodes by 25% within 4 months, as recorded in patient charts and measured by the Richmond Agitation-Sedation Scale (RASS).
c. Delirium: Reduce the prevalence of delirium by 15% within 6 months, as assessed by the Intensive Care Delirium Screening Checklist (ICSDC).
d. Immobility: Increase patient participation in early mobilisation activities by 30% within 3 months, as documented in physiotherapy records.
e. Sleep: Improve patient-reported sleep quality by 25% within 3 months, as measured by the Richards-Campbell Sleep Questionnaire, and reduce the use of pharmacological sleep aids by 20% within 6 months.

2. Human Connection:

To increase patients' sense of human connection by 30% within 3 months, as measured by a custom questionnaire, addressing the isolation experienced during peak pandemic periods.

3. Infection Control Integration:

To demonstrate that 100% of hand massage sessions adhere to updated infection control protocols within one month of implementation, ensuring the safety of this practice in the post-pandemic ITU environment.

4. Staff-Patient Relationship:

To improve patients' perception of their relationship with caregivers by 30% within 3 months, as assessed through qualitative patient interviews and a communication satisfaction questionnaire, focusing on overcoming barriers created by PPE and distancing measures.

5. Touch Therapy Acceptance:

To achieve 80% acceptance rate of hand massage therapy among eligible patients within 6 months, indicating a successful integration of this practice into evolved critical care routines.

6. Staff Adaptability:

To train 90% of ITU staff in hand massage techniques and new safety protocols within 2 months, demonstrating the ITU's ability to evolve and incorporate new care practices post-pandemic.

7. Patient Satisfaction:

To increase overall patient satisfaction scores related to their ITU experience by 20% within 6 months of implementation, with a focus on questions about emotional support and human connection.

8. Family Involvement:

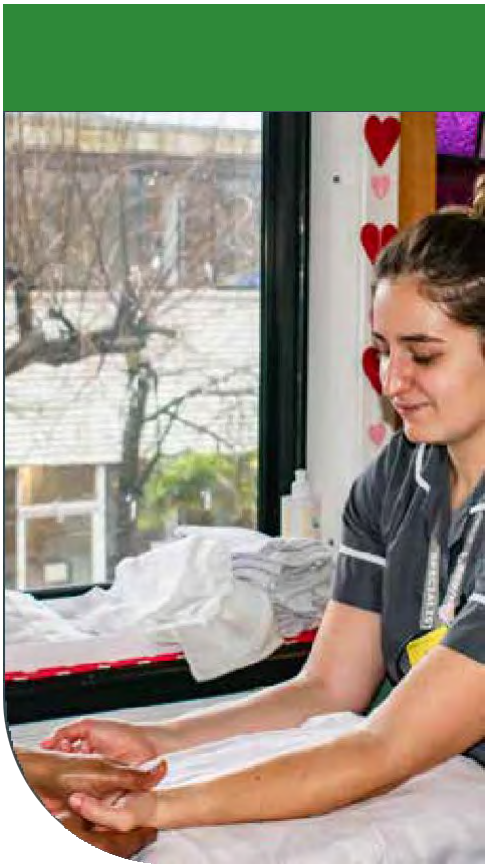
To develop a protocol for teaching family members hand massage techniques (when visitation is possible) within 4 months, addressing the need for family involvement highlighted during the pandemic.

9. Physiological Impact:

To observe a 10% reduction in average heart rate and blood pressure readings among participating patients during and immediately after hand massage sessions, compared to baseline measurements.

10. Knowledge Transfer:

To create a sustainable model of touch therapy in our ITU by having 50% of our staff certified as trainers by "A Touch of Gentleness" within 12 months, ensuring long-term implementation and evolution of the programme.



Methodology

1. Guideline Development - Create a hand massage protocol that compliments ITU care, including enhanced infection control measures and ways to provide human touch safely. Coordinate with the Trust Quality Improvement for inputs.

2. Training:

- Develop a comprehensive training program in collaboration with "A Touch of Gentleness."
- Conduct intensive workshops led by certified trainers from the organisation.
- Training will cover hand massage techniques and strategies for enhancing patient-nurse
- communication
- Implement a "train-the-trainer" model to ensure sustainable knowledge transfer within our ITU.

3. Implementation: Introduce daily 10-minute hand massages for eligible patients, with careful consideration of any ongoing infection control requirements and rightful timing. Proposed hand massage interventions during the nights wherein this can help patient get to sleep.

4. Data Collection: Gather pre- and post-intervention data on patient stress levels, sense of human connection, satisfaction with care, and physiological indicators.

5. Family Education: Develop educational materials and sessions for family members on providing hand massages, when visitation policies allow, to enhance family involvement in patient care especially for patients on End-of-Life Pathway.

Expected Outcomes

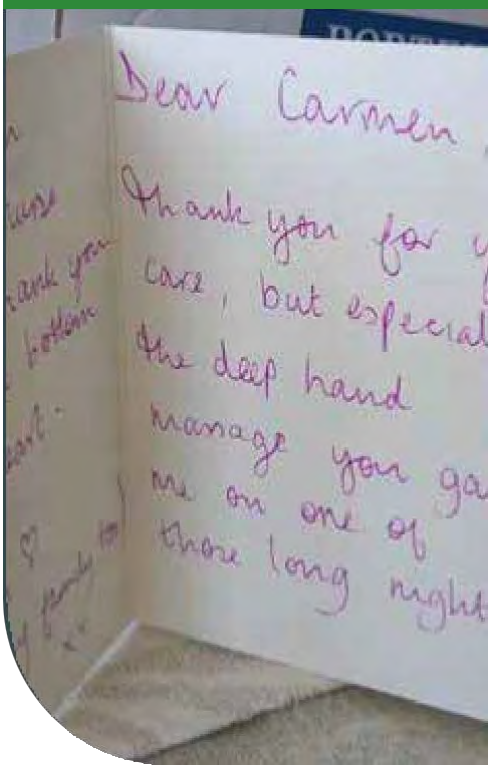
- Significant decrease in patient-reported stress and anxiety levels
- Complimentary therapy to addressing pain within the ITU
- Enhanced sense of human connection among ITU patients
- Improved patient-staff relationships, overcoming barriers exacerbated by isolation
- Increased overall patient satisfaction with ITU care
- Greater family involvement in patient care when possible

Feedback from patients

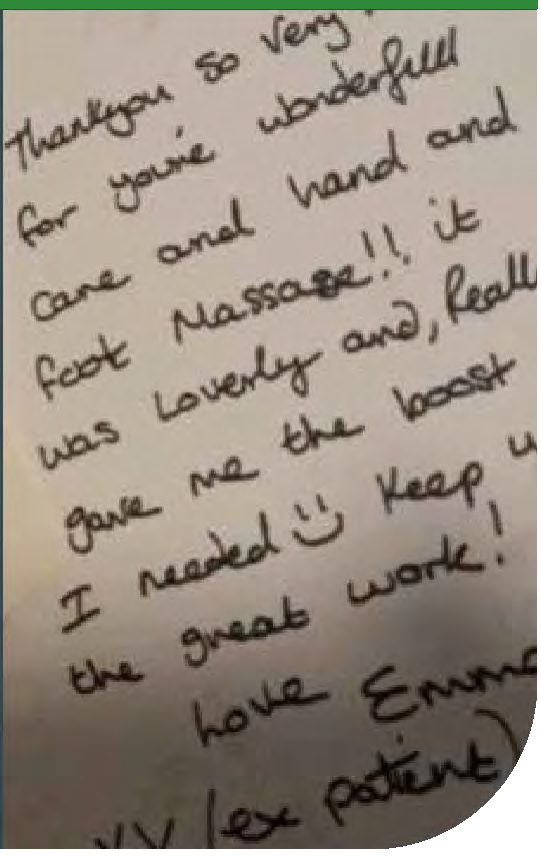
Conclusions

By introducing hand massages as a complementary therapy in the ITU, we aim to address the evolving needs of critical care in the post-pandemic era. This quality improvement project represents a significant step in adapting our care practices to provide more holistic, touch-based interventions while maintaining the highest standards of safety and infection control. It demonstrates our commitment to evolving critical care to meet both the physical and emotional needs of our patients, applying key lessons learned during the pandemic to improve patient outcomes and experiences in the ITU.

Feedback from patients



Feedback from patients



Ten nurses volunteered for the initial study; the group was then able to provide more than 300 hand massages to critically ill patients and the feedback was overwhelmingly positive!

We have since recruited more nurses to join the group and have invited critical care nurses as well from Eastbourne District General Hospital. We have further recruited total of nine Nurses cross site which have further broaden the reach of the project. And just this last September, the group has done another training session for interested nurses.

This Quality Improvement project has been actively campaigning as the group is featured in various Trust communication platforms - the ESHT Critical Care Newsletter **"The Oracle"**, ESHT Trust Intranet News page, ESHT Connected, and Quality Improvement - QI Insider Newsletter. The Project has been recognised as well the by the Trust Quality Improvement Lead as this is further pitched in through one of its programs - **"QI - Dragon's Den - Pitch your project".**

Participation in Clinical Research

The Trust acts as a participating site for national and international research studies, recruiting patients to take part in novel treatments. All research in the NHS is approved centrally by the Health Research Authority. We deliver research recruitment to approximately 53 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	Date Open to Recruitment	Planned Close Date
ABOVE Cerclage after Caesarean	Obstetrics	13.08.2024	05.01.2026
ADDAPT Teenage Pregnancy	Obstetrics	03.02.2025	No date
Add Aspirin Colorectal Cohort	Cancer	25.04.2016	12.07.2024
ADDRESS 2 Type 1 diabetes	Diabetes	08.04.2013	
ASPECT	Respiratory	17.07.2024	31.03.2025
BADBIR	Dermatology	27.07.2023	31.06.2026
BALANCE D HF Heart Failure and Stage 4 Kidney Failure	Cardiology	11.06.24	01.07.2026
BASE Study	Paediatrics	28.05.2024	28.02.2027
CVLP NHS Cancer Vaccine Launch Pad	Cancer	28.05.2024	31.01.2025
DRAFT3 CASP	Emergency Dept & Orthopaedics	24.05.2024	November 2025
eFONAr Emergency Front of Neck Access Registry	Anaesthetics	19.02.2025	No date
Enhanced Midwifery Continuity of Care	Obstetrics	04.11.2023	31.05.2024
EUROASPIRE	Respiratory	05.11.2024	30.06.2025
EXTEND	Surgery	18.10.2022	30.06.2025
FEED1	Paediatrics	24.08.2021	NK

Project Short Title	Disease Area	Date Open to Recruitment	Planned Close Date
Foundation UK Follicular Lymphoma-observational	Cancer	26.07.2023	31.03.2025
FOCUS 2 Fear of Pregnancy	Obstetrics	10.11.2023	01.05.2025
Genetic and cellular analysis of malignant haematological samples	Cancer	04.08.2022	01.03.2037
GenOMICC	Critical Care	15.05.2020	28.02.2030
IMD BIO Resource	Rheumatology	02.03.2018	NK
Improving pts Experience in Bowel Ca	Cancer	23.08.2023	31.07.2024
MagnetisMM-16	Cancer	19.08.2024	30.11.2024
Minder	Dementia	16.01.2024	01.08.2025
MIDI	Neurological	13.08.2021	31.03.2025
MND Motor Neurone Disease Registry	Neurology	07.09.2023	01.08.2025
MYDRESS	Podiatry	27.06.2023	Closed
MyMelanoma Study	Dermatology	08.08.2023	31.08.2027
National Evaluation of Start for Life	Obstetrics	01.10.2024	No date
OBS UK	Obstetrics	09.01.2024	31.07.2026
ONLINE PAWS B	Paediatrics	24.04.2023	10.06.2024
PART (Resurfacing Patella's)	Orthopaedics	01.05.2024	01.08.2027
PARTIAL Nephrectomy	Cancer	07.09.2023	Await confirmation
PHEAST Study	Stroke	06.08.2024	
PQUIP	Anaesthesia	25.02.2019	No Date
PRIME 3 Ageing	Frailty	22.08.2023	30.04.2024
RADAR	Cancer	04.12.2023	30.05.2025

Project Short Title	Disease Area	Date Open to Recruitment	Planned Close Date
RECOmMEnD Prostate cancer	Cancer	17/06/2024	10/20/2024
REDUCE Carbon Inhalers	Respiratory	23.11.2023	on hold 11.03.2024
REDUCE Diabetic Foot Study	Diabetes	22/02/2024	31/10/2024
REFINE-Lung: non-small cell lung cancer	Cancer	13.02.25	31.05.2027
Release ARPV	Critical Care	16.02.2025	31.03.2027
SIGNET Statins for Improving Organ Outcome in Transplantation	Critical Care	01.02.2022	31.03.2026
Self-management in patients with adrenal insufficiency	Diabetes	16.11.2023	30.06.2024
SINFONIA	Critical Care	25.06.2024	01.11.2025
SORCE Patient and clinician experience of nurse and pharmacist delivered SACT	Cancer	25.02.2025	19.09.2025
SPIROMAC Asthma in Children	Paediatrics	23.10.2023	09.04.2025
SWITCH Breast Ca Study	Cancer	17.02.2025	28.11.2025
Targeting Immune Pathways	Gastroenterology	11.04.2019	31.12.2025
The impact of psychological stress on cancer burden and recurrence in ovarian cancer	Cancer	10.03.2023	10.03.2025
TICH-3 Stroke IHC	Stroke	26.06.2024	01.08.2027
UKAITPR Adult ITP	Cancer	17.09.2024	17.09.2025

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2024/25 that were recruited to participate in clinical trials approved by the HRA (Health Research Authority) was 3433 participants.

Commissioning for Quality and Innovation (CQUIN)

The Trust agreed five CQUINs with Sussex ICS for 2024/2025.

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

Ref	Scheme	Target	Detail	Reporting	Service	Q1	Q2	Q3	Q4
Scheme 1	Flu vaccinations for frontline healthcare workers	100%	Report actual uptake of flu vaccinations by frontline staff with patient contact (100% staff offered vaccination)	Monthly Sept - March	Occupational Health	N/A	16%	46% uptake (100% offered)	47.4% uptake (100% offered)
Scheme 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	98.50%	96.30%	97.4%	99.7%
Scheme 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	61%	73%	82%	80%
Scheme 7	Recording of NEWS2 score, escalation time for unplanned Critical Care admissions	75%	75% of all unplanned critical care unit admissions from non-critical care wards having a NEWS2 score, escalation and response recorded.	Quarterly	ITU	91.60%	89%	71.4%	76%
Scheme 10	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	CHIC	60%	50%	76%	67%

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 2024/25.

The CQC monitors and review information from all available sources about the Trust and contacts us for further information whenever they identify any matters of concern. In addition, we hold quarterly engagement meetings with the CQC which allows is to discuss any current issues that may be impacting on the delivery and quality of our services.

During 2024/25 the CQC found no breaches that justified regulatory action, no requirement notices were issued, and no enforcement actions were taken.

Data Quality

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

During 2025/26 we will support improvement in data quality by:

- Reinstatement of Data Quality Steering Group and review of associated reports.
- Review and update of Data Quality Policy with involvement of key stakeholders.
- Review process and planned use of Spine User Death Report to support update of our PAS system.
- Digital attendance at health Inequalities steering group supporting data capture of protected characteristics.
- Digital attendance at Veteran Steering group supporting data capture.
- Review of management of transgender health records and associated risks and policy.
- Backlog of historic morphed records reviewed and rectified.
- Restricting PAS access until appropriate training completed with escalation reports of non-compliance.
- Continued engagement with departments / users for advice and guidance for accurate data input.
- Liaison with Sussex Premier Health to advise and review process due to data input errors.
- Backlog of duplicate hospital numbers against one NHS number being reviewed and merged.
- Validation reports reviewed and wards engaged with where filing errors identified.

NHS Number and General Medical Practice Code Validity

For latest period April 2024 to Jan 2025 (admitted patient and outpatient care)
For Accident and Emergency April 2024 to March 2025

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
- 99.4% 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 and 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. For 2023/24, the Trust was 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's DSPT assessment score for 2023/24 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 report from the Trust's auditors gives a 'moderate' confidence level against the Trust's self-assessment submission for 2023/24. The deadline for the DSPT submission covering the 2024/25 period is due at the end of June 2025 and therefore has not yet been made. The Trust is therefore still covered by the 2023/24 toolkit whilst continuing to work on the 2024/25 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 96.05%.

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

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

Levels of attainment - percentage accuracy targets for Acute Trust

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

Overall Audit Results Summary - 2024/25 (200 **FCE's)**

Percentages of Diagnoses / Procedures Correctly Coded				
Area audited	Primary Diagnoses Correct %	Secondary Diagnoses Correct %	Primary Procedures Correct %	Secondary Procedures Correct %
DSPT AUDIT October 23	97.5	93.3	97.6	95.8
Overall	97.5	93.3	97.6	95.8

East Sussex Health Trust (ESHT) achieved an overall accuracy percentage of 96.05% highlighting 3.95% 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 were omitted due to not extracting relevant information from care pathways in gastroenterology during data extraction.
- Some of the errors were due to inconsistencies in documentation and full scanned record not available at the time of coding.
- Systems issues impacting on coders time with disruption in some system or the other quite often.
- Clinician awareness in coding terms and in recording co-morbidities is limited.

The Trust 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 to include care pathways in gastroenterology
- Increase engagement and awareness with clinicians across all specialities
- Liaise with management to improve the availably of scanned record in time for coding
- Liaise with IT to reduce frequency of systems issues.

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 as '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 2024 and December 2024, 1,946 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 2024 to December 2024)

Reporting period	Number of deaths
Q4 2023/24: January 2024 to March 2024	547
Q1 2024/25: April 2024 to June 2024	450
Q2 2024/25: July 2024 to September 2024	448
Q3 2024/25: October 2024 to December 2024	501
Total: January 2024 to December 2024	1946

Number of case record reviews or investigations

By 07/04/2025, 1946 case record reviews and 68 investigations had been carried out in relation to the 1,946 deaths. In 68 cases, a death was subject to both a case record review and an investigation.

Number of case record reviews or investigations per quarter (January 2024 to December 2024)

Reporting period	Number of case record reviews or investigations
Q4 2023/24: January 2024 to March 2024	547
Q1 2024/25: April 2024 to June 2024	450
Q2 2024/25: July 2024 to September 2024	448
Q3 2024/25: October 2024 to December 2024	501

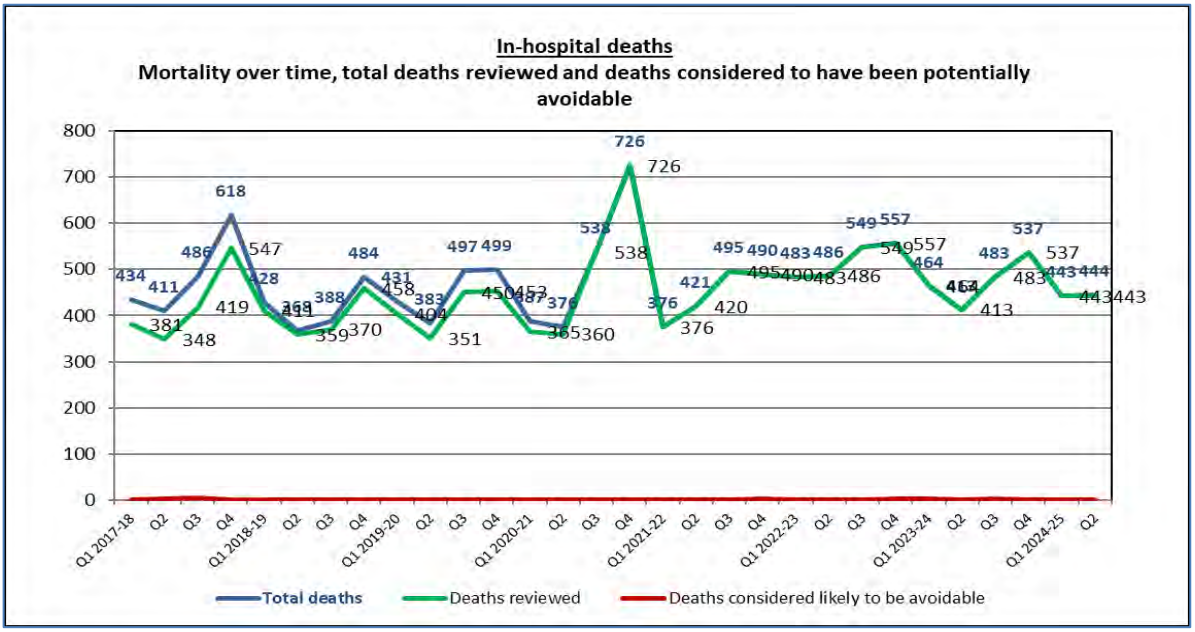
Two deaths, representing 0.10% of the patient deaths between January 2024 and December 2024, were judged to be more likely than not to have been due to problems in the care provided to the patient.

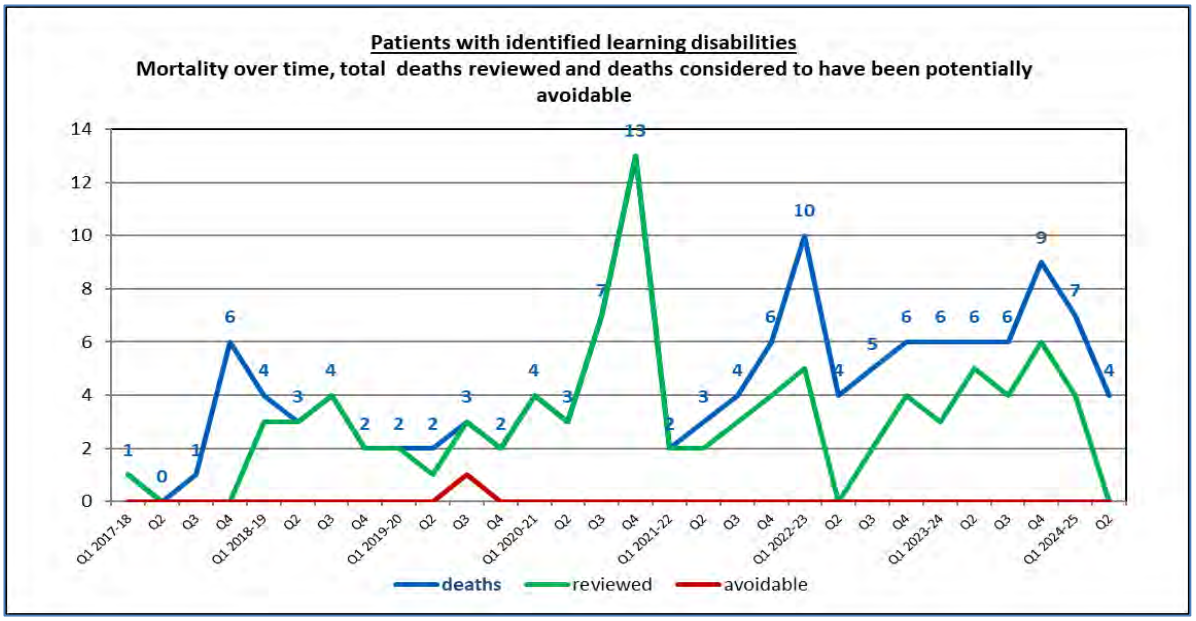
Estimated deaths per quarter considered likely to have been avoidable (January 2024 to December 2024)

Reporting period	Number of patient deaths considered likely to be avoidable	Percentage of the patient deaths considered likely to be avoidable
Q4 2023/24: January 2024 to March 2024	0	0%
Q1 2024/25: April 2024 to June 2024	1 / 450	0.22%
Q2 2024/25: July 2024 to September 2024	1 / 448	0.22%
Q3 2024/25: October 2024 to December 2024*	0	0%

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

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





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

Both of the cases identified as potentially avoidable, were graded 3 ("probably avoidable: more than 50:50 likelihood of avoidability"). They were reviewed at the Trust quarterly review meeting. Neither of the patients had a learning disability.

There were 5 cases graded 1 or 2 in the period. The learning was as below:

Case 1

This patient presented to A+E on the morning of 07/08/24 with a fever, tachycardia and 3/52 history of left leg pain and swelling. They were admitted under the medical team and treated, as lower limb cellulitis, with antibiotics.

An Ultrasound of the leg the following day, showed gas in the tissues and findings consistent with necrotising fasciitis. However, the treating medical team were not made aware of the report for 12 hours, delaying the institution of the appropriate antibiotic regime for necrotising fasciitis, and referral for surgical debridement. The mortality review group considered this to be a significant delay in treatment for a rapidly- evolving condition.

Case 2

A 75-year-old patient with 2 previous lung cancers was lost to follow up, due to human error, following a CT scan showing progression and metastatic disease, following their most recent surgery. The patient was subsequently admitted with widespread and terminal disease 13 months later. Though the patient would still have succumbed to their cancer, they may have had palliative options, were unaware of the fact it had spread widely and unable to prepare for the greatly reduced life expectancy associated with metastatic lung cancer.

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:

Though the tracking of patients on cancer pathways, from referral to first treatment, is rigorous and proactive, there was no specific system for tracking patients' follow-up scans and related appointments following definitive lung cancer surgery. This has now been addressed, with construction of a database tracking completed scans, follow-up appointments and correspondence after these, and planned future scans, administered by the lung cancer specialist nurses.

There is now a mechanism for urgent notification to the requesting clinical staff, or the acute admitting team, of imaging results raising urgent immediate concerns.

In addition, extensive work is under way, continuing throughout 2024-25, 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.

Assessment of the impact of the above actions described which were taken by the provider during the reporting period:

A more robust and reliable tracking of patient investigations and follow up of patients with known cancers. Considerably reduced likelihood of patients becoming lost to follow-up.

More rapid and timely communication of urgent adverse results, speeding up access to appropriate treatment.

Rota Gaps

Staffing

The Trust is currently conducting a formal medical workforce review. In the meantime, we have submitted expressions of interest in 6-9 new medical training posts, at FY1-2 level, and are awaiting responses to these. 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 relevant 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 in staying 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.

Supporting Safe Working Hours

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 Eastbourne DGH. 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 can 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

Staff who speak up

Speak Up Guardian

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 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 data collection began in 2017. Over 30,000 cases were brought to Freedom to Speak Up Guardians nationally throughout 2023/24 - the highest ever recorded, a 27.6% increase on the previous year.

The Trust's Speak Up Guardians were trained by the National Guardian's office. The National Guardians Office provides support and challenge to the healthcare system in England on speaking up, as well as leading, developing and supporting the Guardian workforce.

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 can help to develop restorative practice, de-escalating cases which otherwise become adversarial. Working with staff representatives, managers and individual workers, innovative solutions have been developed which help support staff and build better relationships. The Guardians feel that this is so important at a time of huge pressure on the NHS where civility and respect are vital to working effectively together to keep our patients safe.

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. Our Guardians endeavour to ensure that the reach extends to minority groups and those that may face barriers to speaking up.

Progress has been made in increasing visibility, providing training in the Trust, delivering bespoke speak up awareness sessions and listening events and supporting line managers to feel confident to receive concerns and to promote psychological safety. Speaking up now forms part of the leadership toolkit and new posters

were launched this year to guide colleagues as to how to raise their concerns. The Guardians regularly attend staff network group meetings and contribute to specific projects, including the task and finish group for internationally recruited colleagues, the workforce equality group and the transforming workplace behaviours group.

All staff are encouraged to undertake the online 'speak up' module and a further 'listen up' module is mandatory for line managers to complete. 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. Case studies highlight the diversity of cases that Guardians support and demonstrate how their involvement has helped to improve patient and staff safety, enabled learning and improved working lives.

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.
Themes and learning from cases and anonymised data is shared at the People and Organisational Development Committee, a sub- committee of the Trust Board, every quarter and the Guardians report in person to the Trust Board every 6 months.

243 speak up concerns were brought to the Trust Guardians between April 2024 and March 2025 with registered nursing and midwifery staff reporting the most concerns in each quarter. Key themes, trends and reasons for speaking up are in line with national data submitted to the National Guardian Office from across the country. Rates of anonymous reporting are extremely low at the Trust and significantly lower than the national average, suggesting a positive perception of psychological safety when speaking up in our organisation.

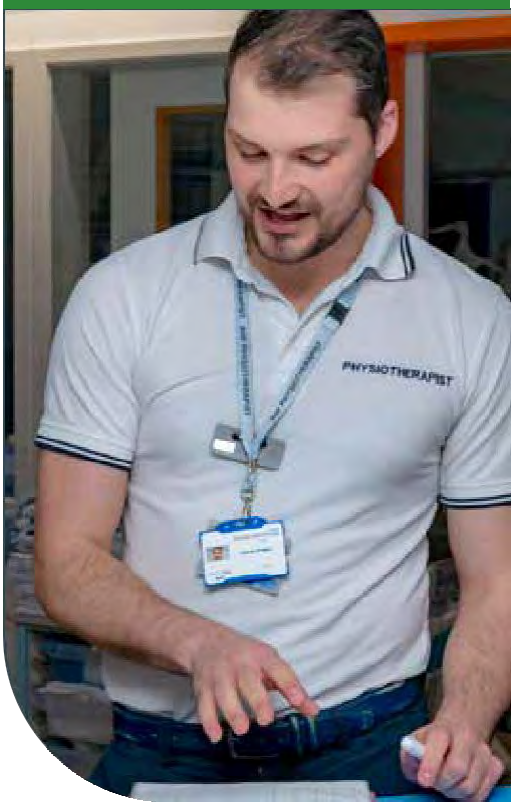
Data sets from this year's staff survey show that 58.5% of respondents feel safe to speak about anything that concerns them in the Trust, with 69.8% of respondents feeling secure to raise any concerns specifically relating to unsafe clinical practice.

The survey asks whether staff feel confident that the organisation would address their concern, and this figure had decreased from 47.3% in 2023 to 44.9% in 2024. We recognise that colleagues can speak up through several channels, including Datix and their line management. Work is underway to ensure that managers are confident to receive and act on concerns brought to them and that colleagues receive timely and proportionate feedback in relation to their concern.

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 and all felt that their concerns had been listened to. Every respondent felt supported by the Guardian and stated that they would recommend the service to colleague.

Wellbeing of our People

Psychological wellbeing and safety



The increasing demands and complexities associated with service delivery are having an impact on the psychological wellbeing of all who work within healthcare. With the prospect of no quick or effective solutions emerging over the horizon, a focus on encouraging self-care to support psychological wellbeing amongst colleagues, whilst influencing a culture that promotes psychological safety continues to be a priority.

TRiM, (Trauma Risk Management), is now well established within the Trust with areas regularly accessing this service following a traumatic event at work. Since April 2024 the TRiM team have offered 82 referrals for TRiM, 319 of our people have been offered TRiM, 104 people have had the initial TRiM assessment, 58 of our people have had the one month follow up and five of our people have had the three month follow up. In addition, seven supportive conversations have been held. Additionally, the TRiM team are also delivering Restorative Supervision of which 61 sessions have been conducted.

Feedback from colleagues accessing TRiM is overwhelmingly positive. Many comment that the TRiM intervention has been pivotal in enabling them to continue at work and their career. The immediacy of offering the TRiM risk assessment and support following a traumatic event will greatly reduce the risk of colleagues going on to develop PTSD in the future and reduces likelihood of burnout as colleagues feel less overwhelmed and able to cope.

The TRiM team work very closely with the Violence Prevention Reduction leads as quite often incidents at work happen because our colleagues are managing challenging patients and relatives. The insights gathered through the TRiM process have been pivotal in shaping and informing improvements to the overall violence prevention and reduction agenda.

What has been noted is the increase in colleagues going on to access individual trauma therapy following their TRiM assessment, as the impact of the work-related incident upon them, has been so great. Access to individual trauma therapy, (for work related incidents), continues to be supported by the Trust, who employ six trauma therapists via the Temporary Workforce Service.

The numbers of referrals for individual therapy from a variety of sources have increased over the past year. To date, 60 referrals have been received and processed with all colleagues accessing individual trauma therapy. This is in comparison to 40 referrals at the same point in time in 2023/24.

Evaluations, including the use of validated screening tools, from colleagues at the end of this therapy indicates an improvement in the symptoms and distress they are experiencing as well as their ability to cope with the demands placed upon them.

Retention

The retention priorities for 2024/25 were aligned with the People Promise resulting in 7 pledges to our people:

People Promise		Retention Priority: Pledge to our People
	We are compassionate and inclusive	Improve the onboarding and first year for those new to the NHS, newly qualified and international colleagues and provide assurance that changes are embedded and sustained.
	We are recognised and rewarded	Improve the experience of colleagues retiring from and/or returning to ESHT and extend the reach of the ESHT Alumni for all colleagues who leave voluntarily by exploring opportunities to return in a substantive, temporary or voluntary capacity.
	We each have a voice that counts	Establish ways for our people to share their reasons for moving within the organisation or leaving, by improving our exit and staying with the Trust feedback mechanisms. Act on insights gathered from this feedback and promote a positive leaving experience for colleagues.
	We are safe and healthy	Promote and provide a culture of psychological wellbeing and safety by fully establishing a framework and good governance for Restorative Supervision. Continue to embed TRiM, (Trauma Risk Management) and access to Trauma Therapy for colleagues experiencing work related trauma.
	We are always learning	Promote a culture where all colleagues are encouraged to flourish through the offer of Thrive and Grow Conversations at any point in the employee life cycle. Create opportunities for our people to realise their full potential through delivery of Action Learning Sets and by focusing on leadership development, culture and shared values.
	We work flexibly	Promote a culture where flexible approaches to work are possible and positive for both individuals and services by encouraging areas to explore different ways of organising and allocating work.
	We are a team	Share expert knowledge, skills and experience within teams through a legacy mentoring programme, to improve team resilience and stability.

Work has progressed successfully in these seven areas and a refresh of the pledges for 2025/26 is being drafted currently.

1. An internationally recruited colleagues' task and finish group will be closing in March 2025. Several improvements to the recruitment, onboarding and experience of colleagues where identified which the group has been working on, checking in with a reference group of internationally recruited colleagues who inform and endorse all actions. This will now form part of the wider EDI monitoring and governance for the Trust so that assurance can be given that improvements are sustained.

2. Two retirement seminars were offered throughout the year at both acute sites. They were very well attended with colleagues having the opportunity to access 1-2-1 advice from SBS (the Trust's pension specialists). These interventions have allowed colleagues to make informed decisions around when and if they want to retire. Further seminars are being planned for 2025. In addition, the ESHT Alumni has continued to grow over the year with over 70 members to date. 31 of these are retired colleagues whilst the remaining 40 have gone on to work in other areas. The Alumni receive a quarterly newsletter with updates from the Trust plus opportunities to return either in a paid or voluntary capacity. Recently Alumni members have joined the Legacy Mentoring programme which supports those new to the NHS, role or area.

3. Two new surveys: an Exit and Staying with the Trust, were launched on 1st August 2024. This was to improve the quality of the data collected from those either leaving the Trust or moving to a new role.

   The surveys are anonymised other than role or division, but some early insights have been gathered from these sources:

   To date 129 responses have been received to the Exit survey. The top reason for leaving (20%) is to improve work life balance, retirement is next, with lack of opportunities within the Trust coming up as third. 42% indicated that they would consider returning to work for the Trust in the future.

To date, 69 responses have been received to the Staying with the Trust survey. The top reason (29%) for moving to a new role is to improve work/life balance with promotion coming up as second.

Further work is needed to promote these surveys and improve response rates. The survey template has already been updated to provide an optional field where colleagues can indicate the team they worked for. This may help to further target retention efforts.

Alongside this a review of the exit interview template and process has been undertaken and a new approach to this will be launched in the coming months, once the Ending Employment policy has been updated to reflect changes as discussed earlier in this paper in relation to psychological wellbeing.

4. Thrive and Grow conversations have been piloted and feedback given on the templates and process. It has been agreed that it sits better within the Talent Management work and so will be picked up once this work is revived later in the spring.

   Action Learning Sets have been piloted and very well received with the matrons in medicine. The programme will now continue with a view to the sets becoming self-sufficient. A further seven teams have engaged in this pilot and will be accessing Action Learning Sets over the coming year.

5. A flexible working action plan has been developed for the Trust aligned with the ICB recommendations. Steady progress is being made with this, but financial and operational challenges are restricting the range and pace with this work.

6. A Legacy Mentoring pilot programme is starting in January. Currently there are 13 colleagues registered to undertake this in a variety of areas and roles. The aim is to better support those new to the NHS, role or area but the programme will be carefully monitored and evaluated to assess whether this is something that can be sustained and extended.

Wellbeing of our People

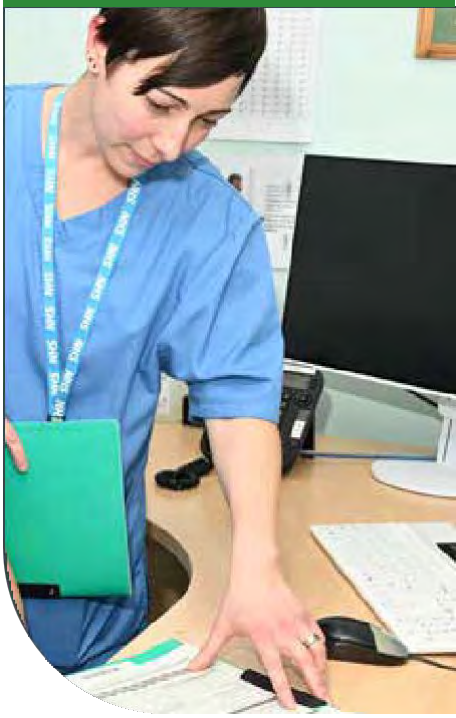
We continued to support the physical and emotional wellbeing of colleagues during 2024 and adapted the range of support that we offer to our people, reflecting the impact of work pressures. We focused on the areas our people articulated that made the biggest difference to them through surveys, anecdotal feedback and visits.

We have trained 240 of our people in the Mental Health First Aid qualification and a further 28 are due to be trained during 2025/26. We have increased our offer of Mental Health Aware Training, to date 126 of our people have been trained since this was introduced in 2023 (52 trained in 2023 and 74 in 2024). A further 140 places are available during 2025.

We have continued to support Wellbeing Conversations with colleagues in the Trust - 314 managers have attended Wellbeing Conversation training, supporting them to hold Wellbeing Conversations with their team members. In 2025 we are exploring offering a blended approach to Wellbeing Conversation Training via MST facilitated sessions and e-learning on MyLearn. This will enable training to be available and accessible to all colleagues.

In 2024, we delivered on our wellbeing menu of support and have strengthened our Wellbeing Programme for our people - this programme includes further increased support and a focus on Mental and Physical Health, Men's Health sessions, Menopause Workshops (Demystified and Mind), Structured Wellbeing Days which include Self-Care and wellness sessions, and External providers onsite promotional events (Gyms, Samaritans, Wills), all of which our people have articulated are important to them through verbal and written feedback and during visits. We have also introduced a Trust wide Staff Smokefree Focus Group, Trust wide Quarterly Wellbeing Meeting with the support of the Non-Executive Wellbeing Guardian, and we have relaunched the Wellbeing Champions, resulting in 158 Wellbeing Champions now working across the Trust.

There has been an emphasis on the offering of Men's Health support in the Trust, and this has been supported by three members of the executive team. Seven sessions/ workshops were delivered in 2024 covering a variety of topics including Men's Wellbeing, Mind, Stress and Resilience, and Health and Life Phases. These are supporting to decrease the stigma of talking about men's health.



There has been a focus on Menopause support offered, quarterly Menopause Demystified' workshops have been delivered with 127 in attendance (71% attendance), and Menopause related absence is recorded and reviewed on ESR, enabling us to support and signpost individuals where required.

In conjunction with One You East Sussex, we provided 101 health checks for colleagues aged between 40-74 (70.9% attendance). Our people have also been supported with their financial wellbeing; we have increased our signposting in 2024 of support services to all our people (including StepChange and Citizens Advice).

We have worked in partnership with local foodbanks with issuing vouchers directly to those in need, and with Wave Community Bank and Barclays to ensure we could offer financial support to colleagues.

We supported the launch of Vivup Employee Support Programme and included this within our support sessions and signposting. 24.1% of Trust employees have now registered with Vivup, equating to 1,925 of our people.

Working collectively with colleagues we are making progress with Flexible Working in the Trust. Key areas of progress have included The Work-life Balance and Special Leave Policy being updated following legislation changes and an electronic process to apply and record flexible working requests. The electronic application is live and to date 92.3% of requests have been approved/ approved with amendments.

We have focused on new ways of working to ensure we can deliver sustainable support to our people that is both time effective and resource efficient. Working in collaboration with colleagues, we have streamlined access to our services, resulting in, all requests coming through one port of entry via a 'Team in Need' form.

In 2024 we visited and have supported many teams in both the acute and community, providing tailored support to them, we provided 165 bespoke 1:1 calls/ support our people, and delivered a variety of support sessions to our teams.

The Trust has achieved the Bronze and Silver Wellbeing at Work Award from East Sussex County Council's Public Health Team. The Wellbeing at Work Award recognises employers' commitment to supporting employee's wellbeing through an accreditation programme.

The programme provides a framework for improving health and wellbeing in the workplace and takes a holistic approach, covering topics which include physical activity, active travel, healthy eating, musculoskeletal health and health and safety, mental ill health, sickness absence - return to work and prevention, alcohol and substance misuse, stop smoking, leadership, management and workplace culture.

Throughout 2024 we were involved in events to thank and celebrate the achievements of our people, including working in collaboration with the wider People Engagement Team on the Trust Awards and the Festive Refreshments events.

Occupational Health

Following our SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation in 2023, the Occupational Health team continued to strive to provide Safe, Effective and Quality care to the people of ESHT. In 2024, several quality improvement projects were undertaken to improve the accessibility and speed of access to the OH service.

Following our QI projects, the waiting time for those using our service improved to an average wait of:

- 8 working days for an appointment after a manager refers (against the 10 working days within our KPI)
- 1.3 working day for pre-employment health clearance (measured from the receipt of the candidate's health questionnaire)

The quality improvement achieved within the service was noted and commented upon within our annual assessment with the external accreditors. With the assessor feedback…

"I would like to congratulate your service for its continued commitment to maintaining SEQOHS standards."

These improvements have seen the introduction of self-booking of some appointment types, which have successfully been implemented in one aspect of our service, improving the information available to both employees and managers on the extranet.

Occupational Health has really become focused on how to improve, taking the feedback of our service users as a starting point, we measure across three core functions of OH:

- Case Management, (4.79 Stars)
- Vaccination Clinic (4.95 Stars)
- Manager Support Feedback (4.86 Stars)

As we move into 2025, Occupational Health continues to be committed to providing the people of ESHT an accessible OH service. We will continue to utilize digital solutions to support further self-serve options, provide clear information which we will continue to flex to the needs of the organisation whilst we continue to deliver our core and statutory care.

NHS Staff Survey 2024

Staff Survey questionnaires were sent to 8,687 staff at East Sussex Healthcare NHS Trust. Of these, 4,046 questionnaires were returned which resulted in a substantive response rate of 47%, which was a 1.5 % decrease on the previous year and just below the national survey provider response rate of 52%.

The NHS Staff Survey is scored on seven People Promise elements and two key themes of Staff Engagement and Morale. These two key themes remain performance indicators for organisations.

We have seen a slight improvement across People Promise element 5 'We are always learning' and can see a significant improvement in the number of colleagues reporting that they have had an appraisal within the previous 12 months. People Promise 4 'We are safe and healthy' shows a significant improvement in the number of colleagues working additional paid hours over above their contracted hours. Colleagues have also responded positively (54.9%) that they can access nutritious and affordable food at work, which is a 2% increase on the previous years' result and is significantly better than the sector score.

However, the number of colleagues reporting personal experience of bullying, harassment and abuse at work from other colleagues has increased from the previous years' results (20.87%) by 1.6% which is disappointing. We have also seen a decrease across the other People Promise elements with scores for 'We are compassionate and inclusive – Compassionate culture' showing a significant decline of nearly 1%.

There has been a significant increase of 1.5% in the number of protected characteristic colleagues who have personally experienced discrimination at work from a manager/team leader or other colleagues. People Promise elements for 'We are recognised and rewarded' and 'We each have a voice that counts' also show a significant decline on the previous years' results.

The Morale People Promise theme results have not significantly changed since the previous years' results and Q26b 'I will probably look for a job at a new organisation in the next 12 months' and Q26c 'As soon as I can find another job, I will leave this organisation' show an improvement and are significantly better than the sector score.

Colleagues however responded negatively (60.6%) to the Staff Engagement People Promise theme – Advocacy for Q25d 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation', which is a significant decrease of 3% from the previous years' results.

This year, 34% of our bank colleagues completed the NHS Bank Staff Survey which was a slight decrease on the previous year. However, this response rate was one of the highest national response rates and demonstrates an engaged bank workforce.

The majority of the People Promise scores for Bank colleagues are in line with the Trust's substantive scores. It is encouraging to see that Bank staff feel well supported and are engaged. People Promise 4 'We are safe and healthy' is significantly better that the substantive staff score.

Bank colleagues have however reported that they are less likely to feel involved in the workplace, in particular with proposed changes which affect them. We will look to promote a culture where bank staff feel their opinions and skills are welcomed, sought after and valued, and that they are given opportunities to show initiative in their role.

Bank colleagues also reported a decline in the number of opportunities available to develop their career (30.2%) which is a decline of 8.3% from the previous years' results.

The results show that 88% of our bank people feel their role makes a difference to patients and service users and 90% say they are trusted to do their job.

A programme of work has begun led by the People Engagement Team in collaboration with HR colleagues which include engagement and listening events with colleagues. Trust priorities will focus on improvements through a Task and Finish approach with representatives from each division. Each division will be responsible for their own action plans and will continue to report to The People Organisational Development (POD).

Part 3 - Review of Quality Indicators and our Priorities for Improvement in 2024/25

Social Media

Facebook: @ESHTNHS | Instagram: @ESHTNHS | YouTube: @ESHTNHS

Part 3.1 - Our Priorities for Improvement in 2024/25

The Trust identified three quality improvement priorities for 2024/25 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 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

Safe Administration/Prescribing of Paracetamol

Why was this 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 did we do in 2024/25?

- Data was collated in 2023, 2024 and 2025 to review paracetamol dosing and recording of patient weights.
- Improvements were made throughout 2023/ 2024 in recording of patient weights. Nervecentre is identified as the primary Trust system for recording weights as is updated weekly when completing patient MUST scores (Malnutrition Universal Screening Tool). Unfortunately, this does not feed into the ePMA (Electronic Prescribing and Medicines Administration digital system), and weight needs to be transferred manually. Data showed an improvement in availability of patient weights from 56% in 2023 to 74% in 2024 on Nervecentre, but this was not always transferred to ePMA or paper drug charts (point of prescribing). Further improvement made to recording of patient weights on Nervecentre as 2025 data shows increase to 80% of patient weights recorded. This was only transferred to the EPMA system in 55% cases (compared to 50% in 2024).
- Updated communications and posters for wards.
- The Pain team have included Paracetamol safety in their training sessions.
- Updated Foundation Year (F1) doctor induction and prescribing assessment to include a 45kg weight patient to prompt prescribers to prescribe for an underweight patient. Unfortunately, only 58% of F1s prescribed the correct dose. This has been fed back via the Trust's Medicines Optimisation Group and the Foundation Doctor Local Faculty Group.
- Reviewed and updated the ePMA with extra prompts - including making a patient's weight more visible when prescribing.
- The ePMA was updated so that nurses and the pharmacy teams can transfer recent weight recordings from Nervecentre to ePMA, to ensure availability at the point of prescribing.
- Review of 'regular' versus 'when required' prescribing.
- Prescribing and administration information was shared with prescribers and wards as part of Medication Safety week (November 2024).

Recent data showed around 80% of paracetamol is prescribed as / when required. Baseline data showed 96% of paracetamol doses were appropriate where the weight was recorded. This increased to 98% in 2024 and 99% in 2025.

Summary of Actions

Aim	Update
100% of wards have the 'Medication Safety Bulletin' for Paracetamol on display across the Trust.	All wards have been sent a poster to display. Database maintained to track compliance.
100% of patients prescribed Paracetamol have their weight recorded to inform dosage	2023 data: 56% of patient weights recorded. 96% patients with correct dose of paracetamol prescribed. 2025 data 80% of patient weights recorded. 99% patients with correct dose of paracetamol prescribed according to weight.
All wards will have appropriate scales/ weighing equipment for inpatients	Confirmed and in place.
Appropriate prescribing advice on ESHT Electronic prescribing and medication administration system including for low weight patients and those with liver impairment	ePMA updated and improved. Alert added to Omnicell cabinets to ask "Has the patient been weighed" needing a Yes or No answer to access when removing intravenous paracetamol from Omnicell cabinet. Also added question to check if patient is 'Nil by mouth' to prompt oral paracetamol when oral route is available. Awaiting data to review.
Develop educational materials and ensure all Healthcare Professionals involved in the prescribing and the administration of Paracetamol have the training	Development of training package for e-learning, this will be updated on the MYLearn later in 2025. Poster trial - posters developed and displayed - reminding staff of the importance of obtaining and recording correct patient weights on the trauma and orthopaedic wards.

Aim	Update
Education and feedback to be provided on wards for Healthcare Professionals and during pharmacy prescribing teaching sessions for doctors	Paracetamol safety is now included in F1 and F2 induction training. Prescribing assessment amended to include patient weighing <50kg. Microguide/ EOLAS guides updated to include a summary of paracetamol prescribing with links to the Trust guideline.
Data to show improvement in prescribing paracetamol in low weight patients	2023 data: 96% patients with correct dose of paracetamol prescribed according to their recorded weight 2025 data 99% patients with correct dose of paracetamol prescribed according to recorded weight

Our plan moving **forward….**

- Use Quality Improvement tools to deep dive into other areas of potential improvements
- Review incidents for 2024/2025 and present findings at divisional Governance meetings
- Use of one system for patient parameters and prescribing will improve data as weight has to be manually transferred from Nervecentre to ePMA currently.
- Review of the multi-route paracetamol prescribing template on ePMA and add in duration. Include nasogastric / route to all templates to reduce need to intravenous paracetamol.
- Add prompts to ePMA to remind staff to transfer weight recordings from Nervecentre to ePMA.

Reducing the number of rejected pathology samples

Why was this 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 additional, unnecessary invasive procedure for the patient. 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.

Our aims

- A use of pathology services policy will be published alongside a publication 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.

What did we do in 2024/25?

A Use of Pathology Services policy has been written, this has gone through numerous rounds of review and editing and is now sitting with the clinical lead for pathology for approval, before going through the divisional and Trust ratification processes.

Our Phlebotomy supplier and training provider is undertaking audits in both A&E departments to better understand the sample taking process and to identify specific improvement actions. This is an ongoing action; the results are not yet available.

We are launching a new Pan-Pathology user newsletter to replace the previous blood sciences newsletter, the first issue (to be released this month) focusses on sample request and labelling best practice. This will continue to be a theme in subsequent issues with focus shifting according to sample rejection data analysis.

Reports have been presented at the integrated Governance Meetings describing specific labelling issues to gain further understanding and support for this issue from senior staff such as the Chief nurse and Heads of Nursing (HoNs) for various areas.

Data continues to be collected regarding the number of rejected samples, the reason for rejection and the location from which the samples were received. We have now collected three years of data, meaning we are able to understand the areas of concern and can formulate further plans to reduce the rejection rates in these areas.

The data below shows the top 5 reasons and locations for samples being rejected:

<table>
<tr><th>Top 5 Rejection Reasons</th><th>Rank</th><th>Totals</th><th>% of all rejections</th><th>Highest ranked locations for each rejection reason</th></tr>
<tr><td>Sample haemolysed. Unable to assay / test.</td><td>1</td><td>19795</td><td>48.4%</td><td>
<table>
<tr><th>Location</th><th>Rank</th><th>Total</th><th>% rejections</th></tr>
<tr><td>Accident & Emergency (DGH)</td><td>1</td><td>5837</td><td>29.49%</td></tr>
<tr><td>Accident & Emergency (Conq)</td><td>2</td><td>5250</td><td>26.52%</td></tr>
<tr><td>Richard Ticehurst Unit</td><td>3</td><td>679</td><td>3.43%</td></tr>
<tr><td>Outpatients Department (DGH)</td><td>4</td><td>646</td><td>3.26%</td></tr>
<tr><td>Special Care Baby Unit (Conq)</td><td>5</td><td>593</td><td>3.00%</td></tr>
</table>
</td></tr>
<tr><td>No potassium EDTA sample sent.</td><td>2</td><td>3911</td><td>9.6%</td><td>
<table>
<tr><th>Location</th><th>Rank</th><th>Total</th><th>% rejections</th></tr>
<tr><td>Renal Secretaries</td><td>1</td><td>944</td><td>24.14%</td></tr>
<tr><td>Accident & Emergency (DGH)</td><td>2</td><td>639</td><td>16.34%</td></tr>
<tr><td>Accident & Emergency (Conq)</td><td>3</td><td>445</td><td>11.38%</td></tr>
<tr><td>Victoria Medical Centre</td><td>4</td><td>150</td><td>3.84%</td></tr>
<tr><td>Little Common Surgery</td><td>5</td><td>128</td><td>3.27%</td></tr>
</table>
</td></tr>
<tr><td>Coagulation specimen insufficient</td><td>3</td><td>3406</td><td>8.3%</td><td>
<table>
<tr><th>Location</th><th>Rank</th><th>Total</th><th>% rejections</th></tr>
<tr><td>Accident & Emergency (Conq)</td><td>1</td><td>1193</td><td>35.03%</td></tr>
<tr><td>Accident & Emergency (DGH)</td><td>2</td><td>1141</td><td>33.50%</td></tr>
<tr><td>Richard Ticehurst Unit</td><td>3</td><td>277</td><td>8.13%</td></tr>
<tr><td>Acute Medical Unit</td><td>4</td><td>247</td><td>7.25%</td></tr>
<tr><td>Acute Assessment Unit</td><td>5</td><td>207</td><td>6.08%</td></tr>
</table>
</td></tr>
<tr><td>No time stated.</td><td>4</td><td>2466</td><td>6.0%</td><td>
<table>
<tr><th>Location</th><th>Rank</th><th>Total</th><th>% rejections</th></tr>
<tr><td>Accident & Emergency (Conq)</td><td>1</td><td>2421</td><td>98.18%</td></tr>
<tr><td>Accident & Emergency (DGH)</td><td>2</td><td>34</td><td>1.38%</td></tr>
<tr><td>Richard Ticehurst Unit</td><td>3</td><td>11</td><td>0.45%</td></tr>
</table>
</td></tr>
</table>

No date on sample.	5	2405	5.9%	

Location	Rank	Total	% rejections
Accident & Emergency (Conq)	1	1957	81.37%
Conquest Outpatients	2	131	5.45%
Quintins Medical Centre	3	90	3.74%
Richard Ticehurst Unit	4	81	3.37%
Outpatients Department (DGH)	5	62	2.58%

Top 5 locations for rejected samples	Rank	Totals	% of all rejections	Highest ranked rejection reasons for each location
Accident & Emergency (Conquest)	1	39118	31.3%	

Location	Rank	Total	% rejections
Sample haemolysed. Unable to assay/test.	1	5250	39.90%
No time stated.	2	2421	18.40%
No date on sample.	3	1957	14.87%
Coagulation specimen insufficient	4	1193	9.07%
Coagulation specimen haemolysed	5	900	6.84%

Accident & Emergency (EDGH)	2	30196	24.1%	

Location	Rank	Total	% rejection
Sample haemolysed. Unable to assay/test.	1	5837	44.36%
Coagulation specimen insufficient	2	1141	8.67%
Coagulation specimen haemolysed	3	934	7.10%
No potassium EDTA sample sent.	4	639	4.86%
No fluoride oxalate sample received.	5	496	3.77%

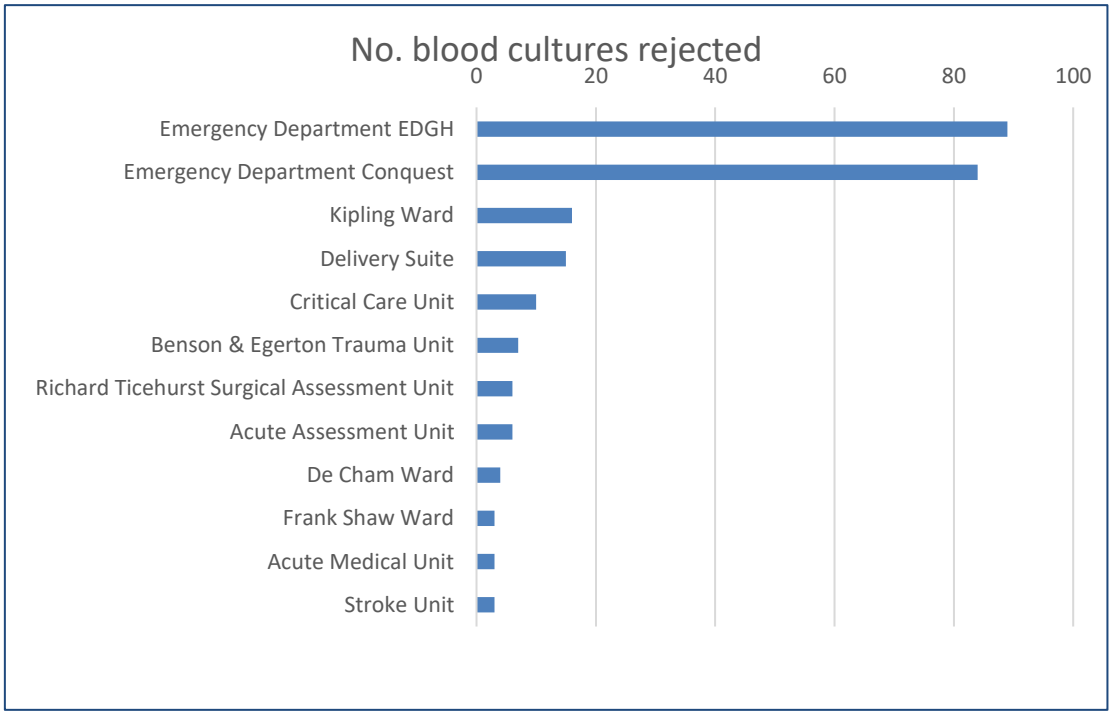
Renal Secretaries	3	5447	4.4%	

Location	Rank	Total	%rejection
No potassium EDTA sample sent.	1	944	7.17%
No urine sample received.	2	535	4.07%
No sample received.	3	28	0.21%
Unlabelled sample received.	4	17	0.13%
No fluoride oxalate sample received.	5	10	0.08%

<table>
<tr>
<td>Richard Ticehurst Unit</td>
<td>4</td>
<td>3627</td>
<td>2.9%</td>
<td>
<table>
<tr><th>Location</th><th>Rank</th><th>Total</th><th>%rejection</th></tr>
<tr><td>Sample haemolysed. Unable to assay / test.</td><td>1</td><td>679</td><td>56.07%</td></tr>
<tr><td>Coagulation specimen insufficient</td><td>2</td><td>277</td><td>22.87%</td></tr>
<tr><td>Coagulation specimen haemolysed</td><td>3</td><td>117</td><td>9.66%</td></tr>
<tr><td>No date on sample.</td><td>4</td><td>81</td><td>6.69%</td></tr>
<tr><td>Sample incorrectly labelled.</td><td>5</td><td>14</td><td>1.16%</td></tr>
</table>
</td>
</tr>
<tr>
<td>Outpatients Department (EDGH)</td>
<td>5</td>
<td>3520</td>
<td>2.8%</td>
<td>
<table>
<tr><th>Location</th><th>Rank</th><th>Total</th><th>%rejection</th></tr>
<tr><td>Sample haemolysed. Unable to assay / test.</td><td>1</td><td>646</td><td>61.06%</td></tr>
<tr><td>No potassium EDTA sample sent.</td><td>2</td><td>128</td><td>12.10%</td></tr>
<tr><td>Coagulation specimen insufficient</td><td>3</td><td>74</td><td>6.99%</td></tr>
<tr><td>No date on sample.</td><td>4</td><td>62</td><td>5.86%</td></tr>
<tr><td>Sample incorrectly labelled.</td><td>5</td><td>57</td><td>5.39%</td></tr>
</table>
</td>
</tr>
</table>

Blood cultures

Number of blood cultures rejected since 1st May 2024 due to being unlabelled, missing details on the label, or mismatched sample and request form:



Our plan moving **forward….**

- Continue to monitor data to assess whether actions undertaken have had a positive impact.
- Continue to raise these issues in Pathology Newsletter and at Trust Meetings
- Work with A&E to implement improvement actions raised by audit.
- Address issues with specific areas: Renal service and Richard Ticehurst Unit.
- Discuss the process of taking Blood cultures with departments to understand why these seem to be a particular issue with these samples.
- Reducing the sample rejection rate is a long-term objective for Pathology - the additional actions identified here will be added to this objective for further progress.

Improving the quality of decision making for people who lack capacity

Why was this chosen as priority?

People with a cognitive impairment frequently lack capacity to make specific healthcare decisions. This could be temporary or permanent and could be caused by several reasons including dementia, a learning disability, a mental ill 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. Additionally, it is paramount that staff follow the law, not doing this can result in safeguarding concerns being raised, with CQC being notified, with a reputational risk to the Trust. There could be financial implications too if the Trust were to be fined by an individual.

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.

Our aims

We will be reviewing the decision-making process for patients who have a learning disability diagnosis, who have attended the Trust for a procedure in various specialties at the Trust over the year 2023-2024. We will be auditing the decision making that affects patients as they access treatment and their journey through the pathway from referral to definitive treatment. The audit will look at the process of the decision-making including consent in this group of patients, compliance with the requirements of the Mental Capacity Act, involvement of appropriate support and professionals, the involvement of carers and relatives, documentation, and the number of delays or cancellations that this group incurs and the reasons for them.

Where we identify issues, we have looked to formulate an action plan regarding documentation, guidance and training.

We would also look to raise awareness around these issues more generally amongst our Trust colleagues.

What have we done so far?

We have identified a patient cohort for people attending 3 different specialties, round 1 of the audit was in Endoscopy, round 2 was in Ophthalmology and round 3 in Urology. Data analysis has been completed, and the initial results are detailed below:

Endoscopy Audit - initial results overview

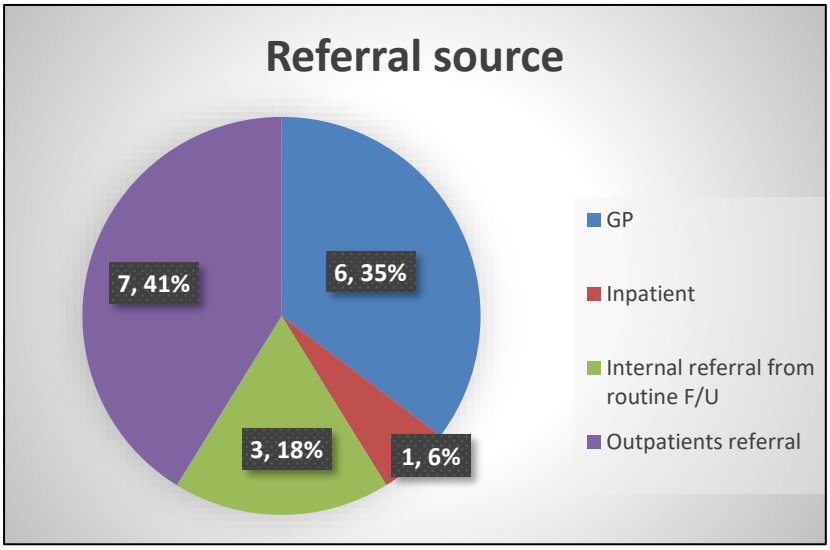
A total of 17 cases were audited. The following was noted:

There was good compliance with ensuring the patient had a Learning Disability alert on e-searcher. However, often the information was limited and not specific to that patient's circumstances. In the majority of cases the detailing on the alert was poor.

The Learning Disability Nurse was involved in a high percentage of the cases reviewed and has an important role to play in the care of these patients.

Referral Source

Good compliance was evidenced with the documentation of a patient's ability to provide consent on the referral form (94%), and excellent recording of the identified decision maker in the notes (100%). Three patients in this audit were deemed to have capacity about their treatment, and a Consent form 1 was used.



A large percentage of the case sample required a consent form 4 (82%), however there was notable variation in the quality of these forms, and how well they had been completed. For example, there is mixed compliance regarding the description of the medical treatment proposed and the evidencing of lack of capacity and reasons why. To add, the narrative around why the proposed treatment is in the patient's best interests is often missing. Information about who has been consulted often is incomplete i.e. the surname of the relative consulted is missing.

General anaesthetic form:

General anaesthetic form: has the consent section been completed?			Have the risks been clearly documented?			Have they been discussed with the person closest to the patient i.e. family member / friend / LPOA Health and welfare / Court appointed deputy?		
YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
11	6	0	8	9	0	9	8	0

Compliance with completing the Anaesthetic forms was poor (100% of all elements should be fully completed).

Cancellations:

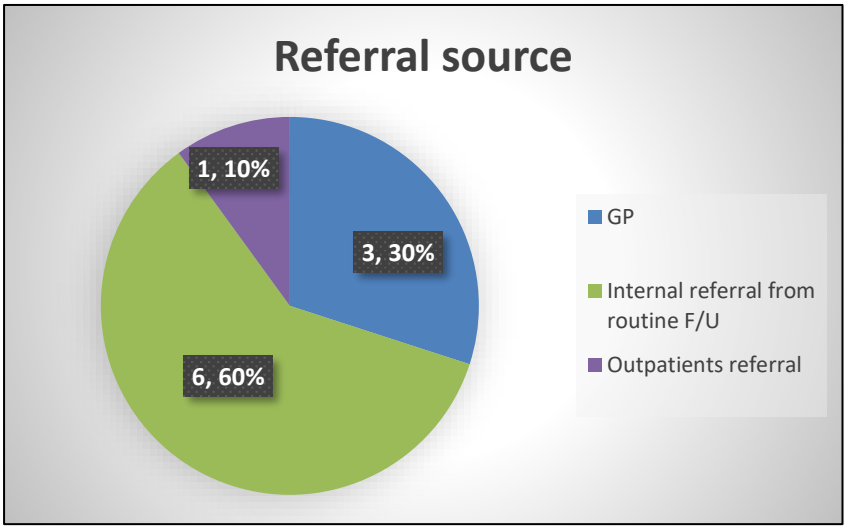
It was pleasing to note that zero procedures were cancelled due to issues with the consent process or consent form.

Ophthalmology Audit - initial results overview

Ten cases were audited, with 100% compliance noted with ensuring the patient had a Learning Disability alert on e-searcher. However, in 70% of cases the detailing on the alert was poor, with information not specific to that patient's circumstances, reflective of the older style of alert.

The Learning Disability Nurse was involved in 80% of the cases, although only half of the cases (50%) were referred to the learning disability multi-disciplinary meeting.

Referral Source



In 60% of cases, there was documentation of the patient's ability to provide consent on the referral form, with a clearly identified decision maker in the majority of cases (90%). 2 patients in this audit were deemed to have capacity about their treatment, and a Consent form 1 was used.

80% of cases required a consent form 4, with the majority being completed to a high standard. This included adequate description of the proposed procedure, relevant boxes and further details regarding capacity being completed. In 90% of patients with a consent form 4, there was sufficient narrative around why the proposed treatment is in the patient's best interests, with reasons stated why the decision could not wait. However, information about who has been consulted was often incomplete (50%). Further information including next of kin's full name, address and mode of contact (via telephone, online or in person) is needed.

General anaesthetic form:

General anaesthetic form: has the consent section been completed?			Have the risks been clearly documented?			Have they been discussed with the person closest to the patient i.e. family member / friend / LPOA Health and welfare / Court appointed deputy?		
YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
10	0	0	8	2	0	8	2	0

Compliance with completing the Anaesthetic forms was poor (100% of all elements should be fully completed).

Ophthalmology pre-assessment:

90% patients had an ophthalmology pre-assessment completed, with mental capacity and reasonable adjustments being recorded in the majority of patients. There was a lack of information documented regarding patients' communication needs.

Cancellations:

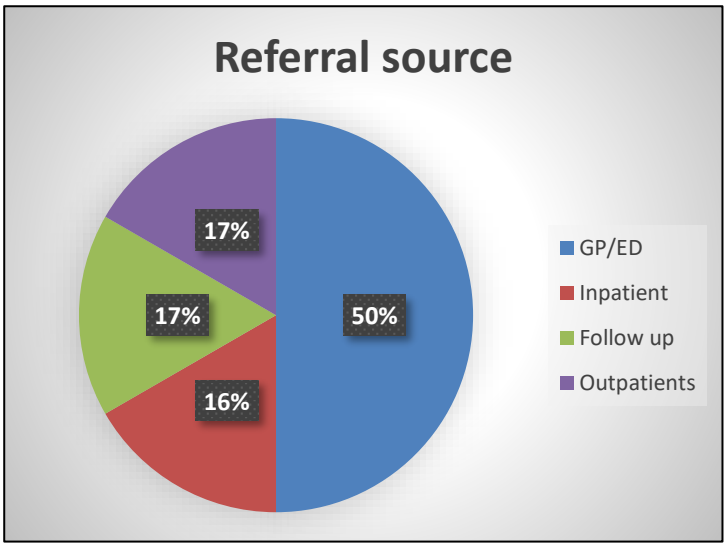
It was pleasing to note that zero procedures were cancelled due to issues with the consent process or consent form.

Urology Audit - initial results overview

Twelve patients were identified and audited in this group. to have had a procedure under the care of urology team between April/2023 and March/2024. All patients had a Learning Disability alert on e-searcher. However, only two patients had a detailed description in the alert about their communication needs while the remaining patients had the older style of alert that does not include any particular description of their condition or needs.

Learning disability nurse was involved in the care of all 12 patients and referral to LD MDT was made for 10 patients.

Referral Source



Consent form 4:

All patients had a consent form 4 completed prior to the procedure. More than 80% had a clear description of procedure with minimal abbreviations, and all patients had clear documentation of how it is in patient's best interest and brief description of why decision cannot be delayed. However, only 40% of forms included adequate recording of who was spoken to about the decision and their details. One patient had a court appointed deputy for health and welfare, but this information was not indicated on the consent form and not recorded on e-searcher as an alert.

General anaesthetic form:

General anaesthetic form: has the consent section been completed?			Have the risks been clearly documented?			Have they been discussed with the person closest to the patient i.e. family member / friend / LPOA Health and welfare / Court appointed deputy?		
YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
12	0	0	10	2	0	9	3	0

All patients had a general anaesthetic form completed, with the consent section completed, however, there has been inconsistency in documenting the risks and who they were discussed with (relative, family, NOK, LPA).

Cancellations:

None of the procedures were cancelled due to issues with consent form.

Summary:

We have closely reviewed and audited the decision-making process of a total of 41 patients who potentially lack capacity presenting to three different specialties for complex procedures. There are several general themes that have emerged from this analysis.

Alerts on E-searcher:

All the patients had an alert regarding their learning disability however the large majority lacked sufficient detail, particularly about their communication needs to ensure better personalised care for this group of patients. This is likely to be due to the old-style alert that had been used which only allows limited information. There is an ongoing plan to update all alerts however his will take some time due to the limited nursing resource available (there is only one Learning Disability Nurse in post across the Trust).

Involvement of Learning Disability Nurse (LDN):

In our audit this was 100% and this reflects the role of the LDN in this group of patients. The LDN plays a valuable role in ensuring that correct processes are followed, and patients and clinicians are supported to ensure best outcomes are achieved.

However as mentioned previously there is only one LDN present in post and therefore this resource is limited. We have yet to audit patients where there has been no LDN involvement. It should also be noted that there is no equivalent support for patients who lack capacity for reasons other than learning disability.

Consent Form 4:

Patients lacking capacity appeared to all have an appropriate consent form 4 recorded in their notes. However, there was notable variation in the quality of how these forms were completed. We discovered variation in documentation of the following elements:

- The description of the medical treatment proposed.
- Evidencing of lack of capacity and reasons why.
- Explanation around why the proposed treatment is in the patient's best interests.
- Information about the person who has been consulted is incomplete, in particular, next of kin's full name, address and mode of contact.

General Anaesthetic Forms:

Procedures requiring general anaesthesia had a completed anaesthetic form but there was variability in quality of information written regarding the consent for anaesthesia and in particular who this was discussed with.

Future plans

We are planning to audit a further specialty and specifically identify patients where there has not routine involvement of a Learning Disability Nurse. We will then have a final review and analysis of data and planning meeting to produce recommendations and action plan for the Trust.

Part 3.2 - Review of our Quality Indicators

Amended regulations from NHS England require Trust's 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 2024/25 the Trust achieved 90.1% compliance.

Mandatory surveillance of healthcare associated infection

Rate of C. difficile Infection

ESHT considers that this data is as described because the Trust has robust data quality assurance processes in place.
The NHS Standard Contract 2024/25 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 2024/25 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.

Due to increasing trends, a more ambitious threshold (for most Trusts) of a 5% reduction for C. difficile (compared to one case count historically).

Recalculating the baseline figures for all Trusts to reflect definition change - where a patient has been admitted directly after attendance to A&E, the decision to admit is the admission date rather than the inpatient admission date. As a result of this definition change, case classifications will change from community-onset to hospital onset.

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 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
No information	The reporting Trust did not provide any answers to questions on prior admission

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 as 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

* admission date refers to the date of admission to the reporting acute Trust, or where the patient was admitted via A&E (of the same reporting Trust), the decision to admit date. As a result of this definition change, case classifications will change from community-onset to hospital-onset.

Performance

East Sussex Healthcare	Case thresholds for 2024/25	Actual Cases reported for 2024/25		
Organism		Total	HOHA	COHA
C. difficile	67	87	59	28
E. coli	109	125	64	61
Pseudomonas	19	28	14	14
Klebsiella sp.	47	45	28	17

Source: ESHT data is from the UKHSA Healthcare Acquired Infections (HCAI) Data Capture System. At the time of writing this report the annual 24/25 surveillance report had not been published so data is subject to slight variation.

A total of 87 cases of CDI were attributed to the Trust for 2024/25 from 81 patients (four patients had more than one reportable CDI), which is higher than the threshold. The increase occurred due to 59 hospital onset healthcare associated infections and 28 community onset healthcare associated infections (COHA is the same as last year).

Nine of the HOHA cases were related to 002 ribotype at Eastbourne DGH with patients identified with the same infection as a community onset case. This was declared as an outbreak. At the Trust there is a focus on antimicrobial prescribing to reduce CDI and resistant organisms and additional enhanced environmental and bedspace cleaning to reduce the risk of outbreak. The CDI incidence returned within threshold limits for Q4 of the year.

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. Patients who seek healthcare at the Trust in an acute and community capacity are likely to have had prior healthcare exposure because of the integrated care provided by the Trust which increases attribution to ESHT compared to non-integrated Trusts. Collaborative working is required to understand how we can positively impact on E. coli and Pseudomonas related infections.

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

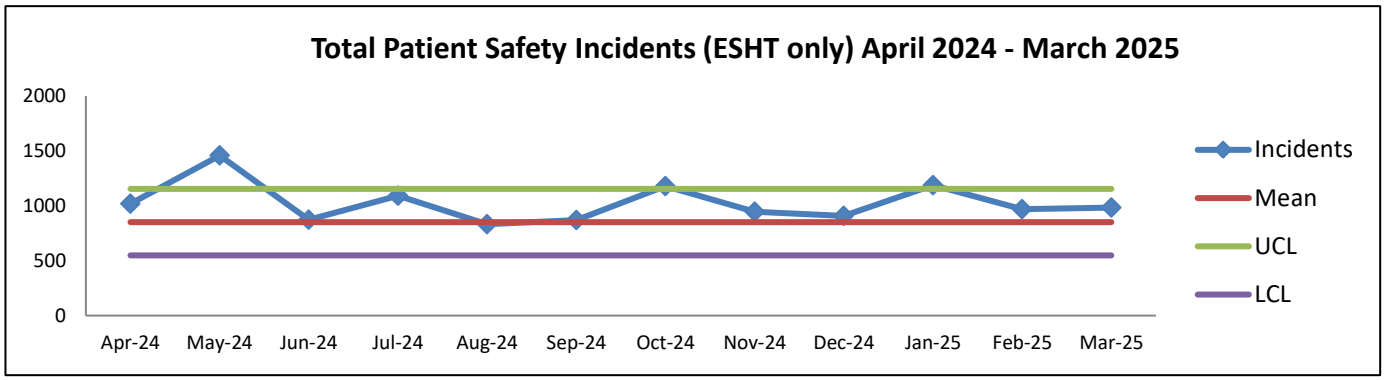
The Trust launched the NHSE Patient Safety Incident Response Framework (PSIRF) on the 20th November 2023. This new framework replaced the previous 2015 Serious Incident Framework. When we launched, in collaboration with our ICB we published our PSIRF Plan and Policy to underpin this change. PSIRF set out a new direction for how NHS organisations respond to patient safety incidents/events, focussing on effective learning and improvement, compassionate engagement with the patient and their family as appropriate and embedding a patient safety culture.

The National Reporting and Learning System (NRLS) ceased to function in the summer of 2023. Learning from Patient Safety Events (LfPSE) has been introduced across the NHS and it is a new national service for the recording and analysis of patient safety incidents / 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 what was deemed the national rate of 71%, this national percentage ceased to be meaningful for organisations across England for the last two years. The National Patient Safety Team advised organisations to review their level of compliance from within and to measure any variables as appropriate. The Trust has continued to record, monitor and report on this element and we have remained in the upper percentile of 71% or higher which shows an organisation where the staff are very good and demonstrating a good and consistent reporting culture.

The patient safety incidents / events are in the main near misses and low/minor in terms of level of harm that is recorded. Those incidents / events that are moderate and above in the level of harm are reviewed and the learning taken forward to ameliorate future occurrences for patients' safety.

Table 1 - Total Incidents from April 2024 - March 2025



The Trust has the following systems and processes in place to improve the number and rate of patient safety events / 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.
- We continue to encourage staff to report incidents and near misses to support a learning culture.
- All moderate, major, and catastrophic harm incidents are quality checked for discussion at the Trust Weekly Patient Safety Summit (WPSS).
- This multidisciplinary and collaborative approach to patient safety incidents / events ensures that early actions can be taken forward to minimise further harm occurring, serious issues are recognised promptly, lessons are shared across the Divisions, Duty of candour is initiated with the patient and their family from the outset of the review / investigation to ensure inclusion with the process.
- Three reported Never Events were recorded during 2024/25.

It is crucial that we learn from every incident and near miss that happens to address concerns and continually learn. The Trust reviews all patient safety incidents/ events to take immediate actions and consider safeguards for patients. In line with national guidance, and the implementation of PSIRF, patient safety PSIRF templates and Patient Safety Incident Investigations (PSIIs) these tools utilise a systems- based approach with the emphasis on improvement on patient safety through systems, processes learning and safety improvement. To support this, the Trust is committed to creating foundations that foster a just learning, restorative, supportive, compassionate culture and behaviour.

Maternity incidents that met the Maternity and Newborn Safety Investigation (MNSI) criteria continue to be investigated externally by this team within the Care Quality Commission.

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.

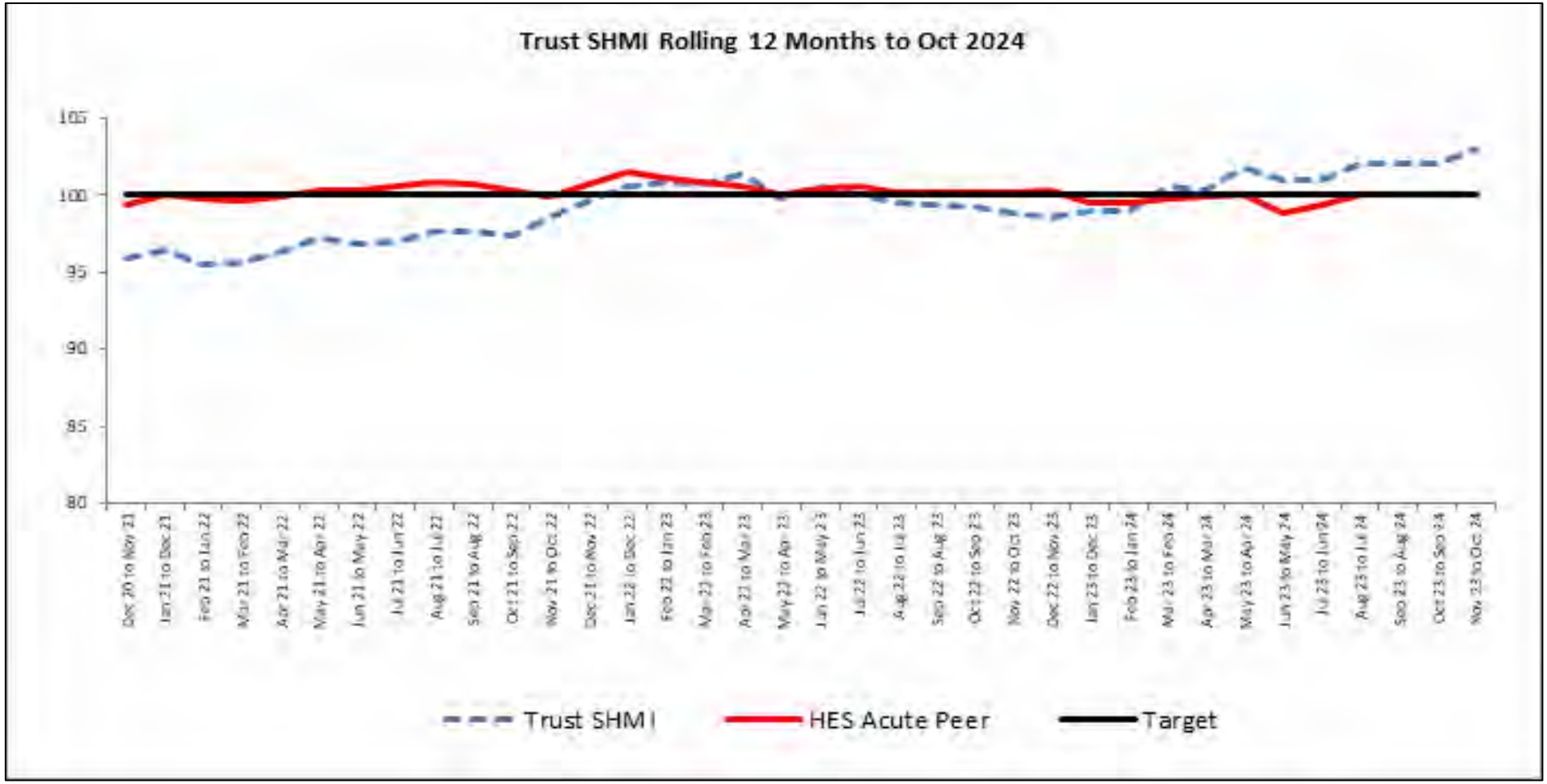
SHMI is one of several statistical mortality indicators used to monitor the quality of care provided by the Trust. We also look at the Hospital Standardised Mortality Ratio (HSMR) and the Risk Adjusted Mortality Indicator (RAMI), as well as crude death rates and associated local metrics.

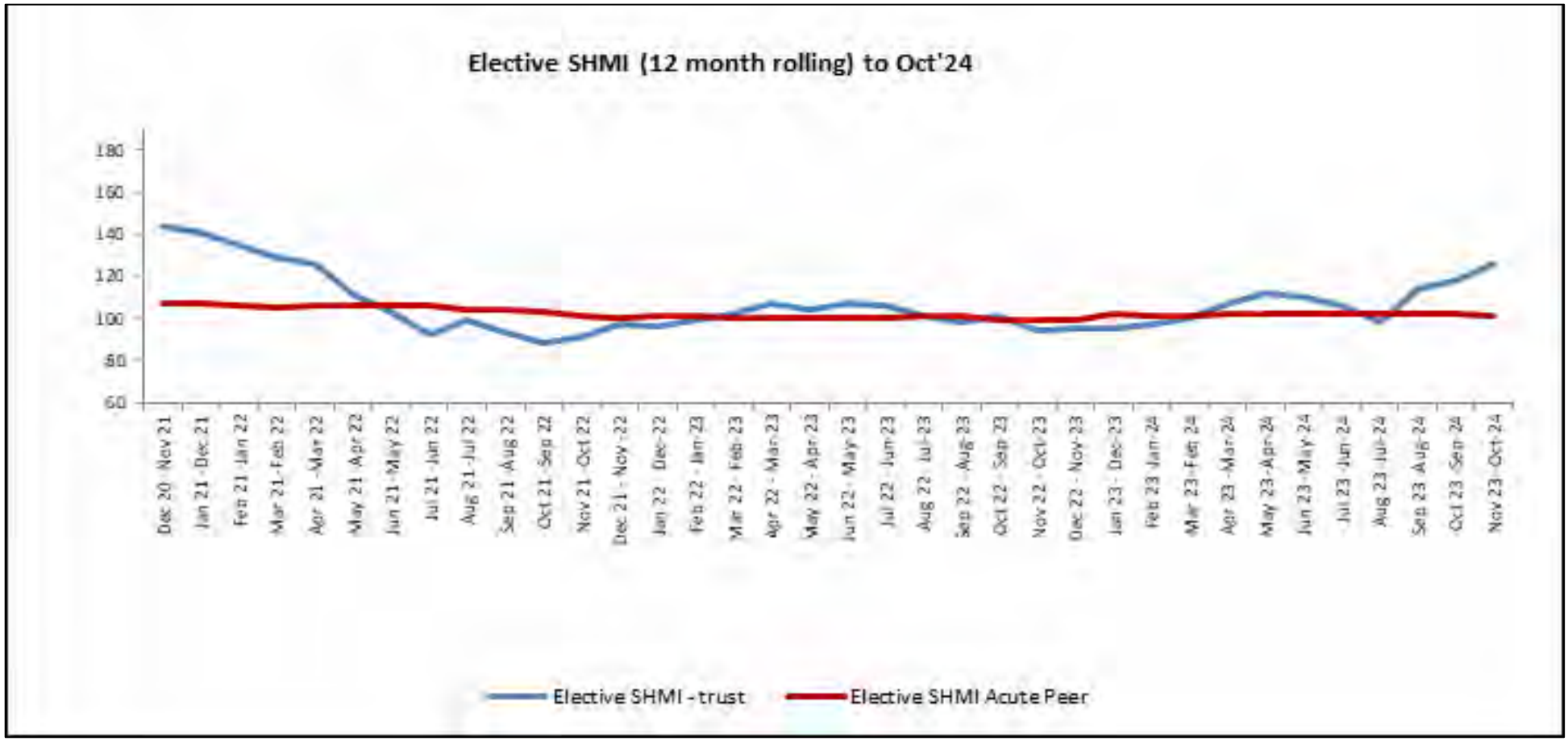
SHMI

SHMI has slowly increased but remains well within the "expected" range.

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	ESHT Dec 23 - Nov 24
SHMI value	1.04	0.97	0.97	0.96	0.96	1.00	0.99	1.04
Banding	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected

Source: NHS Digital




Elective SHMI (12 month rolling) to Oct'24
180
160
140
120
100
80
60
Dec 20 - Nov 21
Jan 21 - Dec 21
Feb 21 - Jan 22
Mar 21 - Feb 22
Apr 21 - Mar 22
May 21 - Apr 22
Jun 21 - May 22
Jul 21 - Jun 22
Aug 21 - Jul 22
Sep 21 - Aug 22
Oct 21 - Sep 22
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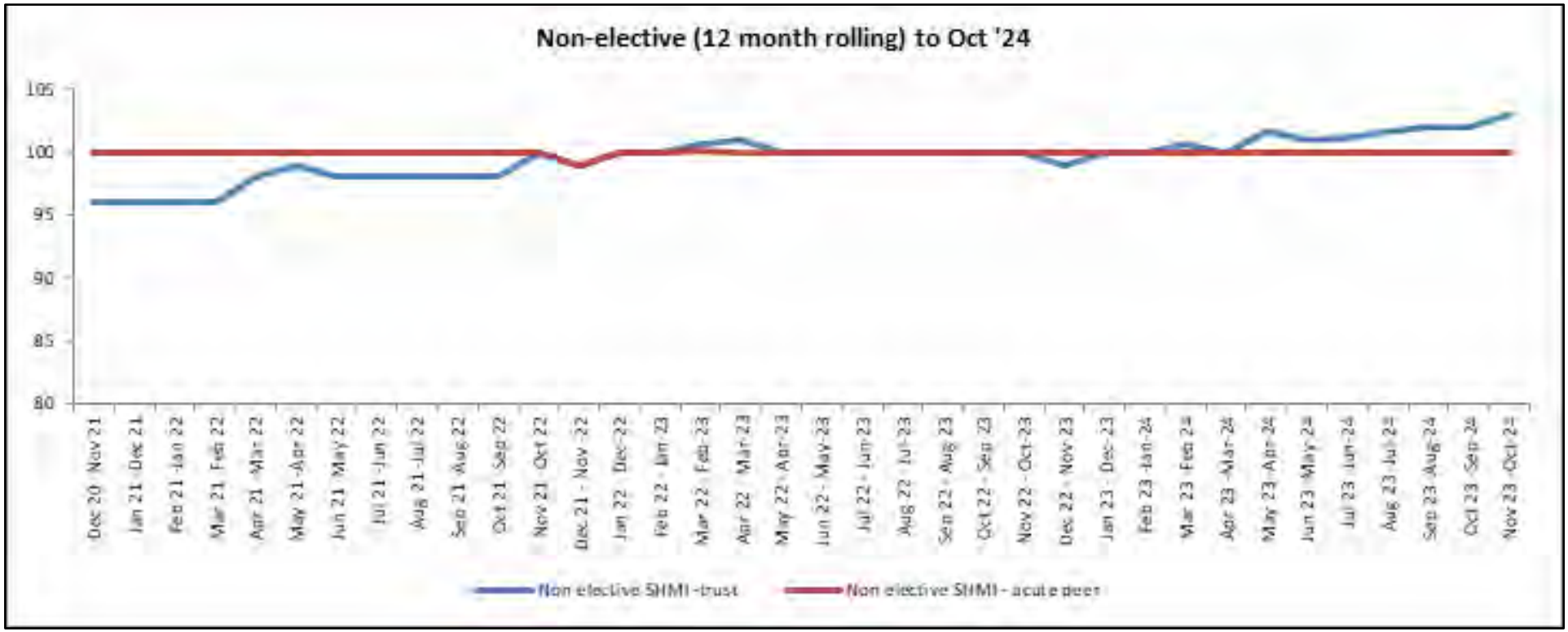
Feb 23 - Jan 24
Mar 23 - Feb 24
Apr 23 - Mar 24
May 23 - Apr 24
Jun 23 - May 24
Jul 23 - Jun 24
Aug 23 - Jul 24
Sep 23 - Aug 24
Oct 23 - Sep 24
Nov 23 - Oct 24
Elective SHMI - trust
Elective SHMI Acute Peer


Non-elective (12 month rolling) to Oct '24
105
100
95
90
85
80
Dec 20 - Nov 21
Jan 21 - Dec 21
Feb 21 - Jan 22
Mar 21 - Feb 22
Apr 21 - Mar 22
May 21 - Apr 22
Jun 21 - May 22
Jul 21 - Jun 22
Aug 21 - Jul 22
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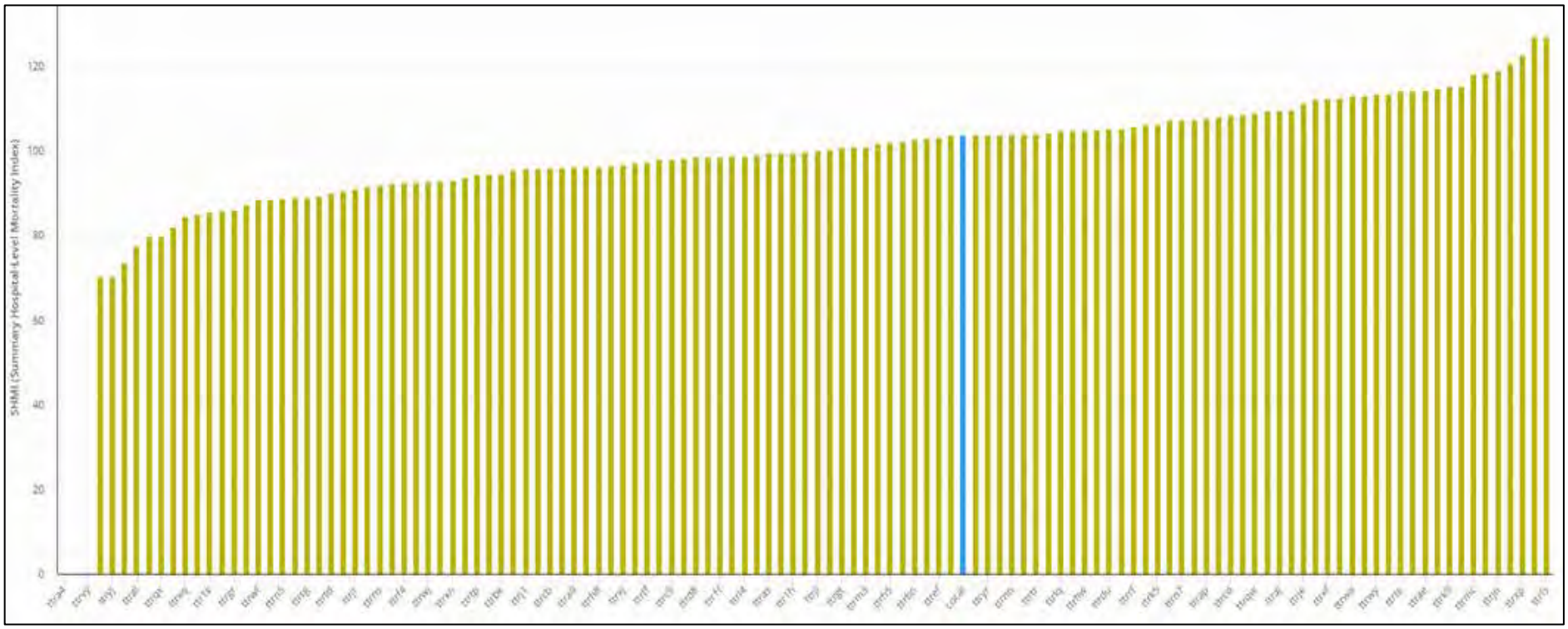
Jun 23 - May 24
Jul 23 - Jun 24
Aug 23 - Jul 24
Sep 23 - Aug 24
Oct 23 - Sep 24
Nov 23 - Oct 24
Non elective SHMI - trust
Non elective SHMI - acute peer

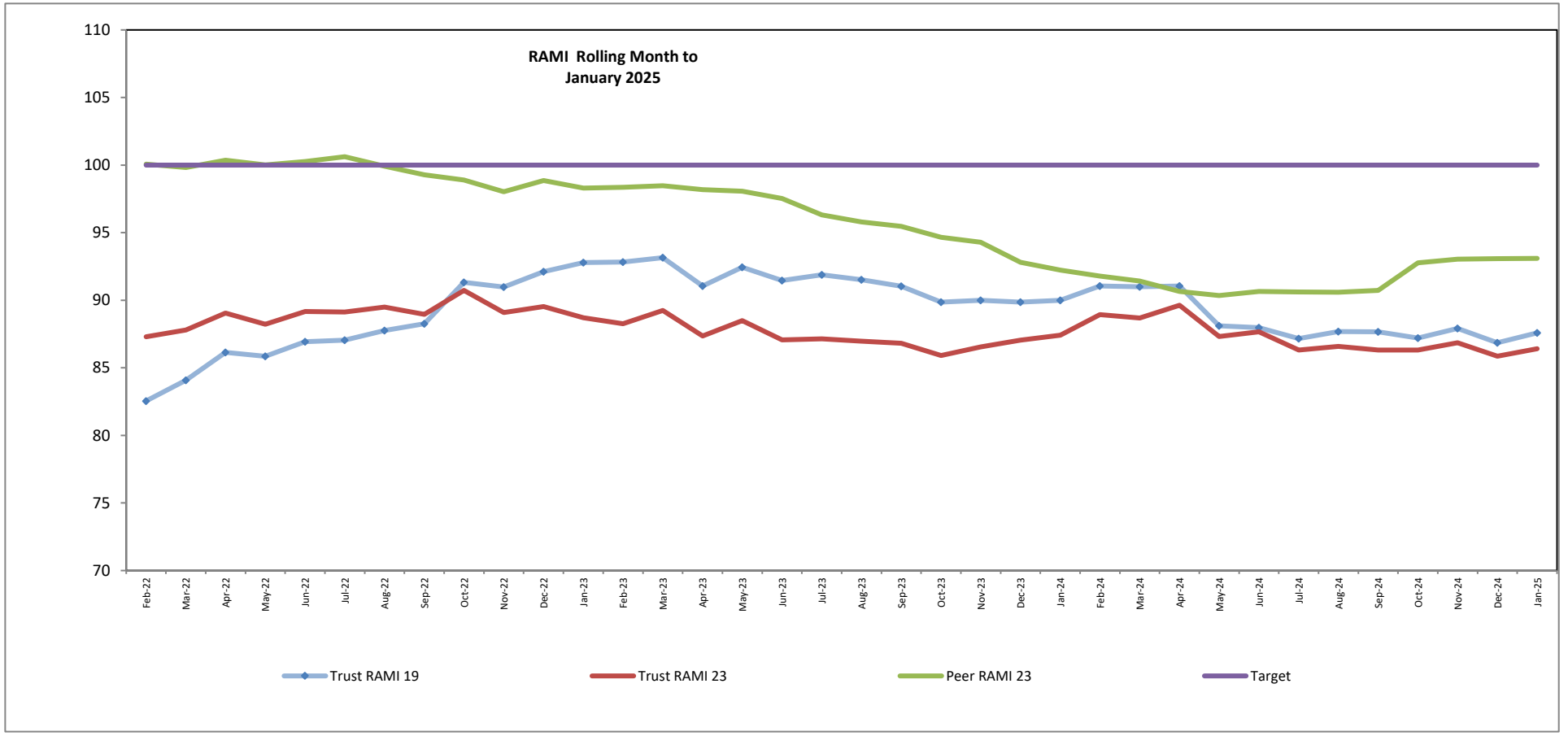
SHMI in comparison with other Trusts



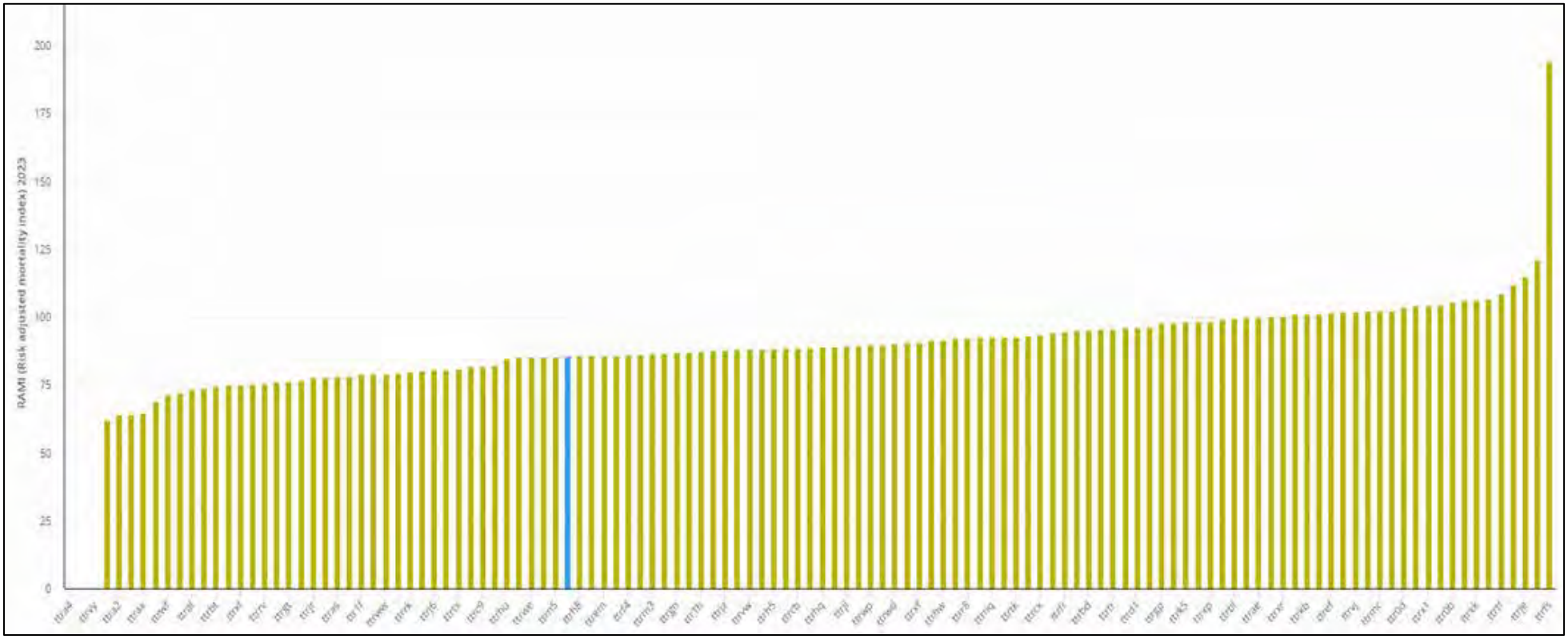
RAMI

A newer version of RAMI has been introduced. Graphs show the new RAMI (RAMI 23) and, for comparison and consistency, the previous RAMI (RAMI19)

The Trust RAMI has remained consistently better than peers and continues to improve.



The Trust ranks 35 out of 120 Trusts



The Trust has taken the following actions during 2024/25, to improve mortality and the quality of its services:

- Further improved consultant staffing in our Emergency Units and Acute Medicine departments so that we can provide optimum care when patients are acutely ill, with consultant presence on our Medical Assessment Units every day for around 12 hours.
- We have produced standards of care for assessment and treatment of acute admissions, to improve patient safety, timely diagnosis, effective streaming to appropriate specialties.

- We have increased the number of doctor residents at night.
- Strengthened provision of Same Day Emergency care (SDEC), with units open on both sites, 7 days a week, taking patients from our Emergency Departments 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 handovers for acute teams using NerveCentre, 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 information ensuring clinicians have full visibility of a patient's observations and can respond at the earliest opportunity.
- Strengthened in-reach from multiple specialties into the Emergency Departments and Acute Units.

- Conducted a series of “MADE” event (multi-agency discharge events) exercises to improve patient flows, lessening the waiting times for assessment and treatment, reducing the numbers of outlying patients and reducing length of stay in the acute hospitals. Benefits to patients include reducing complications of long hospital stays (for example, hospital acquired infection, de-conditioning)
- Expanded the Virtual wards to support more patients safely having acute treatment in a home setting.
- Initiated rapid mobilisation in elderly patients, working with them and their families and carers, to preserve their function and facilitate return home, lessening the need for re-admissions.
- 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 several 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 disabilities, 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 myocardial infarction (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.
- 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 for people with a learning disability.
- The independent Medical Examiner system is now well established, providing an independent review into 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 to improve 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

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

We are compassionate and inclusive

Compassionate culture

People Promise 1, Subscore 1 - Compassionate culture	Org.	Sector	Diff.
	6.89	7.11	-0.22 (Sig.)

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

- Launched a divisional accountability framework to ensure divisional and service level staff survey action plans remain focused, relevant and on target.
- Our colleague recognition programme has been refreshed with long service increased from 10, 25 and 40 years to every 5 years, starting at 5 years up to 50 years' service. Certificates and badges redesigned to reflect new Trust values; Hero of the Month certificates refreshed to reflect Trust values; Retirement events introduced to recognise colleagues who have given 20+ years' service to the Trust and the NHS.
- Divisional dashboards have been developed in conjunction with the HR

Workforce team to allow divisions and services to access all survey question responses, to easily identify where improvement is required; a video tutorial is being developed alongside other resources to support managers

- Listening events on workplace discrimination are being led by the People Engagement Team in July and August 2024 with representation from colleague networks.
- Retention priorities for 2024-25 are aligned with the seven elements of the People Promise and constituted workstreams focusing on psychological wellbeing and retention of our people:

We are compassionate and inclusive:

We worked to improve the recruitment and onboarding experiences of our Internationally Recruited Colleagues through a dedicated task and finish group. Improvements are now embedded and the group closed in March 2025.

We are recognised and rewarded:

We support colleagues considering retirement by holding retirement seminars on site and regular one-to-one meetings. Seminars are well received and continue to be offered twice yearly. We strengthened the ESHT Alumni for colleagues voluntarily leaving the organisation, the Alumni now has 83 members, two of whom have joined our legacy mentoring programme on a voluntary basis.

We each have a voice that counts:

We reviewed our entire exit process to encourage colleagues to provide honest feedback as to their reasons for moving within or leaving the organisation, to enable a positive leaving experience. Two new surveys were launched on the 1st of August 2025: an 'Exit Survey' and a 'Staying with the Trust' survey for those moving to a new role within the Trust. Response rates to both surveys are lower than anticipated and improvements to both the process and communication about these options are underway. Improvements to the Exit Interview process have been proposed with an aim to agree alongside policy review and ratification.

We are safe and healthy:

We have completed phase one of the Restorative Supervision programme; clinical colleagues can use this to regularly decompress. We continue to embed TRiM, (Trauma Risk Management) and access to Trauma Therapy for colleagues experiencing work related trauma.

We are always learning:

We piloted Action Learning Sets with matrons in Medicine – this was very well received and is now embedded across the division. Action learning sets are now available to other leaders with the aim of creating sustainable peer led sets.

We work flexibly:

With operational HR, we have launched a new electronic process for flexible working requests in June 2024. This provides greater oversight and a consistent approach. To date 88% of flexible working requests have been approved with 12% being declined.

We are a team:

We are piloting a Legacy Mentoring programme to support those new to role, an area or the NHS, by upskilling experienced colleagues. The programme started in February 2025 and is due to finish in June 2025 when it will be evaluated.

Homestay:

We strengthened the Homestay offering where ESHT colleagues can host accommodation to other NHS and Social care staff. We now have 41 ESHT hosts, bookings remain steady, and Eastbourne is in the top five viewed locations by guests.

Staff support:

In November 2024, we introduced a new process for receiving requests from staff to the People Engagement team for support. This was to streamline the work being carried out within the team: ensuring the right interventions and support was being offered at the appropriate time and to create a mechanism of evaluating the impact of our work. To date 29 teams have been supported via this process.

- Updated – A new 5-year leadership roadmap has been agreed by the Executive team and collaborative work has been underway with our integrated education team to develop a Train the Trainer approach for coaching and mentoring.
- Updated – The Wellbeing team has achieved a Silver accreditation for Wellbeing at Work.
- Updated – A six monthly holistic Wellbeing Programme has been developed, informed by wellbeing listening events (including a newly introduced Trust-wide Quarterly Wellbeing meeting with our Non-Executive Director Wellbeing Guardian sponsor, increasing the focus on Mental Health Aware Training).
- Relaunch – We relaunched our Wellbeing Champions, the Wellbeing Champions training and Network meetings / channel for sharing best practice (158 staff are currently undertaking this role across the Trust)

- New ways of working – We have developed an automated death in service process, evaluation of service delivery, and feedback for continuous improvement
- Additional focus: We are piloting Action Learning Sets across the Trust, Pennies from Heaven / Silver Award achieved, Smokefree/Vape free focus, and introduced Smokefree Staff Focus groups- actions progressing.
- An annual Wellbeing Pledge for 2025 has been agreed by Executives and covers the seven elements of the People Promise. This replaces a 5-year Wellbeing Strategy and ensures we are flexible to the changing needs of our people.
- Updated Wellbeing programme developed with self-care resources, informed by wellbeing listening events held throughout the year.
- Occupational Health retained the national SEQOHS accreditation (Safe Effective Quality Occupational Health Service)
- Updated – Following the launch of our new Trust Values in 2024, widespread consultation with our people work is underway to embed the values and underpinning behaviours. A draft Values and Behaviours Framework and toolkit will be shared at the April Partnership Forum with wider stakeholder consultation to follow. We aim to launch in September 2025.
- Working with our Medical Revalidation team to embed values and associated behaviours into our medical and nursing appraisals. A variation of the 360-feedback tool has been developed for in-house use and is under consultation with Revalidation colleagues.

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	ESHT 2023
"Care and treatment"	7.9	8.3	8.3

National Inpatient Survey 2023 (publication date 21 August 2024)

This survey relates to adult patients discharged in November 2023 following an inpatient episode (overnight stay), we are not able to identify inpatient areas or dates that the feedback relates to.

493 of East Sussex Healthcare NHS Trust patients responded to the survey providing a response rate of 42.65%.

Four questions have been noted as either new or wording has changed, therefore results for these questions are not comparable.

Trust Banding

- Results were about the same as other Trusts for 43 questions.
- Results were much better than most Trusts for 0 questions.
- Results were better than most Trusts for 3 questions.

1. If you brought medication with you to hospital, were you able to take it when you needed to?
2. Were you able to get hospital food outside of set mealtimes?
3. During your hospital stay, were you given the opportunity to give your views on the quality of your care?

- Results were somewhat better than most Trusts for 1 question:

1. Were you offered food that met any dietary needs or requirements you had?

- Results were much worse than most Trusts for 0 questions.
- Results were worse than most Trusts for 0 questions.
- Results were somewhat worse than most Trusts for 2 questions.

1. Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping.
2. Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?

Changes since 2022

Average score: 76.3% (up by 0.6% from 2022)
Better by 5% or more: 0 questions (vs. 2022 = 0 questions)
Less than 5% change: 45 questions (vs. 2022 = 49 questions)
Worse by 5% or more: 2 questions (vs. 2022 = 2 questions)

	Question which scored worse by 5% or more	2022 score	2023 score
Q.8	Did hospital staff explain the reasons for changing wards during the night in a way you could understand?	69.9%	65.6%
Q.36	To what extent did hospital staff involve your family or carers in discussions about you leaving?	58.3%	53.3%

National Comparisons

Top 20% of Trusts: 9 questions (vs. 2022= 7 questions)
Middle 60% of Trusts: 43 questions (vs. 2022= 39 questions)
Bottom 20% of Trusts: 3 questions (vs. 2022= 7 questions)

	Question which scored worse by 20% or more	2022 score	2023 score
Q.5	How long do you feel you had to wait to get a bed on a ward after you arrived at hospital?	69.2%	71.5%
Q.6.4	Were you ever prevented from sleeping at night by any of the following: hospital lighting	81.3%	83.8%
Q.11	If you brought medication with you to hospital, were you able to take is when you needed?	83.4%	87.1%
Q.12	Were you offered food that met your dietary needs or requirements you had? This could include religious, medical or allergy requirements, vegetarian/ vegan options or different food formats such as liquified or puree food	83.8%	87.5%
Q.15	Were you able to get hospital food outside of set mealtimes? This could include additional food if you missed set mealtimes due to operational/ procedures or another reason	68.1%	72.2%
Q.16.3	During your time in hospital, did you get enough to drink: No because was not given enough to drink	96.7%	97.1%
Q.25	To what extent did staff looking after you involve you in decisions about your care and treatment?	67.8%	71.8%
Q.27	Did you feel able to members of staff about your worries or fears?	76.8%	79.9%
Q.50	During your hospital stay, were you given the opportunity to give your views on the quality of your care?	N/A%	43.4%

	Question which scored worse by 20% or more	2022 score	2023 score
Q.16.1	During your time in hospital, did you get enough to drink? Yes	91.4%	90.6%
Q.35	To what extent did staff involve you in decisions about you leaving hospital?	67.7%	65.5%
Q.46	After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	62.1%	58.7%

Next steps

Overall, this is a positive report, average score and questions which scored less than 5% change and worse by 5% changed remained about the same. The biggest changes were against the national comparisons, two additional questions were in the top 20% of Trusts, four additional questions in the middle 60% of Trusts and four fewer questions in the bottom 20% of Trusts.

The theme "discharge" featured in questions where improvements can be made, these questions specifically will be shared with the Transfer of Care Hub and the question relating to Virtual Wards will be shared with the team. In addition, this report will be shared widely, with Divisional Directors of Operations, Assistant Directors of Nursing and at Patient Safety and Quality Group.

Report: Annexes

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

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Statement from Commissioners

Thank you for giving NHS Sussex Integrated Care Board (ICB) the opportunity to comment on ESHT Quality Account for 2024/25. We appreciate the collaborative working and open communication with the Trusts clinicians over 2024/25, notably at the Quality Review Meetings (QRMs) and other meetings with NHS Sussex.

NHS Sussex has reviewed the Quality Account for 2024/25 and consider it to be a fair and accurate reflection of the Trust's performance during the year.

NHS Sussex recognises the Trust commitment to using clinical audit to make improvements in patient care and the continued improvement in the key priority areas in 2024/25, notably:

- Raising awareness of the safe administration/prescribing of paracetamol and relevance of patients' weight and other risk factors including liver function, through improving recording.
- Improving the reduction of the number of rejected pathology samples including development of 'A Use of Pathology Services' policy.
- Improving the quality of decision making for people who lack capacity through reviewing the process for patients with a learning disability diagnosis, by auditing the decision making that affects patients as they access treatment.
- NHS Sussex is supportive of three strategic improvement priorities outlined by the Trust, noting the range of wider improvement projects planned during the 2025/26 year including:
- Developing the community Intermediate Care Rehabilitation Model with a single integrated service and a Single point of access ensuring ESHT match the right clinical and care skills to support patients to get home.
- Improving the care of mental health patients through collaboration with wards, local Mental Health Trust, Local Authority, voluntary, community, social enterprises and other arm's length providers, development of an Enhanced Care Team and parallel assessment in the Emergency Department/ wards.
- Increasing the quality of World Health Organisation (WHO) Safety Checklist compliance across the Trust through cross area review and auditing.

NHS Sussex will continue to seek assurance regarding progress of implementation of these priorities throughout the year via our established processes and we look forward to the continued collaborative working with ESHT and wider system partners over the coming year.

Yours sincerely,

Naomi Ellis
Deputy Chief Nursing Officer
On behalf of Allison Cannon, Chief Nursing Officer, NHS Sussex

Statement from Healthwatch East Sussex

Healthwatch in Sussex welcomes the opportunity to review the Quality Accounts but cannot comment on the full content, much of which is outside of our remit. We are always keen that NHS bodies clearly communicate how they've captured patient experiences, what they've heard and how they've used this to support change and improvement in satisfaction and health outcomes. Healthwatch values the partnership working that we have with East Sussex Healthcare NHS Trust and we regularly share insight, ask questions and escalate concerns. We also monitor Trust activity through local and national performance indicators.

Yours sincerely,

Simon Kiley

Deputy Chief Executive
East Sussex Community Voice (ESCV) on behalf of Healthwatch in Sussex

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 Account 2024/25.

HOSC has invited ESHT to attend all its meetings over the past year to look at various issues, including monitoring of the recent changes to paediatric services at Eastbourne District General Hospital (EDGH), missed appointments, the ophthalmology transformation programme, and the Sussex healthcare system's winter plan. In addition, ESHT officers support the Committee in its review of audiology services in the county. The Committee thanks those Trust officers and clinicians who gave their time to attend meetings over the past year.

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. The Committee, therefore, welcomes the success ESHT has achieved in 2024/25, despite the considerable pressures placed on it and the wider health and social care system over the past year.

The Committee also notes that construction of the Sussex Surgical Centre has been ongoing for the past year. The HOSC welcomes its development and looks forward to its opening in the near future for the benefit of patients in East Sussex and beyond.

Quality Priorities

The 2024/25 priorities for improvement focussed on implementing the safe administration and prescription of paracetamol, reducing the number of rejected pathology samples and improving the quality of decision making for those who lack capacity. The Committee is pleased to see that progress has been made in each of these quality priorities and that the Trust is working to embed improvements, noting also the areas where the Trust will continue to make improvements in each of these.

The Committee also welcomes the Trust's chosen priorities for improvement in 2025/26. In particular, HOSC welcomes that Community Intermediate Care Rehabilitation Model has been chosen as the patient experience priority. The Committee sees this as a key priority in reducing waits and delivering better outcomes for patients and ensuring that there are fewer patients in hospital with No Criteria to Reside. HOSC welcomes the integrated and partnership approach ESHT has outlined in this area, recognising that system and patient flow which should be an area of focus for the entire health and care system over the next year. HOSC also

welcomes that improving care for mental health patients will be a priority over the coming year and again supports the partnership approach that ESHT plans to take in delivering improvements in this priority area.

The HOSC welcomes the Trust's has participated all in national clinical audits and national confidential enquiries it was eligible to in 2024/25. The Committee also notes the Trust's participation in 53 clinical studies and is pleased to see that engagement with research remains a Trust priority as it has the potential to benefit patient care. The HOSC also notes the Learning from Deaths information provided in the Quality Account and the actions taken by the Trust to improve in response to these. The Committee believes that continuous learning and improvements to patient safety and experience should remain critical to the work of the Trust over the next year.

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

Councillor Colin Belsey
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

Jayne Black
Chief Executive

Steve Phoenix
Chairman

Report: Appendices

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Appendix 1 - National Clinical Audit and National Confidential Enquiries Programme

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 – Blood Sodium	Y	Y
NCEPOD - Emergency Procedures in Children and Young People	Y	Y
NCEPOD - Acute Limb Ischaemia	Y	Y
NCEPOD – ICU Rehabilitation	Y	Y

National Clinical Audits	ESHT Eligible	ESHT Participation
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
Breast and Cosmetic Implant Registry	Y	Y
National Audit of Seizures and Epilepsies in Children and 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 Clinical Audits	ESHT Eligible	ESHT Participation
National Gastrointestinal Cancer Audit Programme - Bowel Cancer	Y	Y
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Y	Y
National Pancreatic Cancer Audit (NPaCA)	Y	Y
National Prostate Cancer Audit	Y	Y
National Kidney Cancer Audit (NKCA)	Y	Y
National Lung Cancer Audit (NLCA)	Y	Y
National Non-Hodgkin Lymphoma Audit (NNHLA)	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 - Oesohago 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 Emergency Laparotomy Audit (NELA)	Y	Y
National Paediatric Diabetes Audit (NPDA)	Y	Y
National Pregnancy in Diabetes (NPID) Audit	Y	Y
National Gestational Diabetes Audit	Y	Y
National Diabetes Inpatient Safety Audit	Y	Y
National Diabetes Foot Care Audit (NDFA)	Y	Y
National Diabetes Adult Audit	Y	Y
Diabetes Prevention Programme (DPP) Audit	Y	Y
Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	Y
National Diabetes Audit Integrated Specialist Survey	Y	Y
National Ophthalmology Database (Adult Cataract Audit)	Y	Y
Age-related Macular Degeneration Audit (AMD)	Y	Y
Stroke National Audit (SSNAP)	Y	Y
Learning Disability Mortality Review Programme (LEDER)	Y	Y

National Clinical Audits	ESHT Eligible	ESHT Participation
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 – Self Harm	Y	Y
Adolescent Mental Health	Y	Y
Time Critical Medications	Y	Y
Non-melanoma skin cancers	Y	Y
Oral and Dentoalveolar Surgery	Y	Y
National Audit of Care at the End of Life (NACEL)	Y	Y
BAUS Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Y	Y
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Y	Y
BAUS Penile Fracture (SNAP) Audit	Y	Y
British Hernia Society Registry	Y	Y
Perioperative Quality Improvement Programme (PQIP)	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 2024/25, 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 Adult Diabetes Audit	Trust - 7191	100% (all required data submitted)
National Pregnancy in Diabetes Audit	Trust - 26	100% (all required data submitted)
National Paediatric Diabetes Audit	Trust - 192	100% (all required data submitted)
National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standard QS138	EDGH - 37 CONQUEST - 37	100% (all required data submitted)
National Comparative Audit of Blood Transfusion - Bedside Transfusion Audit	EDGH - 25 CONQUEST - 22	100% (all required data submitted)
Non-melanoma skin cancers	Trust - 199	100% (all required data submitted)
Oral and Dentoalveolar Surgery	Trust - 137	100% (all required data submitted)
National Audit of Care at the End of Life (NACEL)	EDGH - 90 CONQUEST - 90	100% (all required data submitted)
BAUS Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Trust - 33	100% (all required data submitted)

BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Trust - 12	100% (all required data submitted)
BAUS Penile Fracture Audit	Trust - 1	100% (all required data submitted)
Society for Acute Medicine Benchmarking Audit (SAMBA)	EDGH - 78 CONQUEST - 39	100% (all required data submitted)
Mental Health – Self Harm	EDGH - 400 CONQUEST - 349	100% (all required data submitted)
Care of Older People	EDGH - 297 CONQUEST - 296	100% (all required data submitted)
NCEPOD - Emergency Procedures in Children and Young People	13 x Clinical Questionnaires 1 x Case note 2 x Organisational Questionnaires	100% (all required data submitted)
NCEPOD - Acute Limb Ischaemia	4 x Case notes 2 x Organisational Questionnaires	100% (all required data submitted)
NCEPOD – ICU Rehabilitation	10 x Clinical Questionnaires 9 x Case notes 2 x Organisational Questionnaires	90% required case note questionnaires submitted All other elements 100%

Report: Glossary

Social Media

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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.

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.

Haemolysed

blood sample where the red blood cells have burst and released their contents, including haemoglobin, into the plasma. This happens during or after blood collection and can lead to inaccurate test results, as the released components can interfere with various laboratory analyses.

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 Staphylococus Aureus (MSSA)

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

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

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

Multidisciplinary

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

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 is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk

NerveCentre

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

NHS Digital

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

NHS England (NHSE) and NHS Improvement (NHSI)

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

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.

Potassium EDTA

A type of blood tube that is used for certain tests, if we don't receive a sample in this tube then those tests cannot be performed.

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

Surgical Site Infection

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

Surgical Site Infection Surveillance Service (SSISS)

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

Supportive and Palliative Care Indicators Tool (SPICT)

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

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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