Quality Account
2018-2019
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Part 1 – Introduction

Statement of Quality from the Chief Executive

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

This report summarises the Trust’s quality achievements during 2018/19 and is designed to assure our local population, our patients and our partners that we provide high quality clinical care to our patients and service users. It also highlights areas for further improvement and sets out what we are doing to improve, in addition to our quality priorities for 2019/20.

Last year was a significant one for the Trust, with our quality improvements being recognised by the Care Quality Commission (CQC). The CQC noted we had made a marked improvement in the quality of our care and concluded that the Trust no longer needs to be in special measures for quality. The CQC rated almost everything they inspected as ‘good’ and for the first time we received ‘outstanding’ ratings in three categories. It is a testament to the hard work of everyone in the organisation that the CQC has acknowledged the significant progress we have made in the quality of our services. The CQC reported that those they spoke to across the Trust placed compassion and empathy as integral to providing good care, and it was evident that many “went the extra mile”. We hope that the CQC will re-inspect the Trust during 2019/20 and we are confident of improving further.

The Trust has made good progress towards the priorities we set in the 2017/18 Quality Account, many of which will continue within programmes over this year. We have seen improvements in the number of patients being identified and quickly treated for sepsis, which has led to a significant reduction in mortality. Throughout the year, we have also seen a reduction in the number of falls leading to harm and a 76% reduction in the number of category 3 and 4 pressure ulcers compared with last year. We continue to see success for our clinical services as part of the national clinical audit programme, and we are proud that in many clinical areas our results feature in the highest levels of performance in the country.

We have maintained the improvements that we have seen in our handling of complaints and incidents and we continue to be encouraged by the high levels of satisfaction that our patients report - we now have a rating of four and a half stars out of five for both of our acute hospitals.

We know that the key to maintaining and improving the quality of our services, care for our patients and the experience of our staff is listening to feedback and ensuring that we make changes and embed improvements based on the feedback we receive. For our patients this means better two-way communication during every step of their care journey and ensuring that they are fully informed and involved in decisions relating to their care. For members of the public this means ensuring that we embed a culture of experience based co-design when redesigning services or care pathways. For members of staff it means continuing to
encourage an open reporting culture so that they feel safe and able to raise concerns. We were pleased to see this reflected in some of the improvements we saw in the NHS staff survey published in March this year.

All of this work is underpinned by the developments we have made alongside our partners in our local Clinical Commissioning Groups and East Sussex County Council as part of our local (Sussex and East Surrey) Sustainability and Transformation Partnership. Our work together to integrate and align primary, secondary, community and specialist services is driving the transformations necessary to meet future health needs of our populations. The Trust’s close relationship with Healthwatch East Sussex has also continued to provide a valuable resource to understand local people’s experience of care at the Trust.

Our aim is to be an outstanding organisation that is always improving; providing excellent healthcare for the people of East Sussex, and a workplace in which people are happy and proud to work. The evidence provided within this quality report demonstrates our commitment to providing consistently high standards of care, across all of our services, and seek out every opportunity to make improvements to achieve our ambition of becoming outstanding in every area.

Dr Adrian Bull
Chief Executive
24 June 2019
About us and the service we provide

East Sussex Healthcare NHS Trust is an integrated community and acute provider, formed in 2011 from the merger of East Sussex Community Health Services and East Sussex Hospitals NHS Trust. We provide a wide range of community, intermediate care, rehabilitation and general acute services to the population of East Sussex and surrounding areas.

As an integrated acute and community Trust, our workforce comprises a number of disciplines including nursing and midwifery, medical, scientific, technical, dental, allied health professionals, estates and ancillary, and administration and clerical staff.

The Trust operates from two acute hospital sites – Eastbourne District General Hospital and Conquest Hospital in Hastings, both of which have Emergency Departments and provide care 24 hours a day. We offer a comprehensive range of surgical, medical and maternity services supported by a full range of diagnostic and therapy services.

We also have over 80 other sites ranging in scale from shared community based premises to community hospitals. At Bexhill Hospital we offer outpatients, day surgery, rehabilitation and intermediate care services. Outpatient services, rehabilitation and inpatient intermediate care services are also provided at Rye, Winchelsea and District Memorial Hospital. We provide day surgery and outpatient care at Uckfield Hospital. We provide rehabilitation services jointly with East Sussex County Council Adult Social Care from Firwood House in Eastbourne and Bexhill Health Centre.

Around 550,000 people live in East Sussex and the Trust is one of the largest organisations in the county. We employ over 7,000 dedicated staff with an annual turnover of £400 million.

Our services are managed and provided through five core clinical divisions:

- Diagnostics, Anaesthetics and Surgery
- Medicine
- Out of Hospitals
- Urgent Care
- Women, Children and Sexual Health
Our Vision, Values and Ambition – to be Outstanding and Always Improving

Our vision at East Sussex Healthcare NHS Trust is to combine community and hospital services to provide safe, compassionate and high quality care to improve the health and wellbeing of the people of East Sussex.

Our values are fundamental to how we undertake our everyday work. They shape our beliefs and behaviours and were developed by our staff.

Our ambition is to be an outstanding organisation which is always improving.

Operational priorities:
- the CQC quality standards in each of their quality domains
- our constitutional standards, such as referral to treatment waiting times
- financial sustainability in the long term

Our Objectives:
- Safe patient care is our highest priority: Delivering high quality services that achieve and demonstrate the best outcomes and provide an excellent experience for patients.
- All members of staff will be valued and respected: Members of staff will be involved in decisions about the services they provide and offered training and development to fulfil their roles and help them progress.
- Our clinical services will be sustainable: Working with commissioners, our local authority and other stakeholders we will plan and deliver health and care services that meet the needs of our local population now and in the future
- We will operate efficiently and effectively: Diagnosing and treating patients in a timely fashion that supports their return to health
• **We will use our resources efficiently and effectively**: Ensuring our services financially sustainable for the benefit of our patients and their care

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**Our vision, values, priorities and objectives** have been embedded across the organisation and made meaningful in our everyday work. They form the foundations for personal objectives, internal communications, and external communication with partner organisations and other stakeholders.
Some of our achievements in 2018/19

April – June 2018

Refurbishment of Acute Admissions Unit at Conquest Hospital
A £70,000 refurbishment of the Acute Admissions Unit at Conquest Hospital was completed in April 2018. The refurbishment included new reception areas, a drug preparation room, new flooring, wipe down surfaces for easy cleaning and an Omnicell drug dispensing cabinet.

CQC acknowledges ‘good’ services at ESHT following inspection
The Care Quality Commission (CQC) rated the Trust as ‘Good’ or ‘Outstanding’ in almost all of the services inspected in March 2018. The CQC noted the Trust had made a marked improvement in the quality of its care and concluded that the Trust no longer needed to be in special measures for quality.

Trust performs well in national Lung Cancer Audit
The National Lung Cancer Audit showed the Trust performing above the national average in all the parameters of performance. In addition, the Trust exceeded the targets set by the National Lung Cancer Audit (NLCA).

Trust awarded for commitment to patient safety by the National Joint Registry
The Trust was awarded a ‘Quality Data Provider’ certificate by the National Joint Registry (NJR), after successfully completing a national programme of local data audits and meeting a number of targets related to patient safety.

Underwater bikes benefit aquatic physiotherapy patients
Our aquatic physiotherapy (hydrotherapy) facilities were one of the first in the NHS in the South East to offer underwater bikes for patients as part of treatment thanks to a donation from the Friends of Eastbourne Hospital.

Cycling programme delivers healthy benefits for hospital staff
Colleagues at Eastbourne DGH completed a free 10 week intensive cycling and walking programme, designed to improve staff health and encourage better lifestyle choices.

Trust performs well in national Inpatient Survey
The Trust continues to be better or equal to the national average in three out of four questions asked in the annual national Inpatient Survey. The survey highlighted that more patients felt they were being consulted about the quality of care received compared with the previous year’s survey.

Trust leads national project for people with swallowing difficulties
The Trust has implemented a new way of classifying modified foods and fluids for people who have swallowing difficulties. In line with recommendations from the Royal College of Speech and Language Therapists (RCSLT), ESHT is an early implementer, spearheading the one-year phased implementation which will be adopted nationally by all healthcare providers by 2019.
New endocrine drug is first to be prescribed in UK
The Trust became the first in the UK to prescribe a new endocrine drug called Natpar, a recombinant parathyroid hormone.

First of its kind robotic hoist in UK at Bexhill Hospital
The Irvine Unit at Bexhill Hospital is the first in the UK to have a mobile robotic hoist, thanks to the generosity of the Bexhill Hospital League of Friends. The Swiss made, state-of-the-art robotic hoist, costing around £60,000, is able to support the weight of patients whilst they learn to balance and walk again, at the same time offering them full protection from falling.

New diagnostic equipment transforms Trust’s pathology laboratories
The latest advanced diagnostic equipment was installed in the pathology laboratories at Conquest Hospital and Eastbourne DGH, in June 2018. The new equipment, which is part of a £10 million, seven year contract with Roche Diagnostics Ltd., is some of the most advanced pathology equipment available.

Refurbishment of Special Care Baby Unit
A £150,000 refurbishment of the Special Care Baby Unit Nursery at Conquest Hospital was completed in June 2018, providing doctors and nurses easier access to the incubators and improved provision of care to the babies.

System to track equipment introduced
A new system called iAsset, which tracks the location of medical equipment and Trust iPads in our acute hospitals, was introduced, helping to reduce the amount of lost equipment and the time spent searching for it.

Increased recognition and prompt treatment of Sepsis helps to save lives
Improvements in the recognition, diagnosis and treatment of Sepsis led to a reduction in mortality rates at ESHT, with a 20 percentage point reduction in our Risk Adjusted Mortality Index (RAMI) between April 2017 and April 2018. RAMI is a ratio used across the NHS to show the actual number of deaths compared to the expected number of deaths in a particular population.

July - September 2018

Newly refurbished Maxillofacial and Orthodontic department opens
The Maxillofacial and Orthodontic department at Eastbourne DGH was opened following refurbishment of the four clinical treatment rooms with the installation of new equipment, including dental examination chairs and operating lights. The £125,000 refurbishment was substantially funded by the Friends of Eastbourne Hospital with a donation of £102,000.

Diabetes Nurses achieve accreditation for educational programme
Our Diabetes Specialist Nurses achieved accreditation to deliver their educational programme supporting people living with Type 1 diabetes. The education programme called SADIE (Skills for Adjusting Diet and Insulin in East Sussex) was approved by the Quality Institute for Self-Management in Education and Training (QISMET) for another three years.
Young adults with a Learning Difficulty or Disability graduate from Project SEARCH
In July 2018, eight young people with a Learning Difficulty or Disability graduated from Project SEARCH, a supported internship programme designed to give young people skills to gain competitive paid employment. Project SEARCH has been running since September 2014.

Endoscopy Units recognised for high quality care
Our Endoscopy Units were awarded by The Royal College of Physicians with Joint Advisory Group (JAG) accreditation for Gastrointestinal Endoscopy. The accreditation is awarded to endoscopy units that are able to meet a stringent set of standards relating to high quality patient care demonstrating a safe, patient centred and efficient service.

Number of births at Midwifery Unit increases by over 25%
The number of births at Eastbourne Midwifery Unit increased by over 25% between April and September 2018, compared to the same period in 2017. The increase in births reflects growing confidence in the Unit and the excellent birthing experience provided to women and their families by the midwives on the Unit.

October – December 2018

Patients give excellent feedback on their cancer care
Care of cancer patients at the Trust was again highly praised in a national survey of patients who were diagnosed with the disease. The National Cancer Patient Experience Survey, now in its seventh year was completed by over 500 local patients. Patients were asked to rate their care overall on a scale of 1-10 and patients in East Sussex rated their care as 8.9 out of 10, an increase on the previous year’s survey of 8.6.

Trust’s Pathology Departments achieve national accreditation
Our Pathology Departments achieved ISO accreditation, a mark of quality that can be used to identify safe, efficient and patient-focused services.

Trust improves its rating for Emergency Response
The Trust made significant improvement against the core standards for Emergency Preparedness, Resilience and Response and is now rated as ‘Substantially Compliant’ compared with ‘Partially Compliant’ in 2017.

High quality trauma care at Trust
Data published by the Trauma Audit and Research Network (TARN) highlighted the high quality of trauma care provided at Conquest Hospital and Eastbourne DGH. The data looked at the whole trauma patient journey from the Emergency Department through the hospital and showed that Conquest Hospital was the fourth best in terms of survival outcome with Eastbourne DGH 22\textsuperscript{nd} out of all the
country’s hospitals that provide a similar level service.

Trust team win prestigious award
The prestigious Royal College of Speech and Language Therapists (RCSLT) Sternberg Award for Clinical Innovation for work to introduce a One Stop Swallow Disorder Clinic which has reduced waiting time from 24 to 5 weeks and improved patient safety and satisfaction.

Trust joins national collaborative study for orthopaedic surgery
The Trust successfully applied to participate in a national collaborative study aiming to improve outcomes in elective orthopaedic surgery. The Trust is one of only 30 in the country participating in this innovative Quality Improvement, Patient Safety and Research trial which aims to improve outcomes after total hip and total knee replacements.

New CT scanner suite opened at Eastbourne DGH
A new CT scanner suite with two state-of-the-art CT scanners was officially opened. The new CT scanner suite cost £2.9 million, which included a £500,000 CT scanner funded by The Friends of Eastbourne Hospital.

Trust awarded £1.7million funding to implement electronic prescribing
The Trust will introduce a new electronic prescribing and medicines administration system supported by £1.7million of additional funding from the Department of Health and Social Care. The system will free up time for staff by moving away from paper-based systems, help to reduce medication errors and reduce duplication of information.

Doctors offer first pacemaker linked to an Android Smartphone in the South of England
An East Sussex patient became the first person in the South of England to receive a permanent pacemaker which communicates directly with an Android smartphone and tablet. The pacemaker monitors the patient’s heart rhythm and, via a downloaded app, can communicate with doctors in the hospital. This remote monitoring eliminates the need for a dedicated bedside monitor or other remote monitoring hardware.

New MRI Scanners for Conquest Hospital
Patients at the Conquest Hospital will soon benefit from two state-of-the-art MRI scanners thanks to the generosity of local people, the Friends of Conquest Hospital and the Bexhill Hospital League of Friends. Construction work on the new MRI Scanner Suite is now underway and is expected to be completed in 2019.

New staff Extranet launched
Members of staff at ESHT now have access to the Trust’s new extranet. The new platform will help to support better staff engagement and involvement, facilitate collaboration and initiate a shift in staff culture towards active knowledge.
Trust shows improvement in maternity services
A national survey on maternity services undertaken on behalf of the Care Quality Commission (CQC), found that maternity care at the Trust had improved across a number of areas. Twenty one of the questions showed an improvement or remained the same, when compared to the same survey undertaken in 2017.

New community maternity team deliver first baby
Our Maternity Service became the first in the Sussex and Surrey region to successfully launch a new community maternity team and deliver their first baby in line with the recommendations from The National Maternity Review: Better Births Report.

First to offer new patient test to improve early cancer detection
The Trust was the first in the country to offer patients a simple test as part of the colorectal cancer pathway. The test helps detect hidden quantities of blood in a stool sample which can be an indication of bowel cancer.

Work starts on new Urology Investigation Suite
Work has started on a £1.3 million Urology Investigation Suite at Eastbourne DGH and is expected to be completed by June 2019. Once finished, the new unit will offer a dedicated one stop urology clinic and an enhanced patient experience.

Trust’s successful flu campaign
Our staff flu vaccination rate has improved, 76% of frontline staff had the jab in 2018/19, compared to 72% in 2017/18.

Nerve Centre: Live Bed State being introduced
To support effective patient flow we are in the process of introducing Nerve Centre: Live Bed State, which provides clinicians and health care professionals with centralised software to manage patient flow and bed status. The system allows members of staff to view the live bed state in the wards and know the bed status for each ward.

Annual staff survey shows continued improvements
The results of the annual staff survey showed continued year-on-year improvement in areas including the quality of appraisals, our safety culture and addressing bullying and harassment. Members of staff said they felt more supported and valued by their managers and more would now recommend ESHT as a place to work and receive care.

Multidisciplinary Diabetic Foot Clinic launched
A new multidisciplinary diabetic foot clinic has been launched at Conquest Hospital which brings together in one clinic, Vascular and Diabetic doctors and specialist nurses along with Podiatrists, to provide the best possible care for patients with diabetic foot problems.

Intermediate Care sees significant reduction in length of stay
Following an 18 month transformation programme, the Trust’s intermediate care services at Irvine Rehabilitation Unit (Bexhill) and Rye Memorial Care Centre have seen their length of stay reduce by an average of almost 10 days (figures for three months February to April 2018 compared to November 2018 to January 2019).
Our partnerships and collaboration

The Trust continues to work closely with our local commissioners, Eastbourne, Hailsham and Seaford, Hastings and Rother and High Weald, Lewes Havens CCGs and East Sussex County Council to further develop and deliver integrated health and care services for our local population. Working as an alliance with commissioners, primary care and the local authority we are working towards integration of our health and care services; so we can demonstrate the best use of resources to meet the health and social care needs of the people of East Sussex. We have further developed our integrated locality teams who work closely with our local primary care services to ensure that people receive the right care as close to home as possible. A single point of access to many health and care services means that we can respond quickly with the right support, avoid unnecessary hospital admissions and get people home in a timely way.

The Sussex and East Surrey Sustainability and Transformation Partnership (STP) enables us to work in a bigger network. This enables us to plan how our patients can access specialist services that we cannot provide locally, such as major trauma services and specialist cancer services.

As part of a national network, there is a local Healthwatch in every local authority area in England. Healthwatch East Sussex works with the public of East Sussex to ensure that health and social care services work for the people who use them. Their focus is on understanding the needs, experiences and concerns of people of all ages who use services and to then speak out on their behalf. Their role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work and decision making. They do this by gathering people’s experiences and identifying issues that are important to them and, when addressed, which will make services better for everybody.

This year Healthwatch undertook a great deal of activity at ESHT, including a review of maternity services and teams of volunteers observing our care of patients as part of their listening tour and separately over a 24 hours period. The feedback supports us with the continuing improvement of our processes.
Purpose of the Quality Account and how it was developed

The Quality Account is an annual public report 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 are required to produce a Quality Account. The report incorporates mandatory statements and sections which cover areas such as our participation in research, clinical audits, a review of our quality performance indicators and what our regulator says about the services and care we provide.

In addition to the mandatory elements of the Quality Account we have engaged with staff, patients and public, our commissioners and other stakeholders to ensure that the account gives an insight into the organisation and reflects the improvement priorities that are important to us all.
Part 2 – Priorities for Improvement and statements of assurance from the Board of Directors

Part 2.1 – Priorities for Improvement in 2019/20

Our Quality and Safety Strategy (2017 – 2020) outlines the improvements required to achieve the Trust's ambition to become an outstanding organisation by 2020 and describes the main improvement schemes we will be working on to ensure that we are able to deliver our ambition.

For 2019/20 we have developed four quality improvement priorities which are aligned with the strategic priorities of the Trust. These are described in the table below, with further detail on the rationale, what we are planning to do, how we will monitor progress and how we will demonstrate our success in the pages that follow.

Table 1: Priorities for improvement in 2019/20

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<th>Quality Domain</th>
<th>Priorities for improvement 2019/20</th>
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<td>1. Continue to improve the management of the deteriorating patient</td>
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<td>2. Improve compliance against the 7 day working standard for ongoing consultant-directed review</td>
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<tr>
<td>Clinical Effectiveness</td>
<td>3. Continued implementation and development of the Excellence in Care Programme</td>
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<td>Patient Experience</td>
<td>4. Improve communication so that patients feel better informed about their care and treatment</td>
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1. Continue to improve the management of the deteriorating patient

Why this has been chosen as priority

Early detection and treatment of physiological deterioration has been shown to improve the clinical outcomes for patients, and was made an improvement priority for the Trust in 2018/19. The priority in 2018/19 focused specifically on supporting the early recognition and prompt treatment of suspected sepsis, acute kidney injury (AKI) and improving processes for escalation.
As part of the work completed in 2018/19, the Trust has made considerable improvements, including introduction of a new Treatment Escalation Planning (TEP) tool to assist clinical staff with appropriate planning of ongoing care.

The TEP tool was introduced across the Trust from 1 April 2019, and therefore the priority for 2019/20 will be to ensure that use of the TEP tool is embedded into clinical practice and used consistently as an aid to improve management of deterioration and document individualised goals of care. The new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process was also launched in April and will support this process and the ongoing work regarding End of Life Care.

**What we are going to do**

We still have a long way to go to ensure that our TEP is well utilised within the Trust. Embedding a new process into clinical practice can take some time and changing the behaviour regarding planning for escalation may also be challenging. This is why we have identified the embedding of the TEP process as a key priority for the Trust in 2019/20, which has been outlined earlier in this report.

Education is a key part of this. We need to ensure that the evidence and rationale for change is understood and embraced. We will be spending some time with our Junior Doctors both formally (lectures and teaching sessions) and also informally with Ward based “walk abouts”.

To inform our continuing Quality Improvement (QI) work, focusing on colleague engagement, we will also undertake a qualitative baseline survey to gain insight into clinical staff awareness of the current deteriorating patient escalation process. This will be repeated in 6 months to test the effectiveness of the QI interventions to improve recognition and escalation of the deteriorating patient following the launch of the new trust guidelines: The Management of the Deteriorating Patient Clinical Guidelines.

**What will success look like?**

- Increase in the number of patients who have a Treatment Escalation Plan in place following a MET / SET call (baseline zero as new process)
- Reduction in the number of cardiac arrests associated with un-recognised deterioration in the preceding 12 hours (‘Failure to rescue’)
- Reduction in avoidable surgical admissions to Critical Care Unit(s) (baseline to be established)

**How we will monitor progress**

We will continue to monitor progress and track the measures of improvement through the Deteriorating Patient Improvement Group (DPIG) which reports to the Trust’s Clinical Outcomes Group chaired by the Medical Director.

We will continue to monitor and report VitalPAC: clinical observations undertaken on time and time taken to perform and record clinical observations led by the Critical Care Outreach Team.
We will also continue to monitor improvement and embed sepsis screening and implementation of the sepsis 6 pathway across our acute care areas.

2. Improve compliance against the 7 day working standard for ongoing consultant-directed review

Why this has been chosen as priority
The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall there are ten clinical standards for 7DS, of which four clinical standards have been made priorities for delivery by NHS England (NHSE) and NHS Improvement (NHSI). Improvement in delivery against the four priority 7DS clinical standards was identified as an improvement priority in 2018/19, and the Trust has made progress in improving delivery against the four priority 7DS clinical standards throughout the year.

Standard 8 related to ongoing review of inpatients after the initial consultant assessment, recognising that patient outcomes and length of stay improvement with greater ongoing senior input. Patients in critical areas (ITU and HDU) should be reviewed twice daily by a consultant. Those in other inpatient areas should be reviewed once daily. However, these consultant reviews may be formally delegated to another team member. Some inpatients (e.g. patients in rehabilitation or medically stable patients awaiting packages of care or placement in residential care) may not need regular daily medical review unless their condition changes or nursing staff have concerns. In such patients, this should be specified in the patient record.

Our self-assessment of compliance against the 7DS standards in February 2019 indicated that the Trust has not met the standard overall for ongoing consultant-directed review (clinical standard 8), with particular challenge at weekends in a number of specialities where the formalised arrangement for consultant cover does not include a consultant-led ward round. Documentation of need for medical review and delegation of consultant review was also found to be variable across specialities and wards, and remains poor in some.

What we are going to do
The priority for 2019/20 will be to ensure that continued progress is made to deliver on the standard for ongoing consultant-directed review during weekdays and weekends, so that the Trust can deliver on its aim to meet all priority standards by 2020/21.

We will use the Nerve Centre (live bed state system) across the Trust to maintain the record of board round decisions, the agreed level and frequency of review, generate patient review lists that individual doctors can work to (including weekend review worklists) and ultimately allow electronic sign-off to certify that review has occurred.

What will success look like?
The review needs of individual inpatients are determined, agreed, documented and re-assessed regularly at ward rounds or the daily board rounds, to include:

- Review by consultant
- Review by registrar
- Review by FY2/CT1-2
- Review by other health professional (eg specialist nurse)
- No regular medical review required

**How we will monitor progress**
A number of workstreams will be established to focus on key improvements required within clinical services, and report into the divisional Integrated Performance Review (IPR) meetings.

### 3. Continued implementation and development of the Excellence in Care Programme

**Why this has been chosen as priority**
The Trust first identified the introduction of a departmental accreditation programme as a priority in 2017/18, which evolved to become the Excellence in Care Programme in 2018/19. Over the past two years the Trust has made significant progress in developing a comprehensive dashboard to provide one source of data to enable teams and divisions to review, analyse and understand a range of metrics which align with national guidance and local policy. In 2018/19, progress has been made on the development of a suite of ESHT Essential Care Standards for the Quality and Safety domain and aligning the metrics to these. The metrics for access and delivery, leadership and culture and finance measures within the Excellence in Care dashboard have also been refined and made available to a large number of areas across the Trust.

The overall aim of the Excellence in Care programme is to provide one source of robust key performance information to enable ward teams to monitor consistency in care and identify areas for improvement. It is in essence a dashboard with four specific domains (of which Quality and Safety is one) and consists of a large number of Key Performance Indicators (KPIs). The priority for 2019/20 will be to ensure that the Essential Care Standards for all domains within the dashboard are clearly defined, and that teams are supported to implement improvements. Considerable technical support is now required due to a change in focus and also a change in the software used for the programme.

**What we are going to do**
- We will provide support and training to our ward teams and departments to use the information to make improvements and celebrate success.
- Agree standards for all domains with the domain leads.
- Align the KPIs to the standards.
- Confirm the data source of information that will be automatically populated into the dashboard.
- Amend the audit questions to reflect the KPIs and provide staff with data that they can use for improvement.
Agree the number of audits required per clinical area.
Agree phase 2 areas to include following the initial roll out.

What will success look like?
- New format dashboard to be developed and launched
- Heads of Nursing, matrons and team leaders will have received an Introduction to Quality Improvement training session
- Each division will have completed at least three Quality Improvement projects by the end of the year

How we will monitor progress
We will continue to monitor progress through the Trust Excellence in Care steering group and through the divisional Integrated Performance Reviews.

4. Improve communication so that patients feel better informed about their care and treatment

Why this has been chosen as priority
Data from the national inpatient survey, our own internal complaints and inpatient questionnaires highlight a number of areas regarding communication and information provided to patients where we can make improvements. This includes how we involve patients in making decisions about their care, and the information provided to them.

The Trust recognises that there are a number of areas in the patient journey where communication could be improved. The priority for 2019/20 will be to work with patients and staff to review the current systems in place and identify the opportunities to re-design and improve how we communicate with patients. This will include improving the experience of patients with communication barriers, so that they are fully informed and involved in decisions relating to their care. A quality improvement approach will be adopted to identify the specific areas to target, test new approaches and ensure improvements are sustained.

What we are going to do
- During the first quarter of 2019/20, we will review the current systems we have in place for gathering patient and service user feedback, and analyse existing information, including the National Inpatient Survey 2018, to identify and refine areas to focus our improvement work
- During the second quarter of 2019/20, we will design and commence a number of patient and carer feedback events to gather their views and opinions on how we can improve their experience so that they feel more involved in their care and treatment.
- During the third and final quarters of 2019/20, we will use the feedback gathered from the patient and carer engagement events, along with other forms of evidence, to identify areas for improvement and develop action plans to implement and embed changes, using a quality improvement approach
What will success look like?

- We will have analysed our existing data and information to identify areas to focus our improvement work
- We will have completed patient and carer engagement events linked to our areas of focus, to gather feedback on how we can improve
- We will have identified key areas for improving how we communicate and involve patients and carers in their care and treatment, and have initiated improvement plans in key areas

How we will monitor progress

The Patient Experience team is responsible for guiding the delivery of improvement in patient experience, and will work with patient engagement and quality improvement leads in the Trust to support clinical teams with implementing improvements. Overall progress will be monitored by the Trust’s Patient Safety and Quality Group (PS&QG).
Part 2.2 – Statements of Assurance from the Board of Directors

Services provided and income

During 2018/19 East Sussex Healthcare NHS Trust provided and/or sub-contracted 77 NHS services.

East Sussex Healthcare NHS Trust has reviewed all the data available to them on the quality of care in all 77 of these NHS services.

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by East Sussex Healthcare NHS Trust for 2018/19.
Participation in Clinical Audit and National Confidential Enquiries

Clinical audit is used within East Sussex Healthcare NHS 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 importance of this is also described in the ESHT Quality Strategy (2019).

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.

East Sussex Healthcare NHS 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 national confidential enquiries that East Sussex Healthcare NHS Trust was eligible to participate in during 2018-19 are detailed below.

National Audit and National Confidential Enquiries Programme
The Trust participated in 100% of applicable National Confidential Enquiries and 100% of all applicable mandated National Clinical Audits in 2018-2019.

Details of the national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust was eligible to participate in during 2018/19 can be found in Appendix 2.

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, and for which data collection was completed during 2018/19, are listed in Appendix 3, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The Trust also participated in twelve additional (non-mandated) national audits in 2018/19 which can be found in Appendix 4.

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)
NCEPOD issued four reports in 2018/19:
- ‘Common Themes’ was published in November 2018.
- ‘Acute Heart Failure – Failure to Function’ was published in November 2018.
- ‘Cancer in Children, Teens and Young Adults: On the Right Course?’ was published in December 2018.
- ‘Perioperative Diabetes: High and Lows’ was published in December 2018.
Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK

The Women and Children’s division continues to report:

- All late foetal losses between 22+0-23+6 weeks gestational age showing no signs of life, irrespective of when the death occurred.
- Terminations of pregnancy – resulting in a pregnancy outcome from 22+0 weeks gestation onwards.
- Antepartum Stillbirth – a baby is delivered at or after 24th week showing no signs of life and known to have died before the onset of care in labour.
- Intrapartum Stillbirth – A baby delivered at or after 24th week of pregnancy showing no signs of life and known to have been alive at the onset of care in labour.
- Early Neonatal death - Death of a live born baby (born at 20 weeks gestation of pregnancy or later OR 400g where an accurate estimate of gestation is not available) who died after 7 completed days.
- Late neonatal Death - Death of a live born baby (born at 20 weeks gestation of pregnancy or later OR 400g where an accurate estimate of gestation is not available) who died after 7 completed days but before 28 completed days after birth.

UKOSS UK Obstetric Surveillance System

The UK Obstetric Surveillance System is a national system established to study a range of rare disorders of pregnancy, including severe ‘near-miss’ maternal morbidity. The Women’s Health unit contributes, where possible, to their studies.

The studies undertaken during the period 2018/19 include:

- Amniotic Fluid Embolism (0 cases reported)
- Cirrhosis in pregnancy (0 case reported)
- Fibrinogen Deficiency in Pregnancy (0 cases reported)
- High Neuraxial Block (0 cases reported)
- Near-Miss Suicide in Pregnancy (0 cases reported)
- Seasonal Influenza in Pregnancy (6 cases reported – January 2018 = 1 case; February 2018 = 4 cases; March 2018 = 1 case)

Successes in National Audit

A number of national audit reports published throughout 2018-2019 confirm that the Trust is performing above the national average in many clinical areas and is achieving (or exceeding) best practice clinical standards, delivering consistently good clinical outcomes for our patients.

Trauma and Research Network (TARN) National Audit

One such example is the ongoing Trauma and Research Network (TARN) mandated national audit – a ‘must do’ for the Trust, this audit enables us to assess our performance in managing and treating trauma patients. Through the audit we can directly compare our results on a national scale and identify improvements to optimise clinical outcomes. The Trust’s TARN Coordinator, Kelly Tuppen, was named ESHT ‘Employee of the Month’ in October 2018 and in February 2019 Kelly won the national ‘TARN Coordinator of the year’ Award!
Over the past 16 months with great determination and perseverance, Kelly has successfully turned around Trust performance (in terms of the number of cases reported to TARN) from 22% in 2016-17, to 100% in 2018!

This is a great achievement not only for Kelly personally, but also for the Trust as our TARN data is now much more reliable than in previous years. Through the complex data that Kelly has worked hard to submit, the Conquest Hospital is now ranked fourth best in the country in terms of survival outcomes!

Kelly is now extending her remit to incorporate departments that have not submitted data to TARN previously (for example the Rehabilitation team) in order to ensure a more inclusive and thorough data set.

**National Audit of Dementia Quality Review**

Dementia is the term used to describe a range of symptoms caused by diseases which damage the brain, such as Alzheimer’s disease, or a series of strokes. Symptoms vary extensively but may include memory loss and difficulties with thinking, language and problem solving, and changes in mood and behaviour. The National Audit of Dementia examines and measures the performance of general hospitals against criteria relating to care delivery which are known to impact people with dementia while in hospital.

The Trust participated in round 4 of this nationally mandated audit in 2018/19. Cases were submitted to the Royal College of Psychiatrists who then randomly selected the Trust for a snapshot quality review of results to check accuracy.

Dr Oliver Corrado (Consultant Geriatrician and ‘Dementia Champion’ at Leeds Teaching Hospitals NHS Trust) visited the Trust in February 2019 and concluded that the patients’ notes were clear and well formulated. The notes ‘flowed well’ with frequent updates and entries and were easy to follow. Discharge summaries to GPs were extremely thorough particularly from the Orthopaedic Department:

“The Integrated Hip Fracture Care Pathway document is excellent, it is extremely comprehensive, and it is really good to see that given Hastings was one of the first places to practice ‘ortho-geriatrics’ that elderly orthopaedic patients are still routinely seen by a Geriatrician and that the pathway incorporates a routine assessment of frail older people by the ortho-geriatric team”.

Many aspects of the routine nursing and medical assessment documentation help to facilitate the good care of people with dementia. The admission clerking proforma includes the 4AT delirium assessment, the multidisciplinary record ensures that people with dementia routinely have assessments of continence, skin care, functional independence and nutrition (the latter invariably including a calculation of the patient’s BMI). The Trust’s snapshot review confirmed accurate data submission.
National Clinical Audit Reports in 2018/19
The reports of 42 national clinical audits were reviewed in 2018/19. The Trust scrutinises each set of results to benchmark the quality of care provided, identify successes for celebration and / or identify any risks for mitigation. Recommendations for local improvement and change are considered and tracked via a central clinical audit action plan.

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

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

Actual and Potential Deceased Organ Donation Audit

**Overview:**
The potential donor audit commenced in 2003 as part of a series of measures to improve organ donation. Information is gathered for each patient that dies in a critical care unit (intensive care or emergency department) in all UK hospitals; this data is gathered by the Specialist Nurse for Organ Donation (SNOD) and input to NHS Blood and Transplant for analysis. The audit measures compliance against NICE clinical guidance 135 (Organ donation for transplantation) - namely those patients who have the potential for organ donation are notified to the Specialist Nurse for Organ Donation. The GMC requires that all clinicians consider organ and tissue donation as an integral part of end of life care.

**Key Results:**

**Goal:** A SNOD should be present during the formal family approach as per NICE CG135¹ and NHS Blood and Transplant (NHSBT) Best Practice Guidance.

**Goal:** The agreed 2017/18 national targets for Donation after Brainstem Death and Donation after Circulatory Death consent rates are 73% and 67%, respectively
**Goal:** Every patient who meets the referral criteria should be identified and referred to NHSBT’s Organ Donation Service as per NICE CG135 and NHS Blood and Transplant Best Practice Guidance on timely identification and referral of potential organ donors.

**Conclusions:**
- When compared with UK performance East Sussex Healthcare NHS Trust was exceptional (gold) for Specialist Nurse presence when approaching families to discuss organ donation.
- When compared with UK performance the consent rate in East Sussex Healthcare NHS Trust was average (bronze).
- When compared with UK performance the Trust was exceptional (gold) for referral of potential organ donors.

No specific actions were required following publication of the national report.
Overview:
Active orthopaedic SSI surveillance commissioned by the PHE Surgical Site Infection Surveillance Service remains a requirement of the Department of Health. This is endorsed by the NHS litigation authority which advocates using surveillance and reporting for compliance with national requirements and as formation of a learning system to be used by Trusts to improve performance and outcome.

Routine standardised surveillance of SSI enables Trusts to compare their infection rates against a national benchmark, providing a means for identifying and investigating rates and causes of SSI. The PHE reports that findings continue to prove that surveillance and feedback is essential in achieving reductions and maintaining a low incidence of SSI whilst the implementation of NICE guidelines provides the means of achieving an optimised patient safety culture.

The aim of this audit is to meet the current DOH requirement by submitting a standardised study of orthopaedic surveillance to PHE using the SSISS system and to feedback the analysis of data alongside national results to all relevant teams.

Key Results:

**Hip prosthetic replacement surgery including resurfacing and revision but excluding 1st stage revision where a spacer implant is used**

<table>
<thead>
<tr>
<th></th>
<th>Total number of patients</th>
<th>Number of SSI</th>
<th>SSI %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest</td>
<td>139</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>EDGH</td>
<td>115</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>ESHT Total</td>
<td>254</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>National Average (Apr-12 to Mar-17)</td>
<td>198,180</td>
<td>1,264</td>
<td>0.6</td>
</tr>
</tbody>
</table>

**Knee prosthetic replacement surgery including resurfacing and revision but excluding 1st stage revision where a spacer implant is used**

<table>
<thead>
<tr>
<th></th>
<th>Total number of patients</th>
<th>Number of SSI</th>
<th>SSI %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conquest</td>
<td>179</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>EDGH</td>
<td>174</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>ESHT Total</td>
<td>353</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>National Average (Apr-12 to Mar-17)</td>
<td>206,994</td>
<td>1,155</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Conclusions:
During the period from 01/04/16 – 31/12/16 the Trust’s SSI rate for Hip prosthetic surgery was higher than the national benchmark at 0.8% (however the knee prosthetic surgery SSI
rate remained low at 0.3%). A high outlier notification was sent to ESHT; the relevant Consultants in Orthopaedics and Microbiology reviewed the cases and determined that there were no particular causal trends, and that each case was managed appropriately.

**Lessons Learnt and recommendations**

- A yearly comparison of data provides a more accurate reflection of SSI rate than a quarterly comparison.
- Any high outlier notifications should continue to be dealt with via a multidisciplinary team approach.
- Patients must continue to be informed about their own post-operative role in wound management, and to be aware of the signs and symptoms of SSI.
- GPs and District Nurses should be made more aware of the need for wound swabbing before prescribing antibiotics to patients post-operatively.
- Undertake the ‘One together audit’ to demonstrate best practice as per the Associate of Perioperative Practice.
- Adherence to *Surgical site infections: prevention and treatment (2008) NICE guideline CG74*:
  - MRSA screening: Systems in place to screen all Orthopaedic elective cases prior to admission and for the decolonisation treatment for all previously / currently colonised / infected patients. Emergency patients to be screened on admission and all patients to be screened prior to movement into elective areas, thereby reducing the risks of cross infection.
  - Isolation of any MRSA positive cases within Orthopaedic surgery areas.
  - Ongoing systematic review of Orthopaedic beds to prevent Outliers.
- Compliance to national recommendations of core evidence based principles for reducing SSI.
- Creating a disciplined culture by encouraging staff to adopt adherence to strategic evidence based programmes and promote awareness with a continuous focus on the update of education and training.
- Continued challenge and reporting of poor practices.
- Continue prospective surveillance as a rolling program. It is difficult to establish infection rate patterns, follow up and readmissions, unless there is an uninterrupted flow within the study.
- The Trust needs to engage and encourage staff to actively support the surveillance programme as a team. The PHE has assured that Orthopaedic surveillance will continue to be a mandatory requirement.

**ESHT Actions following the audit**

1. Provide a single room for patients identified as MRSA positive and prevent unnecessary bed movements post-surgery - Ongoing
2. Provide information to relevant patients about SSIs with the resources available to them - Ongoing
3. Trust compliance and awareness / education of NICE Guidance CG74 - Ongoing

*The Trauma and Orthopaedic Consultants are currently reviewing recent cases of infection and will liaise with Microbiology and Infection Control to devise a further plan of action.*
Overview:
A significant proportion of children attend the Emergency Department (ED) due to injuries and fractures to their arms and legs. These injuries are painful and distressing, and children require analgesia and review in a timely fashion.

This audit was conducted for the seventh time to continue the work of the 2009/10 and 2011/12 data collections. It identifies current performance against RCEM clinical standards, showing the results in comparison with other departments.

Key Results:

Lessons Learnt and Recommendations
• Pain after analgesia should be tracked, parents and children should be encouraged to self-report pain and assist in re-evaluation of efficacy of analgesia in a patient-centric timeframe.
• Children presenting with injuries to the department should have a documented assessment for possible Non-Accidental Injury (NAI)
• Administration of analgesia pre-hospital must be documented in the notes in order to prevent medication errors and ensure patient safety.
• Pain level should be assessed and documented using a pain score.
• Nurse led prescribing (PGDs) should be utilised to ensure timely administration and documentation of analgesia to children with moderate or severe pain.
• The department should provide analgesia advice to patients and their parents on discharge.
ESHT Actions following the audit

1a) Improve the reassessment of pain at 60mins by:
   • Targeted education (meeting presentation, poster development, email and 1-1 discussions) of clinical staff to remind of the importance of complying with this standard and documentation of reassessment via the pain score – **Complete / Ongoing**

1b) Re-evaluation of pain scores will be audited on a weekly basis and live feedback given to staff at time of feedback – **Ongoing weekly**

2) Improve the documentation of NAI assessment:
   • Targeted education (meeting presentation, poster development, email and 1-1 discussions) of clinical staff to remind of the importance of documentation of NAI assessment - **Complete / Ongoing**

3) All department staff to be trained in PGD’s Paracetamol, Brufen and Cocodamol – **Complete at EDGH, CONQ in progress**

4) Improve the advice provided to patients / parents regarding analgesia:
   • Develop a patient information leaflet in conjunction with Pharmacy and Paediatric that could be given to parents and to patients regarding appropriate analgesia on discharge – **Under review**
   • Educate staff following the introduction of these leaflets and the process for dissemination – **awaiting completion of the patient information leaflet.**
### National COPD Audit Programme – Secondary Care Unit

#### Overview:
The National Asthma and COPD Audit Programme (NACAP) for England, Scotland and Wales aims to improve the quality of care, services and clinical outcomes for patients with asthma (adult; children and young people) and chronic obstructive pulmonary disease (COPD).

#### Key Results:

<table>
<thead>
<tr>
<th></th>
<th>2017 Mean</th>
<th>EDGH</th>
<th>CONQ</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time of arrival to admission, in hours</strong></td>
<td>3.9</td>
<td>4.3</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Review by an acute physician of ST3 or above</strong></td>
<td>82.3%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Time in hours from admission to respiratory team review</strong></td>
<td>27.0</td>
<td>51.4</td>
<td>34.4</td>
</tr>
<tr>
<td><strong>Respiratory team review within 24hrs of admission</strong></td>
<td>54.8%</td>
<td>30.6%</td>
<td>59.5%</td>
</tr>
<tr>
<td><strong>DECAF score recorded</strong></td>
<td>14.5%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Discharge bundle completed for the admission</strong></td>
<td>53.0%</td>
<td>86.1%</td>
<td>83.8%</td>
</tr>
<tr>
<td><strong>Length of stay – days</strong></td>
<td>5.8</td>
<td>10.1</td>
<td>4.9</td>
</tr>
</tbody>
</table>

#### Lessons Learnt and Recommendations
- A spirometry result must be available for all patients admitted to hospital with an acute exacerbation of COPD.
- All current smokers must be identified, offered, and if they accept, prescribed smoking cessation pharmacotherapy.
- All patients requiring NIV on presentation (i.e. that have evidence of respiratory acidosis) must receive it within 60 minutes of the blood gas result associated with the clinical decision to provide NIV and within 120 minutes of arrival for those who present acutely.
- All patients that require oxygen must be receiving it, and to target saturation.
- Colleagues within the Emergency Department, Acute Medical Unit and Respiratory department must work together to ensure patients can access respiratory specialist care within 24 hours of arrival (including at weekends).
- The implementation of a discharge bundle which optimises follow-up and, therefore, can help minimise the chance of a readmission should be considered.
- Specialist COPD care on Medical Assessment Units and non-respiratory wards should be enhanced.
- The number of eligible patients who are offered a start date for PR within 4 weeks of discharge should be improved.
- A 7-day, cross-sector COPD service should be developed / maintained.
ESHT Actions following the audit:

1. COPD nurse to contact GP for spirometry if not available on eSearcher – Ongoing
2. COPD nurses to refer to smoking cessation as part of discharge bundle, the Pharmacy team and COPD nurses to prompt juniors to prescribe smoking cessation pharmacotherapy – Ongoing
3. Develop acute NIV pathways cross site – NIV is provided in A&E, the Acute Medical Unit (AMU), the respiratory ward at Eastbourne and High Dependency Unit at both sites. All of these areas have the facilities for continuous monitoring of ECG, pulse oximetry and rapid access to blood gas results. Additionally, NIV will soon be provided at Baird Ward (Conquest) - just awaiting the delivery of a blood gas from Tressell ward.
4. COPD nurses to check O2 is prescribed and signed for – regular training delivered by the RESPS team - Ongoing
5. Develop educational posters and create a resource folder for each medical ward on both sites, increase the visibility of COPD Nurses across these areas to ensure continuous engagement – Complete / Ongoing
6. Implement the discharge bundle and achieve best practice tariff – the discharge bundle is already being utilised by the RESPS team. With the recent appointment of two additional COPD Nurses the Trust hopes to achieve the best practice tariff of 80% patients admitted with exacerbation by Q1 2019/20.
7. Enhance specialist COPD care across non respiratory wards: Monday – Friday COPD nurses will attend the AMU cross site / Weekends: the RESPS team will attend the AMU – Ongoing.
8. Ensure eligible patients are offered a start date for PR within 4 weeks of discharge – capacity issues with pulmonary rehabilitation to be reviewed by the Respiratory Lead – Ongoing.
9. Ensure 7 day working is achieved for the COPD service – the COPD Nurses provide a 7 day respiratory service - complete
Local Clinical Audit

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

96 local clinical audit reports were developed in 2018/19. Three of these local clinical audits are detailed below with the associated actions that the Trust intends to take to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>Obstetrics &amp; Gynaecology: Re-audit Management of Hyperemesis in Early Pregnancy; are we managing patients in accordance with the local policy?</th>
</tr>
</thead>
</table>

**Background**

Hyperemesis Gravidarum (HG) is common, serious and expensive. Nausea and vomiting in pregnancy affects up to 80% of women, often nutritional intake is so poor that it causes weight loss, clinical dehydration and metabolic disturbances. The psychological and occupational consequences are just as serious; 20% of women will terminate the pregnancy, others will be affected by depression and inability to look after their children or go to work.

Recent randomised controlled trials have proven that management of HG as ambulatory cases is both more cost effective to the health service (approximately one third of the cost of inpatient management) and beneficial to the women in terms of psychological impact.

The Trust’s local guidance on management of HG was written in 2014, this was prior to the publication of national guidance by the Royal College of Obstetricians and Gynaecologists in 2016. We need to update our local practice; one of the crucial and important updates is to offer women the option of being managed as an outpatient. This is cheaper (savings of approximately £3000 per woman) and the social and psychological benefits are notable. At ESHT we currently do not offer this time, money and medically efficient alternative.

**Aims and objective**

- To assess performance of the management of HG at ESHT in accordance with current local policy (2014)
- To identify areas of weakness in our current management and propose new action for improvement
- To conduct an up-to-date literature review; update our current local guideline and management pathway
- To analyse whether women with HG who were admitted as inpatients to the Conquest hospital could have been managed effectively as day case outpatients

**Results**

**Nursing standards** – high compliance was evidenced with the initial assessment process, with the exception of the recording of lying-standing blood pressure (though this is not actually required according to the 2016 RCOG national guidance).
### Vital parameters

<table>
<thead>
<tr>
<th></th>
<th>% compliance 2017</th>
<th>% compliance 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying/standing blood pressure</td>
<td>0%</td>
<td>-</td>
</tr>
<tr>
<td>Weight</td>
<td>85%</td>
<td>-</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>82%</td>
<td>-</td>
</tr>
<tr>
<td>Blood tests: urea and electrolytes, full blood count, liver function tests</td>
<td>88%</td>
<td>86%</td>
</tr>
<tr>
<td>Fluid balance chart</td>
<td>65%</td>
<td>-</td>
</tr>
</tbody>
</table>

### Doctors standards – a number of areas of poor compliance were noted:
- The Pregnancy-Unique Quantification of Emesis/Nausea (PUQE) score was used for less than 30% of patients.
- Documentation of initial hydration status.
- Formal re-assessment at 6 hours.

### PUQE score assessment admission & at 6 hour review

<table>
<thead>
<tr>
<th></th>
<th>% compliance 2017</th>
<th>% compliance 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydration status</td>
<td>34%</td>
<td>32%</td>
</tr>
<tr>
<td>Clinical examination</td>
<td>76%</td>
<td>-</td>
</tr>
<tr>
<td>Medication review; stop exacerbating medication e.g. iron</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Blood tests for re-admissions: amylase, TFT’s</td>
<td>46%</td>
<td>-</td>
</tr>
<tr>
<td>Request TVUSS if not already performed in current pregnancy</td>
<td>84%</td>
<td>36%</td>
</tr>
<tr>
<td>Vitamins prescribed</td>
<td>86%</td>
<td>68%</td>
</tr>
<tr>
<td>VTE prophylaxis</td>
<td>96%</td>
<td>77%</td>
</tr>
<tr>
<td>Review of patient after 6 hours of initial treatment</td>
<td>52%</td>
<td>45%</td>
</tr>
<tr>
<td>IV fluid regimen: 2-4L/day</td>
<td>86%</td>
<td>82%</td>
</tr>
<tr>
<td>Regular and PRN antiemetic prescribed</td>
<td>88%</td>
<td>45%</td>
</tr>
<tr>
<td>Discharge medication: 2 week supply of PO antiemetics + vitamins</td>
<td>72%</td>
<td>-</td>
</tr>
<tr>
<td>Patient information leaflet</td>
<td>0%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Good practice identified

Good performance was evidenced with regard to fluid resuscitation, anti-emetic and VTE prescriptions.
**Identified risks or concerns**

- No formal re-assessment after 6 hours of initial intervention leading to unnecessary overnight admissions to hospital.
- Patients being discharged without the full package of take home medication, accounting for the re-attendance of some patients.
- Patient’s weights being taken but not compared when re-admitted therefore weight loss not being monitored in high risk women.
- The discharge criterion is vague and based mainly on ketones. It was noted that often the decision to discharge is given to the patient rather than being based upon a quantifiable clinical improvement using a clinical examination, urinary ketones and PUQE score.

**Lessons Learnt**

Hyperemesis Gravidarum is a condition which can be managed efficiently in an outpatient setting – this would be beneficial to the women who are not bound to an inpatient stay and its subsequent negative social and psychological impacts. This methodology would also be of huge benefit to the health service; costs are reduced by 66% along with a lessened impact on inpatient beds. HG is not a disease; we need to be providing aggressive IV re-hydration and anti-emetics along with lifestyle/dietary advice, with the aim of allowing these women to go home and reach a tolerable level of symptoms of HG for their pregnancy.

**Actions following the audit**

1. Formal teaching on appropriate HG management at departmental induction – **Ongoing for each cohort.**
2. Develop and use a joint nursing-doctor proforma – **Complete.**
3. Update the Trust’s local 2014 guideline and incorporate the recommendations specified in the RCOG national guidance – **Complete.**
4. Set-up of a hyperemesis outpatient suite; invest-to-save project – **A business case is in development.**
Emergency Department: Re-Audit of Severe Sepsis & Septic Shock in Adults (EDGH) (4187)

Background
Royal College of Emergency Medicine (RCEM) clinical standards for severe sepsis and septic shock were first published in May 2009, the standards were based on the early resuscitation bundle published by the Surviving Sepsis Campaign.

The overall mortality rate for patients admitted with severe sepsis is 35% - approximately 5 times higher than for heart attack and stroke. Sepsis is responsible for approximately 37,000 UK deaths and 100,000 hospital admissions per year.

Severe sepsis is a time sensitive condition, in the most severe cases (septic shock) one study showed that for every hour appropriate antibiotic administration is delayed, there is an 8% increase in mortality. The Sepsis Six is an initial resuscitation bundle designed to offer basic intervention within the first hour.

The first cycle of this audit was completed in 2016 when our sepsis pathway results were evaluated against the RCEM standards of best practice. Areas of poor compliance were identified and measures put in place to facilitate improvement.

Aims and objectives
This re-audit will measure compliance against the same set of standards to determine if the changes implemented in 2016 have made a noticeable difference to the quality of care provided, and if necessary, to highlight any areas requiring further intervention.

Results

<table>
<thead>
<tr>
<th>RCEM standard</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Vital signs</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>2 Senior R/V</td>
<td>100%</td>
<td>64%</td>
</tr>
<tr>
<td>3a O2 sats 1hr</td>
<td>50%</td>
<td>7%</td>
</tr>
<tr>
<td>3b O2 sats 4hr</td>
<td>100%</td>
<td>8%</td>
</tr>
<tr>
<td>4a Lactate 1hr</td>
<td>50%</td>
<td>10%</td>
</tr>
<tr>
<td>4b Lactate 4hrs</td>
<td>100%</td>
<td>26%</td>
</tr>
<tr>
<td>5a Cultures 1hr</td>
<td>50%</td>
<td>12%</td>
</tr>
<tr>
<td>5b Cultures 4hrs</td>
<td>100%</td>
<td>28%</td>
</tr>
<tr>
<td>6a IV Fluids 1hr</td>
<td>75%</td>
<td>12%</td>
</tr>
<tr>
<td>6b IV Fluids 4hrs</td>
<td>100%</td>
<td>25%</td>
</tr>
<tr>
<td>7a Abx 1hr</td>
<td>50%</td>
<td>9%</td>
</tr>
<tr>
<td>7b Abx 4hrs</td>
<td>100%</td>
<td>25%</td>
</tr>
<tr>
<td>8 Urine output</td>
<td>100%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Good practice identified:
Following the interventions made in 2016, all aspects of the sepsis pathway have now improved at the EDGH Emergency Department.
Average completion standard across all fields is 83% by RCEM standards. The most improved standard was the ‘administration of oxygen delivery within 4 hours’ (3b) which increased by 87% equating to a 12 fold improvement.

Identified risks or concerns:
‘Monitoring of urine output’ was poor – only 38% compliance to the standard was noted. The least improved standard was the ‘involvement of a Senior clinician before leaving the Emergency Department’; only a 5% increase in compliance was evidenced between 2016 and 2017.

Conclusions and Lessons learnt
Whilst it is important for septic patients to receive antibiotics within the hour, many patients are being prescribed these before being properly reviewed by a doctor and therefore may not receive the correct targeted antibiotics; it is important that any intervention does not encourage the liberal use of broad spectrum antibiotics just to meet the one hour target, but encourages judicious use of appropriate antibiotics and prompt review.

A focus must be placed upon the early recognition of sepsis in order to start the Sepsis 6 pathway as soon as possible after the patient enters the Emergency Department. NICE guidance sets out Red Flags which should increase suspicion of the presence of sepsis and when used alongside the National Early Warning Score (NEWS) it can help rapidly identify septic patients.
**Actions following the audit**

1. Education of Emergency Department Junior Doctors regarding the importance of informing a senior clinician early - Include Sepsis 6 and the departmental protocol in the induction training for all new staff. **Complete / ongoing for every new batch of trainees.**

2. Improve completion of the Sepsis 6 screening proforma - Nominate an individual to track and review completion of the forms, individual training needs can then be identified and targeted to improve compliance. **Complete / ongoing – the Trust’s Sepsis Link Nurse is now responsible for this.**

3. Addition of a sepsis pack with blood cultures included as a dropdown menu on the eSearcher Pathology interface – Discussion with Laboratory staff and IT, this will help to ensure appropriate investigations are done. **Complete.**

Create a sepsis pack that will include the purple sheet (I-O chart) to stress urine output measurement – Initiate a trial run in the department for one month and evaluate compliance. **Complete, the new pack was trialled and deemed not to be as effective as the original version.**

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**Respiratory - Miscoding of pneumonia in a district general hospital (4397)**

**Background**

A local audit performed three years ago found that a high number of patients were miscoded for community-acquired pneumonia (CAP), potentially causing an increase in the length of hospital stay and in turn, a loss of income to the Trust. This audit aims to review recent accuracy in coding following the actions implemented after the original study.

**Aims and objectives**

- Identify how many patients coded with pneumonia were correctly diagnosed.
- Identify the most commonly associated comorbidities.
- To review the proportion of radiological and microbiological investigation in patients coded for pneumonia.
- Identify the alternative diagnoses.

**Results**

True Pneumonia

From the 48 patients audited – 22 truly had pneumonia positive radiological findings that supported their symptoms.

Hospital stay

The average length of stay for the entire cohort was 14.4 days, for the 22 correctly diagnosed patients it was 12.4 days.

Co-morbidities (COPD, Heart Failure or Asthma)

For the ‘true’ Pneumonia patients – 9/22 had at least one of the above comorbidities. From the entire patient cohort – 24/48 had at least one of these comorbidities. The commonest
comorbidity was COPD.

**Radiological evidence**
98% of the entire patient cohort had a chest X-ray (CXR) and a total of 22.9% had a CT scan. Together these investigations confirmed that 22 patients had ‘true’ Pneumonia i.e. evidence of consolidation on a radiograph.

**Microbiological investigation**
58.3% (28/48) of the entire patient cohort had their blood cultures taken; blood cultures were taken in 36.6% (14/22) of patients with ‘true’ Pneumonia – all of which showed no growth. 5/22 patients with ‘true’ Pneumonia had sputum cultures taken – all of which grew an organism.

**Antibiotics**
All 48 patients received antibiotics.

**Alternative diagnosis**
The most common alternative diagnosis was a Lower Respiratory Tract Infection.

**Good practice identified**
- Only one chest X-ray consolidation was disproved by a chest CT scan, suggesting good sensitivity.
- All patients with suspected pneumonia had either a chest X-Ray or a CT scan, which has a more positive predictive value than clinical auscultation findings.

**Identified risks or concerns**
- 54% (26/48) patients were incorrectly coded for Pneumonia.
- There was a lack of sputum cultures and urinary antigens for patients suspected to have pneumonia; this reduces the strength of a more targeted antibiotic therapy.

**Conclusions and Lessons learnt**
A large proportion of patients were miscoded, misdiagnosed and most likely mistreated by empirical guideline antibiotics.

The average length of stay was similar between the entire ‘coded’ cohort and those with ‘true’ pneumonia - a mean difference of 2 days. This could suggest that incorrectly diagnosed Pneumonia caused Physicians to delay discharge as they monitored for a suitable decrease in the infective markers (WCC and CRP) for pneumonia with antibiotic treatment. Furthermore, despite 100% of patients receiving antibiotics only 58% had blood cultures taken. This represents a poor initiative in targeted antibiotic therapy. Junior Doctors should be encouraged to take blood cultures in suspected infections and preferably prior to antimicrobial therapy.

In addition, the prevalence of sputum cultures was also disappointing. These results would
allow for targeted sensitive antibiotic therapy, quicker eradication, a quicker drop in white cell count (WCC) and c-reactive protein (CRP) and a quicker relief of symptoms / discharge.

The urine antigen had an even poorer uptake - 4% of the patient cohort had this investigation done. For reasons unknown none of these samples were actually processed or repeated during the inpatient episode. Blood, sputum and urine tests all help to localise the infection for a targeted antibiotic therapy, however to diagnose Pneumonia radiological evidence is central.

A Chest X-ray is the most common test performed when investigating Pneumonia and almost 98% of the patient cohort had this done, the other 2% had a CT scan performed and therefore the radiological uptake was 100%. These investigations confirmed that 22 patients truly had Pneumonia i.e. symptoms with radiological evidence of consolidation and thus satisfied the BTS criteria for diagnosing pneumonia in the hospital.

The most common alternative diagnosis was found to be lower respiratory tract infection - despite bearing similar symptoms to pneumonia, this condition holds no focal consolidation and hence requires less aggressive treatment, monitoring of WCC and CRP, and a shorter hospital stay. Education on Pneumonia compared to other similarly presenting alternative diagnosis would benefit Junior staff in their diagnosis, initial investigations, interpretations and subsequent treatment of the patient.

**Actions following the audit**

1. Teaching for diagnosis of pneumonia – organise and deliver targeted teaching sessions to junior staff and trainees – **Underway**.
2. Educate microbiology investigations and importance in suspected pneumonia - organise and deliver targeted teaching sessions to junior staff and trainees – **Underway**.
3. Re-audit for both radiological use and sputum after teaching session – **Due December 2019 following the delivery of training sessions**.

Audit of culture growth and antibiotic use in patients with pneumonia – **Due December 2019**.
Participation in Clinical Research

National studies have shown that patients cared for in research active NHS Trusts have better clinical outcomes. Participation in clinical research demonstrates our commitment to improving the quality of care that we offer and to making a contribution to wider health improvement.

The Health Research Authority (HRA) defines research as ‘The attempt to derive generalisable or transferable new knowledge to answer questions with scientifically sound methods’.

The number of patients receiving NHS services provided or sub-contracted by East Sussex Healthcare NHS Trust in 2018/19 that were recruited to participate in research approved by a research ethics committee was 911. This is a slight increase from the previous year where 890 patients were recruited to participate in research studies in 2017/18. At the beginning of this year, the Trust pledged to recruit 511 patients into trials, which was based on there being reduced capacity within the clinical research team to support this activity. The team have exceeded expectations by working collaboratively with speciality teams across the Trust, and assisting new teams to develop research activity.

The clinical research team work closely with specialist teams, supporting Principle Investigators, Clinical Nurse Specialists and Allied Health Professionals in a number of specialities. The Trust is currently conducting over seventy clinical research studies and supporting research activity within several clinical fields including: oncology, cardiovascular, gastroenterology, infectious diseases including sexual health, mental health, children, orthopaedics, podiatry / diabetes, musculoskeletal (MSK) including physiotherapy and rheumatology, ophthalmology, surgery, renal disorders, injuries and emergencies, health services research, neurological, and anaesthesia.

We will shortly be opening studies in critical care and respiratory medicine and aim to increase diabetes research activity for 2019/20. We will also continue to participate in a Health Service Research programme – Quality Improvement in Surgical Teams (QIST) which is a whole system change in screening pre-operatively for MSSA and providing patients with a decolonisation pack where necessary.

Achievements 2018/19

- Gastroenterology has been a novel specialist area that has grown significantly during this year. This is due to the collaboration with a Specialist Nurse who has taken the role of Principal Investigator for a genetic registry study. This team received an award as Highly Commended from the Clinical Research Network Kent Surrey and Sussex (CRN KSS) for ‘Best contribution to non-commercial research’.
- The Head of Research also received a CRN KSS award for ‘Involving patients in research’ and this too was Highly Commended. This was due to a whole team effort in relation to the Patient Research Experience Survey. ESHT patients contributed the largest number of responses across KSS (17.7%). We are in the process of examining the responses to further improve our research offering and patient
experience. Together these awards attracted £500 and will be utilised to increase our capacity to deliver effective research opportunities for patients.

- To help recognise the role of research in delivering quality patient care and to strengthen the assessment of research activity in the CQC inspection of NHS Trusts, new assessment guidance and indicators as part of CQC’s monitoring and inspection programme have been developed under the regulator’s well-led key question.
Commissioning for Quality and Innovation (CQUIN)

East Sussex Healthcare NHS Trust, like all NHS Trusts, are required to make a proportion of their income conditional on achieving quality improvement and innovation goals, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The baseline value for CQUIN is 2.5% of the Trust standard contract value and 2.5% for Specialised Services commissioned through NHS England. If milestones and goals are not fully achieved, a proportion of CQUIN monies may be withheld.

During 2018/19 East Sussex Healthcare NHS Trust undertook five national schemes, three specialised service schemes and four public health schemes agreed with NHS England.

Table 2: CQUIN priorities 2018/19

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td></td>
</tr>
<tr>
<td>Improving staff Health &amp; Wellbeing</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td>Reducing the impact of serious infections</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td>Improving the services for people with mental health needs who present to A&amp;E</td>
<td>Achieved</td>
</tr>
<tr>
<td>Offering Advice &amp; Guidance</td>
<td>Achieved</td>
</tr>
<tr>
<td>Prevention of Risky Behaviour; alcohol &amp; tobacco</td>
<td>Achieved</td>
</tr>
<tr>
<td>Specialised Services (NHSE)</td>
<td></td>
</tr>
<tr>
<td>Patient Activation Measures</td>
<td>Achieved</td>
</tr>
<tr>
<td>Dose Banding IV SACT</td>
<td>Achieved</td>
</tr>
<tr>
<td>Medicines Optimisation</td>
<td>Achieved</td>
</tr>
<tr>
<td>Public Health (NHSE)</td>
<td></td>
</tr>
<tr>
<td>Diabetic Eye Screening Programme</td>
<td>Achieved</td>
</tr>
<tr>
<td>CHIS</td>
<td>Achieved</td>
</tr>
<tr>
<td>Secondary Care Dental: Referral Management and Triage</td>
<td>Partially Achieved*</td>
</tr>
<tr>
<td>Secondary Care Dental: Orthodontic Buddy Arrangements</td>
<td>Achieved*</td>
</tr>
<tr>
<td>Secondary Care Dental: Participation in Dental MCN</td>
<td>Achieved*</td>
</tr>
<tr>
<td>SMSKPE – Personalised care &amp; Support planning</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td>SMSKPE – Timely care plans / discharge summaries &lt;7 days of discharge for physiotherapy</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

* Awaiting confirmation of outcome from commissioners

Statements from the Care Quality Commission

East Sussex Healthcare NHS 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. The Trust has not participated in any special reviews or investigations by the CQC in the reporting period.

The CQC published reports in June 2018 following an inspection of Eastbourne District General Hospital and Conquest Hospital in March 2018. The CQC commended the Trust on its notable improvements and the good, outstanding and innovative practice observed during the inspection. The CQC recommended to NHS Improvement (NHSI) that the Trust no longer met the criteria to be in Special Measures for Quality and NHSI accepted this recommendation.

Services inspected included urgent and emergency care, and medical care (including older person’s care) at both Eastbourne DGH and Conquest; surgery and maternity at Conquest; outpatients at Eastbourne DGH; and a well-led inspection Trustwide. The inspection did not review paediatrics, surgery at Eastbourne DGH, the midwifery led unit at Eastbourne DGH, outpatients at Conquest, critical care, community services or End of Life Care. The ratings for these services were therefore carried forward from when they were last inspected by the CQC.

In the areas inspected by the CQC, all domains were rated as ‘good’ or ‘outstanding’ apart from the Emergency Department at Eastbourne which was rated as ‘requires improvement’ but ‘good’ for well led and caring. For the first time ‘outstanding’ ratings were given in three categories.

The report highlighted one ‘must do’ and twenty one ‘should do’ actions that required addressing across the organisation. The ‘must do’ was for the Trust to urgently review the workload of the urgent care administration and clerical team and implement a strategy to review staffing levels and the impact on team wellbeing. This concerned administrative staff working night shifts and is being reviewed. Twelve of the should do actions relate to Urgent Care, mainly at the Eastbourne site, three to maternity, two for outpatients, one for surgery, one for medicine and two Trustwide. These actions include strengthening the application of policies and processes, ensuring consistency of record keeping, improving mandatory training in some areas, improvements to the estate and reducing the number of outlying patients. An action plan was developed to address the concerns raised and build on our improvements, as well as sharing learning and best practice. Good progress is being made in all areas and this is being monitored as part of quality reviews and through the Trust’s governance structure.

Overall Ratings (Arrows indicate progress since last report)

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires improvement Jun 2018</td>
<td>Requires improvement Jun 2018</td>
<td>Good Jun 2018</td>
<td>Requires improvement Jun 2018</td>
<td>Good Jun 2018</td>
<td>Requires improvement Jun 2018</td>
</tr>
</tbody>
</table>
### Conquest Hospital

<table>
<thead>
<tr>
<th>Service</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>Good, Apr 2018</td>
<td>Good, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Outstanding, Jun 2018</td>
<td>Good, Jun 2018</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>Good, Mar 2018</td>
<td>Good, Jun 2018</td>
<td>Outstanding, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Good, Jun 2018</td>
</tr>
<tr>
<td>Overall*</td>
<td>Requires improvement, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
</tr>
</tbody>
</table>

*Services for Critical care, children and young people, End of Life Care and Outpatients were not inspected in March 2018, the ratings relate to the inspection in 2016

### Eastbourne District General Hospital

<table>
<thead>
<tr>
<th>Service</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>Good, Apr 2018</td>
<td>Good, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Good, Jun 2018</td>
<td>Good, Jun 2018</td>
</tr>
<tr>
<td>Overall*</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
<td>Requires improvement, Jun 2018</td>
</tr>
</tbody>
</table>

*Surgery, Critical care, Services for children and young people and End of Life care were not inspected in March 2018, the ratings relate to the inspection in 2016

The full reports and ratings are available at [www.cqc.org.uk/provider/RXC](www.cqc.org.uk/provider/RXC)
Data Quality

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

During 2019/20 we will support improvement in data quality by:

- Working collaboratively with divisions to identify areas for data quality improvement and determine actions to overcome long term data issues. This includes addressing issues with new systems and services that have been introduced to the Trust, such as SystmOne and Evolve
- Continuing to ensure training materials and scripts are accurate and support good data quality practice
- Continuing to validate correct attribution on the Patient Administration System of GP Practice through the national register (SPINE)
- Continuing to undertake regular audit of completeness of NHS Numbers to ensure continued progress
- Continuing to provide advice, instruction and guidance to all levels of staff on good data quality practice through training workshops and presentations to specific staff groups e.g. ward clerks, outpatient staff

NHS Number and General Medical Practice Code Validity

East Sussex Healthcare NHS Trust submitted records during April 2018 to December 2018 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 99.7% for admitted patient care
- 99.8% for outpatient care
- 98.2% for accident and emergency care

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

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care
Data Security & Protection Toolkit attainment levels

During 2018/19, the Data Security and Protection Toolkit (DSPT) has replaced the Information Governance Toolkit (IGT). The toolkit is an online performance tool developed by NHS Digital to support organisation to measure their performance against the National Data Guardian’s data security standards. The Care Quality Commission uses the results to triangulate their findings.

All health and social organisations, including ESHT, are mandated to carry out self-assessments of their compliance against the DSPT assertions. The Trust is required to evidence 40 assertions over the following ten standards:

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

ESHT’s DSPT assessment score for 2018/19 was submitted with 100 out of 100 pieces of mandatory evidence provided and all standards graded as met. This is a self-assessment, but is reviewed by our auditors to provide assurance of accuracy to the Trust. The Trust’s internal auditors report gives ‘reasonable assurance’ that the Trust’s submission is robust for 2018/19.
Clinical Coding Error Rate

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

To ensure accuracy of clinical coding a number of internal audits are undertaken in addition to an external Data Security and Protection Toolkit (DSPT) Audit conducted by a Clinical Classifications Service Registered Auditor.

Results of the DSPT Audit

We have achieved advisory level in primary diagnosis, secondary diagnosis and secondary procedure fields and achieved mandatory level in primary procedure field. Attainment levels are summarised in table 3 below.

Table 3: Levels of attainment – percentage accuracy targets for Acute Trust

<table>
<thead>
<tr>
<th>Levels of attainment – percentage accuracy target areas</th>
<th>Mandatory</th>
<th>Advisory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td>≥ 90%</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>≥ 80%</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>Primary procedure</td>
<td>≥ 90%</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Secondary procedure</td>
<td>≥ 80%</td>
<td>≥ 90%</td>
</tr>
</tbody>
</table>

Table 4: Overall Audit Results Summary – November 2018

<table>
<thead>
<tr>
<th></th>
<th>Primary diagnosis</th>
<th>Secondary diagnosis</th>
<th>Primary procedure</th>
<th>Secondary procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97.01%</td>
<td>95.02%</td>
<td>93.79%</td>
<td>92.98%</td>
</tr>
</tbody>
</table>

East Sussex Healthcare NHS Trust achieved an overall accuracy percentage of 94.7% highlighting 5.3% error rate.

In conclusion, the general standard of Clinical Coding was noted as very good with national standards for clinical coding being followed well. Most errors made in the primary diagnosis and primary procedure field are due to incorrect sequencing and indexing. Some relevant and mandatory co-morbidities, secondary procedures have been omitted due to lack of data extraction skills. Staff vacancies and a greater number of trainees are the contributory factors for some of these errors.

A number of recommendations have been made and are being implemented within the department.
Learning from Deaths

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

Most deaths are unavoidable and would be considered to be ‘expected’, however there will be cases where sub-optimal care in hospital may have contributed to the death. 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 and December 2018, 1819 East Sussex Healthcare NHS Trust patients died. Table 5 summarises the number of deaths which occurred in each quarter of that reporting period:

*Table 5: Number of deaths per quarter (January 2018 to December 2018)*

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2017/18: January 2018 to March 2018</td>
<td>624</td>
</tr>
<tr>
<td>Q1 2018/19: April 2018 to June 2018</td>
<td>432</td>
</tr>
<tr>
<td>Q2 2018/19: July 2018 to September 2018</td>
<td>371</td>
</tr>
<tr>
<td>Q3 2018/19: October 2018 to December 2018</td>
<td>392</td>
</tr>
<tr>
<td><strong>Total: January 2018 to December 2018</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Number of case record reviews or investigations**

By 20/05/2019, 1682 case record reviews and 104 investigations have been carried out in relation to the 1819 deaths included in the table 6. In 96 cases, a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out is summarised in table 6.

*Table 6: Number of case record reviews or investigations per quarter (January 2018 to December 2018)*

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Number of case record reviews or investigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2017/18: January 2018 to March 2018</td>
<td>555</td>
</tr>
<tr>
<td>Q1 2018/19: April 2018 to June 2018</td>
<td>414</td>
</tr>
<tr>
<td>Q2 2018/19: July 2018 to September 2018</td>
<td>359</td>
</tr>
<tr>
<td>Q3 2018/19: October 2018 to December 2018</td>
<td>362</td>
</tr>
</tbody>
</table>
3 representing 0.16% of the patient deaths between January and December 2018 are judged to be more likely than not to have been due to problems in the care provided to the patient. The numbers relating to each quarter is outlined in table 7.

**Table 7: Estimated deaths per quarter considered likely to have been avoidable (January 2018 to December 2018)**

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Number of patient deaths considered likely to be avoidable</th>
<th>Percentage of the patient deaths considered likely to be avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2017/18: January 2018 to March 2018</td>
<td>1</td>
<td>0.16%</td>
</tr>
<tr>
<td>Q1 2018/19: April 2018 to June 2018</td>
<td>1</td>
<td>0.23%</td>
</tr>
<tr>
<td>Q2 2018/19: July 2018 to September 2018</td>
<td>1</td>
<td>0.27%</td>
</tr>
<tr>
<td>Q3 2018/19: October 2018 to December 2018</td>
<td>0</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

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.

**Summary of lessons learnt**
The lessons learnt summarised below relate to all patient deaths which were reviewed as part of this process.

**Clinical Treatment**
- Sepsis – importance of following the Trust’s sepsis pathway
- Importance of consultation with microbiologists and repeat blood culture when response to initial antibiotic treatment is poor
- Accuracy of image reporting
- Individual responsibility for results of tests ordered (follow up or hand over)
- Need to over-rule patient wishes when patient without capacity refuses critically important test (following discussion with LPA/IMCA)
- Early decisions on appropriateness of resuscitation
- When to withhold chemotherapy

**Communication and Documentation**
- Poor quality of patient documentation
- Improved communication on handover between wards
- Advance Care Planning and documentation of amendments to these
- Importance of documenting & sharing treatment escalation plans/ceilings of care
- Need for discussion between ITU and patient consultant when ITU admission felt inappropriate by ITU
- Inaccurate image reporting
• Accuracy of cause of death – need for junior to discuss with consultant/senior doctor before completing
• Confusion between palliative care and end of life care.

These lessons learnt summarised above are shared with staff via a number of communication channels including; Divisional and specialty governance meetings and Divisional governance newsletters; the Trust weekly patient safety forum; the Trust Mortality Review Group, and Clinical Outcomes Group; and direct email communications to staff or specific staff groups.

Description of actions taken during 2018/19
• Alignment of junior and senior medical rotas and job plans and appointment of additional staff to increase availability of senior staff in evenings and weekends.
• Construction of a pleural pathway for prompt investigation and treatment of pleural effusions
• Extension of daily multidisciplinary board rounds
• Review of all inpatient admission documentation including handover documentation
• Multiple communications to staff on personal responsibility for investigation results
• Introduction of ReSPECT documentation replacing previous DNACPR documentation
• Education of clinical staff and tracking of performance on recognising and treating Sepsis, under the Sepsis Steering Group
• Inaccurate image reporting reviewed at radiology discrepancy meeting
• Instituted a daily Resuscitation team de-briefing for the on take teams
• Sharing of investigation reports with families.

Description of proposed actions to take during 2019/20
• Actions for 2019/20 will to a large extent be determined by learning from quarterly mortality reviews and SI/internal investigations.
• We anticipate moving to a “Medical Examiner” system to increase the objectivity of review of all inpatient deaths, though the timing of this will be affected by progress in the national legislation required to underpin this system.
• Through the course of the year we will be installing a new clinical information and flow management system (Nerve Centre) which, amongst many other benefits to patient care, will support improved handover and task allocation.

Assessment of the impact of actions taken
Overall the many changes instituted have contributed to a continuing reduction in all the risk adjusted mortality indices, including the Standardised Hospital-level Mortality Indicator (SHMI), Risk Adjusted Mortality Indicator (RAMI), Hospital Standardised Mortality Ratio (HSMR), and in crude mortality (unadjusted for risk factors and co-morbidities). At the same time we have also been able to reduce the average length of stay for patients admitted to the Trust.
Non-elective SHMI (12 month rolling) to Sep 2018 *(source: CHKS)*

HSMR (CHKS) rolling 12 months to Feb 2019 *(source: CHKS)*

RAMI rolling 12 months to Dec 2018 *(source: CHKS)*
Reviews and investigations which relate to deaths in the previous reporting period

65 case record reviews and 1 investigation were completed after 29/05/2018 which relate to deaths in the previous reporting period (April 2017 to December 2017).

0 representing 0.00% of the patient deaths in the previous reporting period, which were reviewed or investigated after 29/05/2018 are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Royal College of Physicians National Structured Judgement Review methodology in conjunction with internal Serious Incident investigations, Amber Investigations, Complaints, Inquests and Quarterly Mortality Review Audits.

Our revised estimate of the number of deaths reported in the previous reporting period (April 2017 to December 2017) judged to be more likely than not to have been due to problems in the care provided to the patient, remains the same.

There were 7 representing 0.53% of the patient deaths between April and December 2017 judged to be more likely than not to have been due to problems in the care provided to the patient.
Seven Day Hospital Services

The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall there are ten clinical standards for 7DS, of which four clinical standards have been made priorities for delivery by NHS England (NHSE) and NHS Improvement (NHSI).

The priority clinical standards are:

- **Standard 2 – Time to first consultant review.** Patients wait no longer than 14 hours to initial consultant review after admission
- **Standard 5 – Access to diagnostic tests.** Patients get access to diagnostic tests with a 24 hour turnaround for non-urgent patients. For urgent patients this drops to 12 hours, and for critical patients, one hour.
- **Standard 6 – Access to consultant-directed interventions.** Patients must have timely 24 hour access, 7 days a week to specialist, consultant-directed interventions
- **Standard 8 – Ongoing consultant-directed review.** Patients with high-dependency care receive twice daily consultant review and those patients admitted to hospital in an emergency will receive daily consultant directed review

Providers of acute services have been required to submit a self-assessment survey on compliance against delivery of the 7DS standards to NHS England since 2016. In November 2018, a new Seven Day Hospital Services Board Assurance Framework was introduced by NHS England and NHS Improvement process for providers to record a single consistent report for the dual purpose of assurance from their own boards and national reporting.

The new board assurance framework is being implemented gradually, with a trial period followed by full implementation from March 2019. As part of the trial period, ESHT submitted an initial self-assessment to the regional NHS England and NHS Improvement team on 28 February 2019.

The Trust self-assessment of compliance against the 7DS standards completed in February 2019 identifies that:

- Overall the Trust has met the standard for access to consultant-directed diagnostics (clinical standard 5)
- The Trust has not met the standards overall for initial consultant assessment (clinical standard 2), access to interventions (clinical standard 6), and ongoing consultant-directed review (clinical standard 8).

There are plans identified to improve delivery against the remaining three priority standards, with the Trust expected to be compliant with access to interventions (clinical standard 6) by the end of April 2019. The Trust also continues to develop divisional improvement plans for improving compliance against clinical standards 2 and 8 (first consultant review within 14 hours, and ongoing consultant review), and has identified improving compliance against the standard for ongoing consultant-directed review (standard 8) as a priority in 2019/20.
Rota Gaps

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

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

The aim of the GOSWH role is to provide assurance to doctors and employers that doctors are able to work within safe working hours. The GOSWH is there to champion and support junior doctors to deliver this. Where the system fails a set process allows early reporting (exception reporting) to occur which is aimed at giving doctors the confidence that improvement will be made. The GOSWHs provide quarterly and annual reports to the People and Organisational Development (POD) group, and are also involved in the meetings in table 8.

Table 8: Meetings attended by the GOSWH

<table>
<thead>
<tr>
<th>Group</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>People and Organisation Development (POD) Group</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Trust Local Faculty Group (LFG)</td>
<td>Every 4 months</td>
</tr>
<tr>
<td>Oversight Group Meeting</td>
<td>Every 4 months</td>
</tr>
<tr>
<td>Junior Doctors Forum</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Junior Doctors Inductions</td>
<td>Three times a year</td>
</tr>
<tr>
<td>CEO Junior Doctors Forum</td>
<td>Every 4 months</td>
</tr>
<tr>
<td>Local Negotiating Committee</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

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

To improve on reducing rota gaps the GOSWHs continue to review work patterns. The Trust has also introduced a new Doctors Assistant role to support junior doctors with clinical administration and basic investigations such as phlebotomy. This has helped in areas where there have been significant gaps in the rota. The Trust has also introduced Healthroster, an e-rostering system, which enables doctors to access their rotas and to help eradicate conflicts on zero days, nights, study leave and annual leave allocations.
Staff who speak up

In its response to the Gosport Independent Panel Report, the Government committed to the legislation requiring all NHS Trusts in England to report annually on staff who speak up (including whistleblowers).

How staff can speak up
All staff at ESHT are encouraged to raise and share concerns and much work has been done to promote raising concerns and the freedom to speak up. The Trust has a positive incident reporting culture in place and all staff have access to Datix, incident reporting system. All incidents are reviewed and investigated if appropriate and feedback given to the staff member.

- The Trust has a Freedom to Speak Up; Raising Concerns (Whistleblowing) policy
- Staff are actively encouraged to report concerns on Datix, raise concerns with their line manager or to escalate if they feel their concerns are not being acted upon.
- The Trust has an independent Speak Up Guardian to encourage and support staff to confidentially raise concerns through their line managers and leadership team.
- The role of the Speak Up Guardian is promoted through meetings, team huddles, the staff induction process, regularly circulated newsletters, and a range of materials and information is available on the Trust extranet.
- The Speak Up Guardian is contactable by email, on the telephone and through social media. Contact is offered face to face or off-site to suit the needs of the staff member.

Staff can report something they are concerned about either to:

- their line manager
- their professional lead
- Staffside, or other union representative
- Speak Up Supporters
- Speak Up Guardian

The Trust has an independent Non-Executive Director, who can be contacted if there are matters which have not been able to be resolved by line managers, the Speak Up Guardian or Executive Directors, or for serious matters that cannot be discussed with these people.

How feedback is given to those who speak up
A requirement from the National Guardian office is to seek feedback and that is “would you speak up again” where possible, this is asked and recorded:

- Concerns, including feedback and follow ups are monitored via a database, subject to staff consent.
- Feedback is routinely sought from staff who have raised concerns to ensure that they have not suffered detriment as a result of speaking up and any learning can be captured.

How we ensure staff who speak up do not suffer detriment
- Fear of reprisal is discussed and it is recognised that it may not be easy to speak up in certain posts or areas. The Speak Up Guardian reports to the Chief Executive,
and staff are reassured with this reporting line. Any concerns of reprisal would be raised immediately and can be managed down a formal route. Records are made of staff who feel that they have faced reprisal and this is escalated.

- Patient safety concerns are escalated to the appropriate leads by the Speak Up Guardian, if required, and followed up for reassurance.
- Human resources meetings with divisions and the Speak Up Guardian are held to review and address any behaviour related reported incidents for bullying, harassment and discrimination.
- The Speak Up Guardian will attend areas where behaviour concerns have been raised to discuss Trust values, conduct and managing repeated behaviour concerns.
- Staff engagement, Human Resources and the Speak Up Guardian are responsible for providing and reviewing specific training for managers and leads to manage concerns regarding bullying and harassment.
- The Speak Up Guardian meets with the Director of Nursing, Medical Director, HR Director and senior leads to share any recurrent themes and concerns to triangulate the actions and learning.
Staff Survey 2018 Results

NHS Staff are invited annually to take part in the NHS Staff Survey. This is a survey completed by staff to gather views on staff experience at work around key areas including:

- Appraisal and development
- Health and wellbeing
- Staff engagement and involvement, and
- Raising concerns.

Staff engagement and staff survey

Research demonstrates that those organisations with high levels of staff engagement also have better patient outcomes/experience. In 2018, 3,639 staff members at ESHT took part in the survey between October and December 2018, via either a postal or online questionnaire. This constituted an overall response rate of 53%, compared with a national response rate of 41% for similar organisations.

The results of our Staff Survey are shared with our staff members to agree which areas they would like to work together to bring about improvement. Progress is monitored regularly through quarterly Pulse surveys.

Based on the feedback that we have received, we have identified four corporate priorities that link to the key findings and recommendations from the Staff Survey 2018:

1. To ensure all staff are involved in decisions that affect them by introducing and implementing a robust engagement process /framework for when changes are made
2. To understand better why some of our staff do not feel that they are treated fairly in relation to career progression and to take the appropriate action
3. To understand any particular hotspots within each division linked to violence, bullying and aggression and develop a range of interventions to improve staff experiences
4. To continue to support staff wellbeing with specific focus on improving both physical and mental health

Living our Values

Our Trust values were developed by our staff and shape our beliefs and behaviours, and are fundamental to how we undertake our everyday work. The importance of positive behaviours is led by our Chief Executive and senior team and is regarded as everyone’s responsibility. We have spent time with different staff groups to develop a behavioural framework which outlines the behaviours we expect to see and those which are deemed unacceptable. The behavioural framework has been shared with staff through a number of workplace workshops. There are numerous examples everyday where our staff demonstrate the Trust values, and where this does not happen, individuals or teams will be challenged.

Leadership Development

In 2017 we launched our Leadership Pathway. The pathway outlines the leadership, management and coaching development provided in the Trust for aspiring, new and experienced leaders from all staff groups and provides continual professional development for those staff in Leadership roles.
Our leaders play a key role in ensuring the people who use our services receive high quality patient care. The pathway is intended to provide a range of development opportunities to support leaders from all disciplines in their work. Our Managers Essentials programme highlights the importance of induction, regular 1-1’s and team meetings and an appraisal process that allows time for individuals to reflect on their contribution, performance and development needs. Our Leading Excellence programme focuses on developing skills and behaviours to successfully lead change. In addition to the leadership development courses, our staff are also supported through a range of coaching and team development opportunities.

Table 9 below outlines the range of leadership development opportunities available at ESHT and number of leaders who have attended the programmes since April 2017.

<table>
<thead>
<tr>
<th>Programme Name</th>
<th>Number of staff that have attended training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business Essentials</strong></td>
<td>Focus on budget management, contracting, data and information, business cases and business planning</td>
</tr>
<tr>
<td><strong>Management Essentials</strong></td>
<td>Workshop to refocus managers on the basic/essential expectations of their role to promote a common experience of management for all staff across the Trust</td>
</tr>
<tr>
<td><strong>First Line Managers</strong></td>
<td>Development of core leadership skills including effective communication as a manager and managing organisational change</td>
</tr>
<tr>
<td><strong>Leading Service</strong></td>
<td>Refreshing core and advanced leadership skills including: leading self, leading others, understanding change, leading into the future</td>
</tr>
<tr>
<td><strong>Leading Community Together</strong></td>
<td>Aimed at the leads of Community nursing services, covering a range of leadership and management skills</td>
</tr>
<tr>
<td><strong>New Managers Orientation</strong></td>
<td>Overview of ESHT 2020 / ESBT strategies, management behaviours, ESHT values, qualities of a manager, knowledge sources for managers</td>
</tr>
<tr>
<td><strong>Systems Wide Leadership</strong></td>
<td>Programme 1 – Sussex &amp; East Surrey Systems Leadership Programme Programme 2 – OD Practitioner Programme</td>
</tr>
</tbody>
</table>

**Health and Wellbeing**

The emotional and physical wellbeing of our staff is really important to us and this year we launched our staff Health and Wellbeing strategy which outlines 7 priorities to help us support staff’s wellbeing. Some of the work that has taken place so far:
- **Free Health checks for Staff** – The wellbeing team delivered health checks for 1069 eligible staff (aged between 40 and 74).
- **Physical wellbeing** – Staff have been offered the opportunity to improve their physical wellbeing with Pilates, lunch break walks, take a break campaign, staff discount at local fitness centres and support for those staff who want to use healthy alternatives to travel to work.
- **Emotional wellbeing** – All of our staff have access to a range of support including pastoral support, counselling and psychology services Schwartz round and various training events e.g. Compassion without Burnout workshops, Mindfulness.
- **Employee support** – 140 staff have been supported with a range of issues linked to flexible working, childcare and financial wellbeing.

The investment in leadership development, improving staff engagement and involvement, promoting and supporting staff wellbeing has contributed to the Trust working towards becoming Outstanding. We have continued to develop a positive safety culture for both our staff and patients as well as making a number of improvements linked to patient experience and outcomes. We are demonstrating ongoing improvement in staff retention especially for staff groups such as nursing. Over the past three years our Staff Survey results have continued to improve. The survey and the staff family and friends test has highlighted that staff feel better supported by their line managers with improvements linked to quality of appraisal, support and communication. More staff than ever have also said they would recommend ESHT as a place to work.
Part 3 - Review of Quality Indicators and our Priorities for Improvement in 2018/19

Part 3.1 – Our Priorities for Improvement in 2018/19

The Trust identified eight quality improvement priorities for 2018/19 to contribute towards the delivery of our Quality and Safety Strategy. Overall the Trust has fully delivered and achieved the objectives for four priorities in 2018/19. For the other four priorities that are currently only partially achieved, the Trust has delivered demonstrable improvement from the original baseline.

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

**Table 10: Priorities for improvement 2018/19**

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Quality Improvement Priority 2018/19</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety</strong></td>
<td>1. Improving the early recognition, escalation and management of the deteriorating patient</td>
<td>Fully achieved</td>
</tr>
<tr>
<td></td>
<td>2. Continue to reduce the number of avoidable falls</td>
<td>Partially achieved</td>
</tr>
<tr>
<td></td>
<td>3. Continue our focus on reducing avoidable grade 3 and 4 pressure ulcers</td>
<td>Fully Achieved</td>
</tr>
<tr>
<td></td>
<td>4. Working towards providing consistent high quality care for our patients seven days a week</td>
<td>Partially achieved</td>
</tr>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td>5. Continued implementation of the Excellence in Care Programme</td>
<td>Fully achieved</td>
</tr>
<tr>
<td></td>
<td>6. Safe and effective discharge and improving our patients’ experience of getting home</td>
<td>Partially achieved</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>7. Continue to improve end of life care by improving processes and documentation</td>
<td>Fully achieved</td>
</tr>
<tr>
<td></td>
<td>8. Improving the experience of young people in hospital</td>
<td>Partially achieved</td>
</tr>
</tbody>
</table>
Patient Safety Improvements 2018/19

1. Improving the early recognition, escalation and management of the deteriorating patient

Why we chose this priority
Early detection and treatment of physiological deterioration has been shown to improve the clinical outcome for patients. In 2018/19 we committed to further improve our escalation processes to ensure consistent early recognition of deterioration so that patients are assessed and treated with ongoing care planned appropriately. Amongst the main causes of deterioration are Sepsis and Acute Kidney Injury (AKI), so our work over the year has focused in particular on supporting the early recognition and prompt treatment of suspected sepsis and AKI.

Our aims
- Develop and implement a revised and improved escalation pathway
- Reduce cardiac arrests associated with suboptimal management of physiological deterioration
- Increase the percentage of patients screened for Sepsis in our acute hospitals
- Increase the percentage of patients with Sepsis who receive antibiotics within one hour of diagnosis
- Implement a Sepsis screening tool in our community hospitals and teams
- Implement a revised and improved AKI pathway
- Implement a pharmacy medication review alerting process

How have we done?

Revised and improved escalation pathway developed and implemented
We ran a number of workshops across the Trust inviting all members of our multi-disciplinary teams that contribute to the care of Deteriorating Patients to assist us with developing an improved escalation pathway at ESHT. These workshops were attended by doctors and nurses from the Emergency Department, Critical Care and Acute/General Medicine.

Discussion and feedback during the sessions helped us to identify a common theme regarding communication of plans about escalation. Although there were many different ways within the Trust of communicating about escalation plans, knowledge and awareness of the processes was variable. In addition there was no standardised means of documentation and often decisions regarding “what happens next” were not addressed or effectively communicated.

To address these challenges, we have introduced the following:

- We developed a standardised ESHT Treatment Escalation Plan (TEP) that provides a tool for clear and consistent documentation in every ward area. The development process for the TEP involved introducing the new tool initially to one area (Critical Care Outreach Team) and using quality improvement methodology, was amended and shaped by feedback from the teams that were using it. We widened our trial area...
to include more clinical areas, and the final version of the TEP was introduced across the Trust at the beginning of April 2019.

- We have also developed a new in-house Deterioration Assessment Response and Treatment (DART) training course, which focuses on ensuring our nursing teams have the skills and competencies to recognise the Deteriorating Patient and act rapidly.

**Reducing cardiac arrests associated with suboptimal management of physiological deterioration**

We are able to evidence a reduction in cardiac arrests associated with suboptimal management of physiological deterioration in 2018/19 compared with last year. The proportion of cardiac arrests where there was evidence of deterioration in the preceding 24 hours which was not escalated was 27.69% between April 2017 and March 2018, compared with 20.48% between April 2018 and March 2019. Our Critical Care Outreach team continue to monitor this indicator and will develop plans to support improvement where required.

**Improving the recognition and management of Sepsis in our acute hospitals**

We have implemented a number of actions to improve the recognition and treatment of sepsis at our acute hospitals.

- We reviewed and re-launched our screening tools and clinical guidelines for sepsis.
- We introduced a 'live' audit process to enable more timely feedback for clinical teams on their practice of identifying patients who meet the criteria for sepsis screening in our acute in-patient areas. This live audit process helped to support real time feedback and sharing of learning, so that clinical teams were empowered to make changes to their practice and see the results of their actions.
- We have developed a new patient information leaflet for use with adult inpatients to promote awareness of sepsis. This leaflet was developed through public engagement and consultation.
- We have introduced sepsis screening to our community teams, including electronic screening available on our community clinical system, SystmOne.

As a result of these actions, we have increased the percentage of patients screened for sepsis in our emergency departments and ward areas, and where patients are identified with red flag sepsis, we have increased the percentage of patients who receive antibiotics within 1 hour. This has led to significant improvements in the recognition, diagnosis and treatment of sepsis, which has also positively impacted on reducing our mortality rates related to sepsis at ESHT.
Revised and improved AKI pathway
A snapshot clinical audit completed in October 2018 identified several areas for improvement in the recognition and management of AKI. The results of the audit guided us to introduce the following improvements:

- The Trust AKI guideline has been revised and updated with input from key stakeholders including nephrology and urology
- The Trust Intravenous (IV) fluids guideline has been ratified and published, and we continue to enhance education and awareness around IV fluid therapy
- The pathway for pharmacy medication review of patients at risk of AKI has been updated and further work is required in implementing this effectively
- AKI will be incorporated into the Doctors’ induction package

Further improvements identified for 2019/20
Whilst the TEP has been implemented within the Trust embedding a new process into clinical practice can take some time and changing the behaviour regarding planning for
escalation may also be challenging. This is why we have identified the embedding of the TEP process as a key priority for the Trust in 2019/20, which has been outlined earlier in this report.

Our work to improve the recognition and management of sepsis and AKI also continues, and includes:

- Continuing our work to embed the processes for early screening and treatment of sepsis so that our divisional and ward teams have the information readily available to identify the need for improvement and adjust their practice
- Developing a simulation training day for our new Foundation Doctors that will join the Trust in August 2019. The simulation training will focus on improving recognition, appropriate escalation and planning for deterioration, and the use of the TEP.
- Implementing an electronic alerting system for AKI, including a process for prioritising patients at risk of AKI based on co-morbidities
- Providing further training for ward nurses and healthcare assistants (HCAs) on identification of AKI based on urine output monitoring
- Including a new primary measure of the number of cardiac arrests where a patient is assessed as having a National Early Warning Score (NEWS) score greater than 5 in our Excellence in Care dashboard, so that we have a robust mechanisms for monitoring our performance

2. Continue to reduce the number of avoidable falls

Why we chose this priority
The number of patient falls at the Trust has reduced each year over the previous three years. However we know from investigating serious and moderate incidents that there are occasions when we could have done more to try and prevent a fall from occurring. Injury to patients from a fall whilst in hospital can be devastating, or at best result in further pain and suffering with an increased length of stay and delayed recovery. In 2018/19, we committed to continue to roll out the new falls assessment and care plan to all wards and raise the profile of falls prevention through education, leadership and challenge.

Our aims
- Meet the challenging target of no more than 5 falls per 1,000 bed days compared with 5.6 in 2017/18
- Continue to reduce the total number of falls occurring within the Trust from the 1,624 reported in 2017/18

How have we done?
Throughout 2018/19, the Trust falls rate has averaged at 5.8 falls per 1,000 bed days, ranging from a high of 6.89 falls per 1,000 bed days in April 2018, to a low of 4.51 falls per 1,000 bed days in October 2018. Although we have not achieved our ambitious target of having no more than 5 falls per 1,000 bed days, or reduced our average falls rate compared with 2017/18, we have seen:
A decline in the total number of falls incidents in 2018/19 compared with previous years. During 2018/19 there were a total of 1,514 falls incidents reported on the Trust Datix incident reporting system. This is a reduction from the 1,624 reported falls during the previous fiscal year (2017/18).

A significant reduction in the number of serious incidents relating to falls (9 serious incidents relating to falls in 2018/19 compared with 19 in 2017/18).

Throughout 2018/19 we have introduced the following:

- A new multi-factorial falls assessment and care plan was rolled out across the Trust during 2018. Staff feedback was sought and was used to inform the development of the latest version which has been included in the Bedside Integrated Patient Documentation. The latest version follows a holistic approach to falls risk assessment and encourages staff to share the findings with patients and their families during their in-patient stay. Their feedback can provide useful input into the individual care planning for those most important to the person.
- Training sessions were held to support the roll out of the new falls assessment and care planning. These included scenario-based training specifically aimed at ward Matrons and senior nursing staff, and additional training sessions held on several wards across the Trust during the roll out period to provide education and support to staff, giving them the opportunity to ask questions.
- To further support staff with falls prevention work, the Prevention and Management of Patient Slips, Trips and Falls Policy has been updated to clearly illustrate staff responsibilities and preventative actions to be considered when carrying out risk assessments and care planning.
- Focussed falls prevention work was undertaken with wards where there were a higher reported number of falls and these wards were prioritised in the roll out of the new style risk assessment and care planning tool.
- Learning from falls serious incident root cause analysis reports is shared at the Weekly Patient Safety Summit meetings which are attended by senior staff from all
divisions and is also shared widely at the Falls Steering Group which has representation Trustwide.

- A daily alert system has been introduced to provide information on patients that have fallen more than once in an inpatient episode. This report is shared with senior nursing staff across the Trust, and ensures targeted focused interventions to assist with falls prevention.

**Further improvements identified for 2019/20**

Although we have not achieved our challenging target, we have made substantial progress in reducing the incidence of falls and number of falls causing harm. We recognise that there is still more to do to reduce harm, therefore reducing patient falls remains one of our Trust priority areas for improvement in 2019/20.

3. **Continue our focus on reducing avoidable Grade 3 and 4 pressure ulcers**

**Why we chose this priority**

We have focused on reducing the incidence of category 3 and 4 pressure ulcers to zero over the previous two years. Prevention of skin damage is an integral part of the care we provide at ESHT. Therefore in 2018/19, we committed to continue our focus on reducing avoidable category 3 and 4 pressure ulcers and ensuring that we have mechanisms in place to assess and manage pressure ulcers on an ongoing basis.

**Our aims**

- All avoidable pressure ulcers are identified, investigated and actions implemented
- Reduction in the number of avoidable category 3 and 4 pressure ulcers from our baseline data collated in the first three to six months of 2018/19

**How have we done?**

In 2018/19, we developed and implemented our improvement plan for pressure ulcer prevention. There have been eight category 3 and 4 pressure ulcers reported in 2018/19. This is a 76% reduction compared with 2017/18 where we reported a total of 33 category 3 and 4 pressure ulcers.

Of the eight category 3 and 4 pressure ulcers reported in 2018/19, five were found to have no lapses that were contributory and three were found to have some contributory lapses.

**Table 11: Number of PUs by with contributory lapses**

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Category 3</th>
<th>Category 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2018/19: April 2018 to June 2018</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Q2 2018/19: July 2018 to September 2018</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Q3 2018/19: October 2018 to December 2018</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Q4 2018/19: January 2019 to March 2019</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>
Our improvement plan included the following actions:

**Understanding the key themes and sharing learning**
- All category 3 and 4 pressure ulcers are reviewed at the monthly Pressure Ulcer Review Group (PURG) with a full Root Cause Analysis (RCA).
- All category 3 and 4 pressure ulcers are defined as avoidable or unavoidable by the PURG. They are deemed avoidable if Trust policy was not followed. Examples of this include if there were lapses in care, delays in equipment being provided, advice not given etc.
- Where the PURG is concerned that there has been a serious breech in policy, the pressure ulcer incident is reviewed at the Weekly Patient Safety Summit (WPSS) to determine whether they should be raised as a Serious Incident (SI).
- Themes and trends relating to pressure ulcers are analysed at PURG so that actions are identified and learning shared

**Training, education and improving awareness**
- Pressure ulcer prompt cards have been introduced to all our hospital and community staff to raise awareness and provide accessible information on prevention and management
- We have reviewed and revised our training plan for pressure ulcer prevention and management to include the revised national curriculum introduced by NHS Improvement and recommendations on defining and measuring pressure ulcers.
- We have identified specific staff on wards and within community teams to work with Tissue Viability Nurses to support improvement in their areas.

**Measuring for improvement**
- Regular audits are being completed in ward and community areas to monitor the compliance with using the Purpose T tool and SSKIN bundle tools
- Two teams in the Trust participated in an NHSI Collaborative programme to improve pressure ulcer prevention. The Collaborative programme has enabled the teams to identify a range of improvements to further enhance pressure ulcer prevention and management across the Trust.

**Further improvements identified for 2019/20**
The work to improve pressure ulcer prevention and management will continue across the Trust and will build upon the work undertaken through the NHSI Collaborative. This includes reviewing and revising the Planning Care Together policy to ensure a collaborative approach to safeguarding and self-neglect for patients that are non-concordant/ resistant to care.
Clinical Effectiveness Improvements 2018/19

4. Working towards providing consistent high quality care for our patients 7 days per week

Why we chose this priority
There is a national drive to improve access to emergency care 24 hours a day, 7 days a week. The 7 Day Hospital Services (7DS) Programme which was established by NHS England (NHSE) and NHS Improvement (NHSI) aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall there are 10 standards for 7DS, of which four standards have been made priorities for delivery. The standards apply to patients admitted in an emergency only, and not planned admissions.

The four priority standards that need to be delivered by the Trust by 2020/21 are:

- **Standard 2 – Time to first consultant review.** Patients wait no longer than 14 hours to initial consultant review after admission
- **Standard 5 – Access to diagnostic tests.** Patients get access to diagnostic tests with a 24 hour turnaround for non-urgent patients. For urgent patients this drops to 12 hours, and for critical patients, one hour.
- **Standard 6 – Access to consultant-directed interventions.** Patients must have timely 24 hour access, 7 days a week to specialist, consultant-directed interventions
- **Standard 8 – Ongoing consultant-directed review.** Patients with high-dependency care receive twice daily consultant review and those patients admitted to hospital in an emergency will receive daily consultant directed review

Achievement of each standard requires meeting the level of care for at least 90% of patients admitted in an emergency. In 2018/19, we committed to improving delivery against the four priority standards and progress towards achieving the priority standards by 2020/21.

Our aims

- Improve our compliance against the priority standards, so that by March 2019:
  a. Standard 2 = 80%
  b. standard 5 = 77%
  c. Standard 6 = 90%
  d. Standard 8 = 50%
- Develop specialty or divisional level plans for further improvement
- Identify and develop implementation plans for an automatic data capture solution

How have we done?
In November 2018, NHSE and NHSI introduced a new measurement system and process for providers to self-assess compliance against the 7DS standards. Overall ESHT has met the standard for access to consultant-directed diagnostics (standard 5). However the Trust self-assessment from February 2019 also indicates that the Trust had not fully met the standards for initial consultant assessment (standard 2), access to interventions (standard 6), and ongoing consultant-directed review (standard 8).
Standard 2 – time to first consultant review
- Our self-assessment of compliance against standard 2 indicated that the Trust was not fully compliant overall. Although the Trust has arrangements in place across our medical and surgical specialities to deliver first consultant review within 14 hours during weekdays, the formalised arrangements for consultant cover in a number of surgical specialities currently provide insufficient cover to consistently deliver review within 14 hours at weekends.
- To assist with monitoring compliance against the standards at ESHT, we have monitored delivery against standard 2, the time to first consultant review within 14 hours, by ward, on a monthly basis as part of our Excellence in Care programme. The overall compliance rate for November – February has been 91-92%, with a further increase in March to 96%. However, we are currently unable to confirm that performance over Saturday – Sunday is at the same level as that for Monday – Friday. Data collected from Excellence in Care highlights a number of areas where we could make improvements, and we are using this information to target our interventions. From May 2019 this data will allow comparison of performance on weekday and weekend admissions.

Standard 5 – Access to consultant-directed interventions
- Our self-assessment of compliance against standard 6 indicated that the Trust was not compliant overall. This is because the Trust has been unable to deliver an interventional GI endoscopy service that consistently complies with the access standards during weekdays and weekends. The configuration of our staffing has been changed to enable delivery of a 24/7 interventional GI endoscopy service. This commenced on 15th April 2019. This rota will enable the Trust to be fully compliant for this standard.

Standard 8 – Ongoing consultant-directed review
- Our self-assessment of compliance against standard 8 indicated that the Trust was not compliant overall. This is because the formalised arrangements in place for consultant cover across a number of specialities do not include a consultant-led ward round at weekends. Documentation of the need for medical review and delegation of consultant review is also variable across specialities and wards.
- Variation in Board Round practice has been audited and education and support is being targeted towards those clinical areas and specialities that are less developed. ESHT has piloted a project to improve documentation of delegation in two specialities in 2018. Educational work has been undertaken across all specialities to improve documentation of daily review and review delegation.

Further improvements identified for 2019/20
The Trust is committed to improving delivery against the four priority standards and progress towards achieving the priority standards by 2020/21. While we expect to be fully compliant with standards 5 and 6 in spring 2019, there is still some way to go to deliver and demonstrate compliance with standards 2 and 8. We have prioritised improving compliance against the standard for ongoing consultant-directed review (standard 8) as a priority in 2019/20.
Additionally:

- The Trust continues to develop divisional improvement plans for improving compliance against clinical standards 2 and 8 (first consultant review within 14 hours, and ongoing consultant review).
- Introduction of the Nerve Centre (live bed state system) across the Trust, expected from spring 2019, will support tracking of patients and their review within 14 hours, provide patient and task lists for medical staff, and provide a robust mechanism for monitoring performance against this clinical standard.
- The Nerve Centre system will incorporate a more reliable mechanism to document when a consultant-led review has taken place, and provide a robust mechanism to document delegated review of inpatients.

5. Continued implementation of the Excellence in Care Programme

Why we chose this priority
The Excellence in Care programme was developed in response to our Trust commitment to continuous improvement, so that clinical teams can be empowered to identify areas that require improvement and take positive action to lead and implement changes that result in improved patient and staff experience. First identified as a Trust priority in 2017/18, the Excellence in Care programme involves developing a user friendly ward performance dashboard, which collates information from the various systems and process that are used across the Trust. In 2018/19, we committed to continue the work to roll out the Excellence in Care dashboard to all our acute inpatient ward areas, to include measures on quality and safety, access and delivery, and leadership and culture.

Our aims

- Quality and safety measures dashboard available to all inpatient wards across the Trust by 31st March 2019
- Monthly reports available to enable review of information to identify areas for improvement
- Improvement measures for access and delivery developed, agreed, piloted and rolled out to at least 50% of areas
- Improvement measures for leadership and culture developed, agreed, piloted and rolled out to at least 50% of areas

How have we done?
In 2018/19, we have successfully identified and agreed measures for all domains of quality and safety, access and delivery, and leadership and culture. Since July 2018, the Excellence in Care dashboard, incorporating information for each of our inpatient wards, has been shared with clinical teams on a monthly basis. The reports enable review of information on a monthly basis to identify areas for improvement.

Further improvements identified for 2019/20
The Excellence in Care dashboard is now being used regularly by our clinical teams to monitor performance and compliance with clinical standards. However we recognise that improvements could be made to refine and streamline the amount and type of information
that is generated, so that it is an effective tool for clinical teams to monitor consistency of care and identify areas for improvement. This is why we have identified the continued implementation and development of Excellence in Care as a priority for the Trust in 2019/20.

Developing ESHT specific standards aligned to local and national policy and guidance will give us an agreed standard to audit against. This will make the information more helpful to teams when identifying areas of care and service delivery to improve on. When staff can see the accuracy of the dashboard they will start to utilise this as the ‘one version of the truth’.

6. Safe and effective discharge and improving our patients experience of getting home

Why we chose this priority
In 2017, the national inpatient survey highlighted a number of areas regarding communication and information provided to patients on discharge where we were underperforming compared to our peers. Data from our own internal complaints and inpatient questionnaire also highlighted poor results from patients receiving written information on discharge and being involved in decisions. In addition, information gathered from some serious incident investigations identified problems regarding information sharing prior to patient discharge and the quality of discharge notification letter sent to GPs. We were also aware that there was no clinical audit process in place to review readmissions within 30 days of discharge.

In 2018/19, we committed to working with East Sussex Better Together (ESBT) and our system partners to design and implement a system for communication and provision of information for patients and their families or carers prior to and during their discharge from hospital. We also committed to complete a clinical audit of a snapshot of patients who had been readmitted within 30 days of discharge from hospital, to identify themes or lapses to determine what improvements can be made.

Our aims
- Improved feedback from the people who use our services about the discharge process, firstly about communication and secondly about information regarding the discharge process
- More positive feedback from our staff
- A system in place for reviewing (a snapshot of) potentially avoidable readmissions within 30 days

How have we done?
- A new bedside booklet has been produced on ‘Information about your stay in hospital’
- Following the result of the 2017 National Inpatient Survey results, the Trust inpatient survey was amended to include the questions which had scored lower in the national survey in order to capture more local results
• Analysis of the three specific questions on the Inpatient survey related to discharge and information has demonstrated an overall achievement of over 70% positive response for each question
• Ward staff identified that patients were being asked to complete the survey before they have been discharged which may make it difficult to respond to the questions. In response to this feedback telephone interviews were undertaken with a random sample of patients one week after discharge and the same three questions were asked as those on the inpatient survey. Overall patients main concerns were:
  o With regard to the information on the doctors discharge letter and lack of written information about medication changes.
  o Delay with medication from Pharmacy; however data from Pharmacy was reviewed which demonstrated a less than 2 hour processing time from receipt of the prescription to delivery of medication.
• Reviewed the sub categories on the Datix system that the PALS team use to classify enquires in order to provide more detailed information. This has demonstrated that a concern for patients has been the lack of discharge information
• Process for audit of readmissions reported by chiefs of divisions through divisional Integrated Performance Reviews (IPR)
• Readmission app in development, for chiefs to use as a tool to identify individual patients
• Standard Operating Procedure for readmissions review and reporting being developed

We will take forward all the feedback and information from 2018/19 to target some of these concerns and we will engage patients to identify solutions.

At the time of this report the 2018 national inpatient survey results had not been published.

**Further improvements identified for 2019/20**
Admissions, transfer and discharge policy to be reviewed in 2019/20, in collaboration with ESCC to reflect the system-wide Let’s Get You Home policy
7. Continue to improve End of Life care by improving processes and documentation

Why we chose this priority
In 2017/18 we made a number of improvements in the care we provide to patients at the end of their life, however despite the improvements made, we recognised that there continued to be a number of improvements required in some of our processes and documentation. Therefore in 2018/19, we committed to focus on specific areas where improvement in systems and processes is a key enabler to enhancing the experience of care that we provide. This included starting the implementation of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT).

Our aims
- ReSPECT advocates from our acute and community teams will be identified and trained to support roll out and provide ReSPECT process training to colleagues in their clinical areas
- ReSPECT process and documents implemented within our acute hospitals
- We will see an improvement in documentation of last days and hours of life care

How have we done?
ESHT was an early adopter of the national ReSPECT process, and has implemented the ReSPECT documentation from 1 April 2019. The ReSPECT documentation has superseded the Do Not Attempt Cardio-Pulmonary Resuscitation document in our hospitals.

To support the roll out and embedding of ReSPECT, we have:
- Identified clinical ReSPECT champions and advocates to support implementation of the new process. Champions and advocates have been provided with training to understand the ReSPECT process, in addition to having a clearly defined set of responsibilities in relation to ReSPECT roll out.
- Delivered training and awareness sessions for clinical staff based on our hospital wards and in the community, including dedicated clinically-led training sessions for clinical staff at all levels, including junior doctors and training grades
- Incorporated ReSPECT training as part of our mandatory Basic Life Support (BLS) and Intermediate Life Support (ILS) training for clinical staff
- Produced dedicated website for the public to raise awareness and provide information relating to ReSPECT and also developed a staff webpage including all resources. A video describing the ReSPECT process is available to staff and members of the public.
- Worked with regional the Kent, Surrey and Sussex Academic Health Sciences Network (KSS AHSN) regional collaborative to share our process for rolling out ReSPECT. This has contributed to shared learning across our system partners.

Our strategy for End of Life Care has been developed with our partners, and includes a specific End of Life Care Strategy for Neonates, Children and Young People. We have
established an End of Life Care Improvement Group to take forward our improvements, and over the past year we have:

- Reviewed and revised our Last Days of Life Personalised Care Plan so that it includes more prompts for staff to guide their actions and documentation.
- Introduced a process whereby neonates, children and young people who have life limiting conditions and their parents/carers have an initial advance care planning discussion with a Paediatrician.
- Established a working group with parent and young person participation to assist us to identify further improvements in the end of life care process for neonates, children and young people.

Further improvements identified for 2019/20
Results from national and local audits have been triangulated with our internal information on complaints and incidents, and are demonstrating that we have sustained improvement in our delivery of end of life care. However findings also indicate that documentation remains poor and requires improvement.

- We will continue to work on improving our end of life care processes, including embedding the ReSPECT process
- We will finalise the process for information sharing with GPs, and continue to work with primary care partners and others to develop and refine processes
- The paediatric nursing workforce will receive bespoke end of life care training from June 2019
- We will create a bereavement suite for parents who have experienced stillbirth or a neonatal death

8. Improving the experience of young people in hospital

Why we chose this priority
Results of the National Children and Young People survey in 2017 highlighted areas that young people were not happy with during their stay as an inpatient in our hospitals. We scored in the bottom 20% of Trusts for the following questions:

- Were there enough things for you to do in hospital?
- Did hospital staff play with you or do any activities with you while you were in hospital?
- When the hospital staff spoke with you, did you understand what they said?
- Did the hospital staff answer your questions?
- Was it quiet for you to sleep when needed in the hospital?
- If you had any worries, did a member of staff talk with you about them?
- Before the operations or procedures, did hospital staff explain to you what would be done?
- Afterwards, did staff explain to you how the operation or procedures had gone?
- If you wanted, were you able to talk to a doctor or nurse without your parents or carer being there?
In 2018/19, we committed to undertake engagement events and communications to consult with young people and their families around what can be done to improve the experience they have.

**Our aims**
- An improved Children and Young People National Survey
- The Trust appearing in the top 50% of Trusts
- Improved FFT response from young people

**How have we done?**
We have consulted with young people and listened to their feedback through the Friends and Family Test (FFT). Our attempts to gather feedback from young people through surveys and establishing forums have generated limited responses, despite providing a range of mechanisms to respond. Despite this, we continue to actively seek feedback through a variety of media as part of our ongoing processes for identifying improvements for our children and young people’s services.

Based on feedback we have received from young people, we have introduced the following:
- Games consoles are now available in our inpatient areas, that can be used by the bedside if requested.
- The recently redesigned playroom on the children’s (Kipling) ward includes a specific area for young people.

The Children and Young People National Survey results for 2018 are not expected until July 2019, so we are unable to report yet on whether we have made improvements in this regard.

**Further improvements identified for 2019/20**
- The Short Stay Paediatric Assessment Unit (SSPAU) playroom is in the process of being redesigned, and will also include activities for young people.
- We are introducing “my dream appointment”. This is concept from ISEND (Inclusion, Special Educational Needs and Disability Service), that gathers the views of young people’s experience and ideas on health appointments that they have attended. The information gathered will be utilised in our outpatient services and paediatric wards, to improve a young person’s experience whilst in hospital.
- We will continue to actively seek feedback from young people and will revisit the opportunity to develop a specific forum for young people as a mechanism to involve them in service improvement.
Part 3.2 - Sign up to Safety pledges

In last year’s Quality Account, we also committed to improving the quality and safety of care we provide and continuing to drive improvement through the following ‘Sign up to Safety’ pledges for 2018/19.

Our progress and achievement for these areas is outlined below:

**Sign up to Safety – Reduce patient falls**

Our aim was to reduce the number of falls to no more than 5 falls per 1,000 bed days; although we did not achieve this target in 2018/19 we have seen a decline in the number of falls incidents. There were 1,514 falls incidents reported in 2018/19, compared to 1,624 reported in 2017/18. There has also been a reduction in the number of serious incidents relating to falls, 9 serious incidents were reported in 2018/19, compared with 19 reported in 2017/18. The Trust acknowledges that there is still more to do to reduce harm, and this remains one of our priority areas for improvement in 2019/20.

**Sign up to Safety – Reduce pressure ulcers**

One of the Trust’s improvement priorities for 2018/19 was to continue our focus on reducing avoidable grade 3 and 4 pressure ulcers. In 2017/18, 33 grade 3 and 4 pressure ulcers were reported and in 2018/19, 8 category 3 and 4 pressure ulcers were reported, a 76% reduction. 567 Category 2 pressure ulcers were reported in 2018/19 compared to 575 in 2017/18. Our focus on category 2 pressure ulcers for 2019/20 will continue with deep dives so themes can be identified and on teaching staff how to use quality improvement methodology to try and reduce variation (and harm) over time.

**Sign up to Safety - Improving Sepsis recognition and treatment**

Our sepsis screening tools were updated and re-launched in our acute hospitals and a screening tool has been implemented within our community team. A live audit process was introduced and a new patient information leaflet was developed to promote awareness. These actions have resulted in an increase in patients screened for sepsis in our emergency departments and ward areas. For patients identified with red flag sepsis, we have increased the percentage that receive antibiotics within 1 hour. Our work to improve sepsis recognition and treatment continues and remains a priority for improvement in 2019/20 as part of our continuation to improve the management of the deteriorating patient.

**Sign up to Safety - Duty of Candour (DoC)**

Our ambitious goal for 2018/19 was to achieve 100% of verbal and written feedback. At the time of the writing the report the Trust is reviewing the duty of candour data collection and
completing an audit. Therefore the trust does not have accurate information to report for 2018/19.

The Patient Safety team are continuing to offer Duty of Candour training sessions throughout the year on both acute hospital sites and provide bespoke training on request. Additionally the team work closely with divisional colleagues to monitor DoC standards and provide support to assist achievement of 100% compliance.

Sign up to Safety - Reduced mortality rates

We have achieved our goal to reduce the Trust Summary Hospital Mortality Index (SHMI) to 1.0. A series of actions have been taken to achieve this, as highlighted on page 68 and actions continue to be taken.

Sign up to Safety - Improve patient experience

We have increased the patient response rate for the Friends and Family Test (FFT), for our Emergency Departments from 12% to 14% (January 2019), however our Inpatient response rates have remained static at 42% (January 2019). We continue to drive and explore new options of collecting this feedback from our patients. This is monitored and tracked through our Patient Experience and Engagement Steering Group.

Sign up to Safety 2019/20

The Sign up to Safety campaign came to a close at the end of March 2019. Although the national campaign has finished, Trusts have been encouraged to continue with the improvement work they had started. To achieve this, the falls improvement work will be monitored and reported by the Falls Steering Group. Pressure ulcer improvement will be monitored and reported through the Pressure Ulcer Review Group. Duty of Candour improvement will be monitored by the Patient Safety and Quality Group and reported by the Patient Safety Team. Sepsis improvements will continue to be monitored and reported through the Clinical Outcomes Group.
Part 3.3 – Review of our Quality Indicators

Amended regulations from NHS Improvement require Trusts to include a core set of quality indicators in the Quality Account. The data source for all indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC).

The Trust performance for the applicable quality indicators are set out below.

Patient Safety Indicators

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>ESHT 16/17</th>
<th>ESHT 17/18</th>
<th>ESHT 18/19 (April 2018 to Dec 2018)</th>
<th>National average (Acute Trusts)</th>
<th>Best performer (Acute Trusts)</th>
<th>Worst performer (Acute Trusts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of admitted patients risk-assessed for Venous Thromboembolism (VTE)</td>
<td>96.30%</td>
<td>96.77%</td>
<td>95.83%</td>
<td><strong>95.83%</strong></td>
<td>95.20%</td>
<td>100.00%</td>
<td>77.80%</td>
</tr>
</tbody>
</table>

_Source: NHS Digital_

East Sussex Healthcare NHS Trust has taken the following actions to improve the rate and therefore the quality of its services by:

- Generating and sending a weekly monitoring email communication to the relevant clinical leads to highlight the compliance rate for individual areas where they have fallen below the 95% national target. This system is also accessible by managers who can monitor compliance with the process on a daily basis and drill down to patient and consultant level as necessary.
- Monitoring of compliance with VTE risk assessment at divisional and specialty levels is through the Integrated Performance Review process.
- Supporting training for junior doctors through an e-induction programme, and specific training in the prescribing of thromboprophylaxis through a Pharmacy Doctors’ prescribing induction.
- Training ward Clerks to enter the VTE Risk Assessment data onto the OASIS/PAS system.
- Conducting Root Cause Analysis of patients who have died with VTE in parts 1a, b or c of the death certificate to support learning, improvement and adherence to NICE VTE Prevention Guidance (CG92)
- VTE Risk Assessment is embedded and continues to be reported nationally on a quarterly basis

**Rate of C. Difficile Infection**

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 14/15</th>
<th>ESHT 15/16</th>
<th>ESHT 16/17</th>
<th>ESHT 17/18</th>
<th>ESHT 18/19</th>
<th>National average</th>
<th>Best performer</th>
<th>Worst performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of C. difficile Infection per 100,000 bed days (aged 2 or over)</td>
<td>23.7</td>
<td>19.2</td>
<td>17.6</td>
<td>15.4</td>
<td>20.1</td>
<td>14.0</td>
<td>0.0</td>
<td>91.0</td>
</tr>
</tbody>
</table>

Source: ESHT 18/19 data is from the Public Health England (PHE) Healthcare Acquired Infections (HCAI) Data Capture System. All other data is from NHS Digital.

In 2018/19, a limit for the rate of C. difficile infections was set at 15.7 which is equal to 40 cases a year. In 2018/19, the Trust reported 51 cases, equivalent to a rate of 20.1 which is in excess of the limit set. We believe this primarily reflects the increase in appropriate antimicrobial use as part of the significant improvement in sepsis treatment and associated reduced mortality, and we are continuing to focus on reducing this rate of infection.

East Sussex Healthcare NHS Trust has taken the following actions to improve the rate of C. difficile infections (CDI) per 100,000 bed days and therefore the quality of its services by:

- Enhancing communication to staff with focus on antimicrobial stewardship, in particular “start Smart and Focus” promoting review at 72hrs and use of ESHT policy and *Microguide* app.
- Implementing an additional weekly review of C. difficile carriers, conducted by a Consultant Microbiologist and Gastroenterologist to improve treatment and minimise risk of infection.
- Introducing weekly Antimicrobial Stewardship (AMS) ward rounds in wards deemed as high risk to ascertain the prescribing practice at ward level. Any issues or concerns are highlighted to the appropriate division. The audit data is provided to the Trust Infection Prevention Control Group (TIPCG) and the Antimicrobial Stewardship Group (ASG).
- Undertaking antimicrobial compliance monitoring and providing feedback to clinicians and via TIPCG and the ASG.
- Escalating higher rates of CDI to senior leaders for engagement in Post Infection Reviews and antimicrobial stewardship.
- Undertaking Post Infection Review on all healthcare acquired infection (HAI) cases and routinely sending samples for Ribotyping to exclude cross infection as a source.
- Enhancing environmental cleaning and additional auditing of hand hygiene and isolation practice on wards associated with CDI.
- Using hydrogen peroxide vaporisation as standard terminal cleaning following diagnosis of CDI.
East Sussex Healthcare NHS Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

<table>
<thead>
<tr>
<th>Indicator – NRLS Data</th>
<th>ESHT 16/17</th>
<th>ESHT 17/18</th>
<th>ESHT 18/19</th>
<th>National average</th>
<th>Best performer</th>
<th>Worst performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of patient safety incidents reported per 1,000 admissions</td>
<td>01/04/16 – 30/09/16</td>
<td>01/04/17 – 30/09/17</td>
<td>01/04/18 – 30/09/18</td>
<td>Rate not provided by NRLS (average of 5458 incidents reported)</td>
<td>51.9 (23692 incidents reported)</td>
<td>13.1 (556 incidents reported)</td>
</tr>
<tr>
<td>% of patient safety incidents reported that resulted in severe harm or death – This is the National and Reporting and Learning System Data between 01/04/2017 and 30/09/2017</td>
<td>Severe 0.2% (12 incidents)</td>
<td>Severe 0.13% (7 incidents)</td>
<td>Severe 0.23% (11 incidents)</td>
<td>Severe 0.2%</td>
<td>Severe 0.3%</td>
<td>Severe 0.5%</td>
</tr>
<tr>
<td></td>
<td>Death 0.03% (2 incidents)</td>
<td>Death 0.0% (no incidents)</td>
<td>Death 0.02% (1 incident)</td>
<td>Death 0.1%</td>
<td>Death 0.1%</td>
<td>Death 0.0%</td>
</tr>
</tbody>
</table>

Source: NHS Digital

East Sussex Healthcare NHS Trust has taken the following actions to improve the rate of patient safety incidents per 100 admissions and the quality of services by:

- The management of investigation of severe and serious incidents continues to be centralised and is embedded in the Trust with an ongoing improvement in the quality of investigations.
- Serious incidents are all managed in accordance with national legislation and times. The Trust has no overdue investigation reports.
- Actions resulting from serious incidents and amber investigations continue to be monitored with updates on the number outstanding provided to the Patient Safety and Quality Group. Work is underway with regards to auditing completed actions to ensure that they have been embedded in clinical practice.
Clinical Effectiveness Quality Indicators

Summary Hospital-level Mortality Indicator (SHMI)

East Sussex Healthcare NHS 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.

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<thead>
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</thead>
<tbody>
<tr>
<td>SHMI value</td>
<td>1.14</td>
<td>1.08</td>
<td>1.15</td>
<td>1.10</td>
<td>1.07</td>
<td>1.00</td>
</tr>
<tr>
<td>Banding</td>
<td>1 (higher than expected)</td>
<td>2 (as expected)</td>
<td>1 (higher than expected)</td>
<td>2 (as expected)</td>
<td>2 (as expected)</td>
<td>2 (as expected)</td>
</tr>
<tr>
<td>% of patient deaths with palliative care coding by speciality and/or diagnosis</td>
<td>18.2</td>
<td>22.4</td>
<td>18.1</td>
<td>18.8</td>
<td>20.2</td>
<td>29.9</td>
</tr>
</tbody>
</table>

Source: NHS Digital

The most recent SHMI value for the data period October 2017 to September 2018 continues to show an improvement in the indicator and the Trust remains in the national “expected” range. This represents huge progress over the last 5 years.

East Sussex Healthcare NHS Trust has taken the following actions to improve the mortality risk score and therefore the quality of its services by:

- Recruiting Consultant staff in our emergency units and acute medicine departments so we can provide optimum care when patients are acutely ill, with consultant presence on MAU every day for around 12 hours.
- Increasing the number of doctor’s resident at night from 2 to 3, and strengthening of the senior nursing and advanced nurse practitioner cover at night.
- Substantially increasing provision of ambulatory emergency care (AEC), with the opening of the new AEC unit at Eastbourne in 2018 and planned expansion of the AEC facility at Conquest in 2019. This has allowed streaming of patients from A&E to the most appropriate assessment area, with resulting more rapid senior input.
- Further improving the recognition and rapid treatment of Sepsis, both at admission and in inpatients, both of which have contributed towards reducing the mortality indicators across the year.
- Improving recognition of Acute Kidney Injury (AKI).
Providing timely senior decision making at ward level through multidisciplinary daily board rounds, led by the consultant.

Improving handover for acute teams. We have also purchased Nerve Centre: a handover, task allocation, and patent tracking tool. The first components of this are currently being introduced and others rolled out across the hospitals.

Increasing recognition of frailty, with specific documentation of this in the Integrated Patient Document (IPD).

Implementing a 24/7 acute GI bleeding service, which will be fully operational from mid-April 2019.

VitalPAC is used across acute inpatient areas to identify patients whose observations are deteriorating. The system is used to record and share the information ensuring clinicians have full visibility of a patient’s observations and can respond at the earliest opportunity. The system will be upgraded in July 2019 with new functionality available including NEWS2, fluid management charts and falls assessment.

The Trust’s Deteriorating Patient Improvement Group (DPIG) is working on improved documentation of agreed interventions for frail patients with multiple comorbidities, with clarity on ceilings of care and treatment escalation.

We continue to track and review all benchmarked mortality indicators, trends and themes in other mortality and quality data on a monthly basis through the Trust Mortality Review Group (MRG). Actions or investigations are taken or recommended when there is variation or any concern identified.

Overview of Trust mortality indicators is provided by the Clinical Outcome Group (COG) which is chaired by the Medical Director. The group also drives improvement in a number of workstreams to improve outcomes for patients.

An additional quarterly review group reviews the case notes of all deaths graded at M&M review as having poor quality of care, deaths involving serious clinical incidents or complaints, to re-assess avoidability and promote learning.

We are moving to an independent Medical Examiner system in 2019, as recommended by the Royal College of Physicians (RCP) and the Department of Health (DOH).

The Trust Board is sighted on our mortality performance with formal quarterly reporting, including the number of avoidable deaths.

Improving clinical coding of patient information to ensure mortality indicators are based on accurate clinical information.

Patient Reported Outcome Measures /Scores (PROMS)

_East Sussex Healthcare NHS Trust considers that the outcome scores are as described because the Trust has robust data quality assurance processes in place._

All NHS patients having hip or knee replacement surgery are invited to fill in a PROMS questionnaire. The questionnaire’s aim is to find out about the patients’ health and quality of life, before and after the operation. This enables hospitals to measure their success and make improvements supported by feedback from patients on the reported outcome of their surgical intervention and compare themselves to other Trusts nationally.
NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Index</th>
<th>ESHT 14/15 Adjusted Average Health Gain</th>
<th>ESHT 15/16 Adjusted Average Health Gain</th>
<th>ESHT 16/17 Adjusted Average Health Gain</th>
<th>ESHT 17/18 Adjusted Average Health Gain</th>
<th>17/18 – National Adjusted Average Health Gain</th>
<th>17/18 Adjusted Average Health Gain Best performer</th>
<th>17/18 Adjusted Average Health Gain Worst performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Reported Outcome Measures Adjusted Average Health Gain Hip Replacement (primary)</td>
<td>EQ-5D</td>
<td>0.45</td>
<td>0.46</td>
<td>0.50</td>
<td>0.44</td>
<td>0.47</td>
<td>0.57</td>
<td>0.37</td>
</tr>
<tr>
<td></td>
<td>EQ-VAS</td>
<td>11.49</td>
<td>12.53</td>
<td>14.54</td>
<td>16.98</td>
<td>14.23</td>
<td>19.05</td>
<td>8.29</td>
</tr>
<tr>
<td></td>
<td>Oxford Hip Score</td>
<td>22.58</td>
<td>23.38</td>
<td>22.85</td>
<td>22.70</td>
<td>22.68</td>
<td>26.30</td>
<td>18.87</td>
</tr>
<tr>
<td>Patient Reported Outcome Measures Adjusted Average Health Gain Knee Replacement (primary)</td>
<td>EQ-5D</td>
<td>0.31</td>
<td>0.33</td>
<td>0.33</td>
<td>0.38</td>
<td>0.34</td>
<td>0.42</td>
<td>0.23</td>
</tr>
<tr>
<td></td>
<td>EQ-VAS</td>
<td>5.28</td>
<td>2.17</td>
<td>4.81</td>
<td>9.61</td>
<td>8.28</td>
<td>14.32</td>
<td>2.51</td>
</tr>
<tr>
<td></td>
<td>Oxford Knee Score</td>
<td>16.38</td>
<td>16.76</td>
<td>16.32</td>
<td>17.62</td>
<td>17.26</td>
<td>20.64</td>
<td>13.16</td>
</tr>
</tbody>
</table>

Source: NHS Digital - PROMS Score Comparison Tool/CSV Data Pack

The NHS Digital Score Comparison Tool is based on modelled records which are the number of records where both the pre- and post-operative questionnaires have been completed, the questionnaire pair has been successfully linked to a record of hospital inpatient activity and key data items used in the case-mix adjustment methodology have valid values recorded.

East Sussex Healthcare NHS Trust has taken the following actions to improve the rate and therefore the quality of its services by:

- Reviewing and sharing the data through our divisional Quality and Governance mechanisms.
Emergency readmissions to hospital within 28 days of discharge

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

The percentage of patients who were readmitted to hospital within 28 days of discharge is shown below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 15/16</th>
<th>ESHT 16/17</th>
<th>ESHT 17/18</th>
<th>ESHT 18/19 (Apr-18 to Dec-18)</th>
<th>National Average</th>
<th>HES Acute Peer 5th Percentile</th>
<th>HES Acute Peer 95th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency readmissions to hospital within 28 days of discharge Age 0-15</td>
<td>13.37%</td>
<td>13.03%</td>
<td>12.70%</td>
<td>14.30%</td>
<td>8.10%</td>
<td>3.46%</td>
<td>14.31%</td>
</tr>
<tr>
<td>Emergency readmissions to hospital within 28 days of discharge Age 16+</td>
<td>7.46%</td>
<td>7.09%</td>
<td>8.18%</td>
<td>9.21%</td>
<td>7.82%</td>
<td>5.81%</td>
<td>10.44%</td>
</tr>
</tbody>
</table>

Source: NHS Digital

East Sussex Healthcare NHS Trust has taken the following actions to improve the rate and therefore the quality of its services by:

- Building on work from the previous year we have expanded the ‘enhanced discharge’ meetings to three days a week, the meetings involve social care and community colleagues to avoid unnecessary readmissions
- Created a readmissions dashboard which divisions will use to identify trends and themes underlining readmissions and will be presented to Executive Directors quarterly at the divisional Integrated Performance Reviews (IPR)
- Daily operational executive calls are held to identify system issues and put actions into place to support effective discharge home
- Our crisis response teams are able to support patients at home for 72 hours post discharge to prevent them requiring readmission
### Patient and Staff Experience Indicators

**Percentage of patients who would recommend the provider to friends or family needing care**

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT Nov 15</th>
<th>ESHT Nov 16</th>
<th>ESHT Nov 17</th>
<th>ESHT Nov 18</th>
<th>National Average</th>
<th>Best Performer</th>
<th>Worst Performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients who would recommend the Trust to friends or family needing treatment (A&amp;E)</td>
<td>89.0%</td>
<td>85.0%</td>
<td>91.0%</td>
<td>94.0%</td>
<td>87%</td>
<td>100.0%</td>
<td>63.0%</td>
</tr>
<tr>
<td>Percentage of patients who would recommend the Trust to friends or family needing treatment (Inpatient)</td>
<td>99.0%</td>
<td>98.0%</td>
<td>97.0%</td>
<td>96.0%</td>
<td>96%</td>
<td>100.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>


East Sussex Healthcare NHS Trust has taken the following actions to improve the rate and therefore the quality of its services by:

- The Patient Experience and Engagement Steering Group has monitored the response rates of Inpatients, Maternity and A&E.
- We have continued to ask patients more questions than the standard Friends and Family question, these questions remain aligned to the national surveys.
- Due to the change in reporting systems for Patient Experience additional support was provided to departments, ensuring that paper questionnaires were available and a team available to help with device issues.
- Revised reports have been created through the new system, these include analysis of each question and free text comments (both positive and negative) allowing wards/ departments to share and use the data.
- The league table and regular reporting by ward on response rate and score continued for inpatient areas. These were included within Patient Experience reports and divisional reports and reinforced at relevant meetings.
We continue our aim to achieve a minimum 50% overall response rate for inpatients. This was a challenge during our changeover of systems.

Our Emergency Departments have taken the following actions:

- A focused drive on increasing the response rate at EDGH has led to a 20% increase in compliance against historical response rate of between 2 to 4%
- We have appointed three volunteers to work alongside our clinical orderlies to support increasing the response rate.
- Patient’s views are shared in our weekly team brief so that staff receive praise to help morale and provide insight and focus on what patients would want us to change.
- We have introduced a ‘know how well you are doing’ board which patients can see. Information on the board is updated on a monthly basis, including details of changes that have been implemented each month.

**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.*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 14/15</th>
<th>ESHT 15/16</th>
<th>ESHT 16/17</th>
<th>ESHT 17/18</th>
<th>National Average</th>
<th>Best Performer</th>
<th>Worst Performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness to inpatients' personal needs. CQC National Inpatient survey score</td>
<td>67.6%</td>
<td>68.1%</td>
<td>66.5%</td>
<td>67.3%</td>
<td>68.6%</td>
<td>85.0%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

*CQC National Inpatient survey was published in June 2018.*

East Sussex Healthcare NHS Trust has taken the following actions to improve the rate and therefore the quality of its services by:

- For the 2017 results, the questions with the lowest scores were reviewed and added to the Trusts inpatient survey to gain further data
- The results of the 2017 survey was provided to teams for areas of improvement to be addressed
- The results were used alongside other feedback as part of the data collection for deep dives into clinical areas where further support may have been indicated
- The 2018 survey results have not been published at the time of this report but will be discussed at the Patient Experience and Engagement Group when available
Percentage of staff who would recommend the Trust as a provider of care to friends or family

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>ESHT 2015</th>
<th>ESHT 2016</th>
<th>ESHT 2017</th>
<th>ESHT 2018</th>
<th>National average For acute and community Trusts</th>
<th>Best performer</th>
<th>Worst performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff who would recommend the Trust to friends or family needing treatment</td>
<td>54%</td>
<td>62%</td>
<td>65%</td>
<td>67.3%</td>
<td>69.9%</td>
<td>90.3%</td>
<td>42.2%</td>
</tr>
</tbody>
</table>

Source: NHS Digital

East Sussex Healthcare NHS Trust has taken the following actions to improve the rate and therefore the quality of its services by:

- Analysing the NHS Staff Survey results and using the information to identify key priorities for the whole organisation to focus on. To deliver those priorities effectively
across the Trust, each division was tasked to create and implement action plans, giving local control and enabling staff to make effective change.

- Using staff FFT results as a source of intelligence to inform and signpost to areas for improvement in staff working life, wellbeing, conditions and work environment. Staff responses are also monitored three times a year through an internal mechanism.

- Launching a Leadership Pathway to develop and support aspiring, new and experienced leaders from all staff groups, including providing continual professional development for those staff in leadership roles.

- The Staff Engagement and Wellbeing Team are working with the Strategy, Innovation and Planning Team to promote Quality Improvement (QI) sessions aimed at all members of staff, to increase awareness and develop capability for continuous improvement across the Trust.
Annexes

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

Statement from Commissioners

Thank you for giving the Sussex and East Surrey CCGs the opportunity to comment on your Quality Account for 2018/19.

Both Eastbourne, Hailsham and Seaford (EHS) Clinical Commissioning Group (CCG) and Hastings and Rother (HR) CCG have reviewed the East Sussex Healthcare NHS Trust (ESHT) Quality Account for the 2018/19 year and consider it to be a fair and accurate reflection of the organisations' performance.

The Trust has continued to improve the quality and safety of services provided to the residents of East Sussex during 2018/19. This Quality Account demonstrates improvement in a range of outcomes for the population who access services at ESHT.

The Trust has continued to improve its safety culture with key highlights including:

- Significantly improved performance in relation to the number of falls meeting the serious incident criteria;
- Significantly improved reduction trust acquired grade three and four pressure ulcers;
- Significantly improved performance across a range of mortality indices;
- Significantly improved performance in relation to the identification of patients at risk of deterioration and treatment for the symptoms of sepsis;
- Significantly improved staff take up of the influenza vaccination (including the successful attainment of 75% of staff being vaccinated in line with the national CQUIN);
- Improved Stroke services (particularly in relation to the provision of therapies)
- Improved national cancer patient experience survey results; and,
- Sustained improvement in meeting the Emergency Department (ED) national four hour wait standard monthly standard.

The 2019/20 Quality Account priorities will ensure the Trust Board is able to seek assurance on the experience of people who are accessing the services provided by the Trust. The key areas below outline where the Trust is required to demonstrate improvement include ensuring that:

- All relevant recommendations into the “Gosport War Memorial Hospital: The Report of the Gosport Independent Panel (2018)” are reviewed and implemented where required;
The National Early Warning System Two v.2 (NEWS2) system is implemented effectively in July 2019; Compliance figures regarding the Duty of Candour are fully validated; Revised maternity IT arrangements are implemented from September 2019; The requirements of the Seven Day Service (7DS) programme are implemented in line with national requirements; All actions within the organisational Cancer action plan are addressed and implemented where required; and, Patients are included in discussions around their discharge (including engaging patients in discharge planning from admission).

Overall the CCG has seen evidence of significant quality improvements being made within the Trust in 2018/19. The CCG looks forward to working with the Trust to make further improvements in 2019/20. The commissioners are therefore pleased to endorse this quality account and we look forward to continuing an effective working relationship so we can all drive forward improvements for our local populations.

Yours sincerely

[Signature]

Allison Cannon
Chief Nursing Officer
On behalf of the Sussex and East Surrey Clinical Commissioning Groups
Statement from Healthwatch East Sussex

Healthwatch East Sussex (HWES) continues to work with the people of East Sussex in gathering their views and experiences of using local health and care services. Many of those experiences are from patients, their families and carers that use services provided by East Sussex Healthcare NHS Trust (ESHT); either by external contact via our Information and Signposting service or directly during our engagement activities speaking to patients, staff and families at the point of care.

HWES endorses the Trust’s commitment to be ‘outstanding’ by 2020 and views the Quality Account for 2018/19 as a balanced reflection of the improvement they have made as part of sustaining the achievements required.

The priority to improve the patient experience, with safe patient care given the highest priority level is particularly encouraging to see included. The commitment to improve communication so that patients feel better informed about their care and treatment is another area HWES is encouraged to see included as an area for improvement. This reflects what patients are telling us about their experiences.

At times HWES’s programme of activity enables us to engage with members of staff; at all levels and across a seven day/24-hour spectrum. We welcome the opportunity to speak to staff and experience on a regular basis now, members of staff approaching our representatives to highlight good practice, to have constructive discussions and becoming increasingly more open to the role and benefit local Healthwatch can have in strengthening patient, family involvement. HWES view the Trust’s role in strengthening staff engagement as important as patient involvement and welcomes the continuing priority to ensure all staff members are valued and respected.

Going forward HWES will continue to include in its regular discussions the progress made with:

- Embedding actions supporting early recognition of Sepsis in Emergency Departments.
- Improving end of life care processes, including embedding the ReSPECT programme.
- Supporting the Trust through the Patient Experience and Engagement Steering Group (PEESG) to improve the Friends and Family Test (FFT) response rates (which contributes to the improvement of services); and
- Working with the Trust at strategic level as the new health and care systems in East Sussex progress.

A further area HWES is keen to strengthen for the future is the relationship and engagement with the executive board and non-executive members and looks forward to progressing these discussions in 2019/2020.
HOSC has welcomed the Trust’s positive engagement with the Committee as evidenced by the attendance of the Chief Executive and other senior officers at each meeting.

We recognise that the Care Quality Commission (CQC) inspection gave the trust an overall rating of ‘requires improvement’ only because not all areas of the Trust were re-inspected, and that those areas that were received either good or outstanding ratings. We hope to see the Trust re-inspected in 19/20 and see it achieve at least a ‘good’ rating overall.

We were particularly concerned by the culture of bullying and harassment that the CQC uncovered during its 2015 inspection of the trust. However, over the last few years we have seen strong evidence that the senior management team has improved ESHT’s organisational culture. As a result, we would expect to see the trust achieve at least a good rating in the well-led domain when the CQC return.

Last year we saw ESHT removed from quality special measures. Following the trust’s success in achieving its planned deficit for 2018/19, we hope to see the trust come out of financial special measures during 19/20.

2018/19 Quality Priorities
Whilst the Committee would have liked to have seen all eight quality priorities for 18/19 achieved, we welcome the evidence of partial achievement of five and full achievement of three. We would expect that the identified further improvements for those five priorities are carried out in 2019/20 as planned.

Last year we highlighted plans to deliver the four core standards of emergency admissions by 2020/21 and improve young people’s experience of being in hospital wards as particularly important areas to address.

We welcome the achievement of the A&E standard for access to diagnostic tests but at the same time recognise that the other three standards have not yet been met. We believe that the standards for time to first consultant review and ongoing consultant-directed review are going to be challenging to achieve before 20/21 if achieving them at weekends, when there are fewer consultants on call, remains a challenge.

The trust has also made welcome additions for young people receiving inpatient care. We look forward to hearing whether the results of the National Survey show that the Trust has managed to appear in the top 50% of trusts for young people staying in inpatient wards.

2019/20 Quality Priorities
It is reassuring to see continuity in quality priorities, with three of the four priorities having been brought forward from 2018/19. The Committee also welcomes the fact that the quality priorities are based on a Quality and Safety Strategy designed to realise the ambition to become an outstanding organisation by 2020. This shows that the trust is operating with focus and a clear goal in mind.
In terms of individual quality priorities, the embedding of the new Treatment Escalation Plan (TEP) and ReSPECT tools into clinical practice across the trust are welcomed as they will help to raise a better, more consistent offer of care to patients from ESHT clinicians.

The introduction of the Nerve Centre to maintain a record of individual inpatients’ needs and generate a timetable of bed rounds, including at weekends, is also a positive development. We hope that this helps to achieve the A&E Standards that were not met during 18/19.

HOSC looks forward to working with the Trust over the coming year and will continue to monitor progress on behalf of local people.
Annex 2: Statement of Directors’ responsibilities in respect of the Quality Account

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

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust’s performance over the period covered;

- The performance information reported in the Quality Account is reliable and accurate;

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the Quality Account is robust and reliable; conforms to specified data quality standards and prescribed definitions; is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

Dr Adrian Bull
Chief Executive
24 June 2019

Steve Phoenix
Chairman
24 June 2019

We have been engaged by the Board of Directors of East Sussex Healthcare NHS Trust to perform an independent assurance engagement in respect of East Sussex Healthcare NHS Trust’s Quality Account for the year ended 31 March 2019 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Rate of clostridium difficile infections

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of the directors and Practitioner
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the 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, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

• the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 (“the Guidance”); and

• the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

• Board minutes for the period 1 April 2018 to 24 June 2019;

• papers relating to quality reported to the Board over the period 1 April 2018 to 24 June 2019;

• feedback from commissioners dated 06/06/2019;

• feedback from local Healthwatch organisations dated 04/06/2019;

• feedback from the Overview and Scrutiny Committee dated 29/05/2019;

• the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated June 2019;

• the national patient survey dated 14/06/2019;

• the national staff survey dated 27/02/2019;

• the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 15/05/2019;

• the annual governance statement dated 24/05/2019; and

• the Care Quality Commission’s inspection report dated 06/06/2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of East Sussex Healthcare NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the
fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and East Sussex Healthcare NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East Sussex Healthcare NHS Trust.

Our audit work on the financial statements of East Sussex Healthcare NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as East Sussex Healthcare NHS Trust’s external auditors. Our audit reports on the financial statements are made solely to East Sussex Healthcare NHS Trust’s directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to East Sussex Healthcare NHS Trust’s directors those
matters we are required to state to them in an auditor’s report and for no other purpose. Our audits of East Sussex Healthcare NHS Trust’s financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than East Sussex Healthcare NHS Trust and East Sussex Healthcare NHS Trust’s directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

The indicator reporting percentage of patients risk-assessed for venous thromboembolism (VTE) did not meet the six dimensions of data quality in the following respects:

- Validity and Accuracy – Our testing identified one case which had been incorrectly excluded from the numerator as risk assessments had been completed in the patient notes, but had not been recorded as compliant on PAS.

- Validity and Accuracy – Our testing identified one case which had been incorrectly included in the numerator as it should have been recorded as non-compliant because the assessment had not been completed within 24 hours.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
2nd Floor
St Johns House
Crawley
RH10 1HS

25 June 2019
### Appendix 1 – Integrated Performance Report

#### Safety and Quality

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Month Comparison</th>
<th>YTD Comparison</th>
<th>Rolling 12 month Avg</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total falls</td>
<td>M</td>
<td>137</td>
<td>146</td>
<td>1612</td>
<td>1508</td>
</tr>
<tr>
<td>Number of no-harm falls</td>
<td>M</td>
<td>109</td>
<td>105</td>
<td>1200</td>
<td>1109</td>
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<tr>
<td>Number of min/moderate falls</td>
<td>M</td>
<td>27</td>
<td>35</td>
<td>402</td>
<td>501</td>
</tr>
<tr>
<td>Number of major/catastrophic falls</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>10</td>
<td>8</td>
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<tr>
<td>All patient falls per 1000 Beddays</td>
<td>5.5</td>
<td>5.4</td>
<td>6.3</td>
<td>5.7</td>
<td>5.7</td>
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<tr>
<td>All patient falls with harm per 1000 Beddays</td>
<td>1.1</td>
<td>1.6</td>
<td>0.5</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Falls assessment compliance</td>
<td>M</td>
<td>69.3%</td>
<td>95.4%</td>
<td>83.5%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Total grade 2 to 4 pressure ulcers per 1000 Beddays</td>
<td>M</td>
<td>2.3</td>
<td>1.9</td>
<td>2.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Number of grade 2 pressure ulcers</td>
<td>M</td>
<td>58</td>
<td>41</td>
<td>555</td>
<td>562</td>
</tr>
<tr>
<td>Number of grade 3 to 4 pressure ulcers</td>
<td>M</td>
<td>1</td>
<td>1</td>
<td>35</td>
<td>10</td>
</tr>
<tr>
<td>Pressure ulcer assessment compliance</td>
<td>M</td>
<td>73.1%</td>
<td>89.8%</td>
<td>82.2%</td>
<td>82.0%</td>
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<tr>
<td>VTE Assessment compliance</td>
<td>95.0%</td>
<td>95.4%</td>
<td>96.5%</td>
<td>95.3%</td>
<td>95.9%</td>
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</table>

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Month Comparison</th>
<th>YTD Comparison</th>
<th>Rolling 12 month Avg</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRSA Cases</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Number of Cdiff cases</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>34</td>
<td>51</td>
</tr>
<tr>
<td>Number of MSSA cases</td>
<td>M</td>
<td>0</td>
<td>4</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Emergency Re-Admissions within 30 days</td>
<td>10.6%</td>
<td>10.5%</td>
<td>9.9%</td>
<td>10.1%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Crude Mortality Rate</td>
<td>M</td>
<td>2.1%</td>
<td>1.5%</td>
<td>1.7%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Month Comparison</th>
<th>YTD Comparison</th>
<th>Rolling 12 month Avg</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Serious Incidents</td>
<td>M</td>
<td>5</td>
<td>4</td>
<td>47</td>
<td>45</td>
</tr>
<tr>
<td>Number of Never Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Number of medication administration incidents</td>
<td>M</td>
<td>41</td>
<td>34</td>
<td>431</td>
<td>373</td>
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</table>

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Month Comparison</th>
<th>YTD Comparison</th>
<th>Rolling 12 month Avg</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient FFT response rate</td>
<td>40.0%</td>
<td>43.3%</td>
<td>48.7%</td>
<td>54.8%</td>
<td>40.3%</td>
</tr>
<tr>
<td>Inpatient FFT score</td>
<td>96.0%</td>
<td>97.2%</td>
<td>97.5%</td>
<td>97.5%</td>
<td>97.5%</td>
</tr>
<tr>
<td>AAE FFT response rate</td>
<td>22.0%</td>
<td>39.9%</td>
<td>85.5%</td>
<td>2.9%</td>
<td>8.7%</td>
</tr>
<tr>
<td>AAE FFT score</td>
<td>68.0%</td>
<td>61.4%</td>
<td>90.7%</td>
<td>4.3%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Outpatient FFT Score</td>
<td>M</td>
<td>96.0%</td>
<td>96.2%</td>
<td>0.2%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Maternity FFT response rate</td>
<td>45.0%</td>
<td>21.5%</td>
<td>16.5%</td>
<td>4.6%</td>
<td>32.3%</td>
</tr>
<tr>
<td>Maternity FFT score</td>
<td>90.0%</td>
<td>66.6%</td>
<td>97.4%</td>
<td>0.8%</td>
<td>98.3%</td>
</tr>
</tbody>
</table>
### Access and Delivery

#### MSA - Unjustified Breaches

**Incidents - Jun 18 to Mar 19**

- Unjustified incidents - EDGH
- Unjustified incidents - CQ
- Total incidents

**Patients Affected - Jun 18 to Mar 19**

- Unjustified patients affected - EDGH
- Unjustified patients affected - CQ
- Total patients affected

#### Indicator Description

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Month Comparison</th>
<th>YTD Comparison</th>
<th>Rolling 12 month Avg</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mar-18</td>
<td>Mar-19</td>
<td>Var</td>
<td>2017/18</td>
</tr>
<tr>
<td>Four hour standard</td>
<td>95.0%</td>
<td>85.4%</td>
<td>53.1%</td>
<td>7.7%</td>
<td>87.5%</td>
</tr>
<tr>
<td>A&amp;E Minor Performance</td>
<td>98.0%</td>
<td>97.3%</td>
<td>96.0%</td>
<td>1.2%</td>
<td>97.8%</td>
</tr>
<tr>
<td>Four hour standard (Local System)</td>
<td>95.0%</td>
<td>89.5%</td>
<td>94.7%</td>
<td>5.4%</td>
<td>93.0%</td>
</tr>
<tr>
<td>12 Hour ETAs</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unplanned re-attendance to Emergency Department</td>
<td>5.0%</td>
<td>2.8%</td>
<td>3.5%</td>
<td>0.7%</td>
<td>2.0%</td>
</tr>
<tr>
<td>% Patients waiting less than 15 minutes for assessment in ED</td>
<td>M 83.2%</td>
<td>84.1%</td>
<td>0.9%</td>
<td>0.9%</td>
<td>82.7%</td>
</tr>
<tr>
<td>% Patients waiting less than 60 minutes for treatment in ED</td>
<td>M 45.0%</td>
<td>44.6%</td>
<td>-0.4%</td>
<td>0.4%</td>
<td>46.2%</td>
</tr>
<tr>
<td>% Patients waiting less than 120 minutes for treatment in ED</td>
<td>M 74.5%</td>
<td>75.1%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>75.0%</td>
</tr>
<tr>
<td>% Patients that left without being seen in ED</td>
<td>M 2.0%</td>
<td>1.7%</td>
<td>-0.9%</td>
<td>0.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>% Patients admitted from ED (Conversion rate)</td>
<td>M 31.4%</td>
<td>32.2%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>29.1%</td>
</tr>
<tr>
<td>Emergency Department attendances</td>
<td>M 10571 11387</td>
<td>7.7%</td>
<td>118946</td>
<td>126080</td>
<td>8.9%</td>
</tr>
<tr>
<td>Ambulance conveyances</td>
<td>M 3388</td>
<td>3344</td>
<td>-1.3%</td>
<td>38731</td>
<td>38447</td>
</tr>
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</table>

#### Indicator Description

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Month Comparison</th>
<th>YTD Comparison</th>
<th>Rolling 12 month Avg</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mar-18</td>
<td>Mar-19</td>
<td>Var</td>
<td>2017/18</td>
</tr>
<tr>
<td>RTT Incomplete standard</td>
<td>92.0%</td>
<td>89.9%</td>
<td>91.2%</td>
<td>1.3%</td>
<td>91.2%</td>
</tr>
<tr>
<td>RTT Backlog (Number of patients waiting over 18 weeks)</td>
<td>M 2839</td>
<td>2381</td>
<td>-458</td>
<td>-458</td>
<td>2839</td>
</tr>
<tr>
<td>RTT Total Waiting List Size</td>
<td>29221</td>
<td>29221</td>
<td>-1064</td>
<td>-1064</td>
<td>29221</td>
</tr>
<tr>
<td>RTT 02 week waters</td>
<td>0.0</td>
<td>0.0</td>
<td>2.0</td>
<td>2.0</td>
<td>0.0</td>
</tr>
<tr>
<td>RTT 35 week waters</td>
<td>M 213</td>
<td>158</td>
<td>-25.6%</td>
<td>213</td>
<td>158</td>
</tr>
</tbody>
</table>

#### Indicator Description

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Target</th>
<th>Month Comparison</th>
<th>YTD Comparison</th>
<th>Rolling 12 month Avg</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Feb-18</td>
<td>Feb-19</td>
<td>Var</td>
<td>2017/18</td>
</tr>
<tr>
<td>Cancer 60 day standard</td>
<td>93.0%</td>
<td>96.4%</td>
<td>96.3%</td>
<td>0.0%</td>
<td>96.0%</td>
</tr>
<tr>
<td>Cancer 62 day urgent referral standard</td>
<td>85.0%</td>
<td>86.5%</td>
<td>85.3%</td>
<td>3.8%</td>
<td>75.9%</td>
</tr>
<tr>
<td>Cancer 60 day standard (treatment)</td>
<td>93.0%</td>
<td>97.7%</td>
<td>97.8%</td>
<td>0.1%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Cancer 31 day standard</td>
<td>96.0%</td>
<td>99.3%</td>
<td>98.4%</td>
<td>0.0%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Cancer 31 day subsequent radiotherapy treatment</td>
<td>99.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cancer 31 day subsequent surgery</td>
<td>94.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Cancer 62 day screening standard</td>
<td>90.0%</td>
<td>90.0%</td>
<td>85.2%</td>
<td>-4.3%</td>
<td>88.3%</td>
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</table>

101
### Activity and Effectiveness

<table>
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<tr>
<th>Indicator Description</th>
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<th>Month Comparison</th>
<th>YTD Comparison</th>
<th>Rolling 12 month Avg</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department attendances</td>
<td>M</td>
<td>10571</td>
<td>11387</td>
<td>118640</td>
<td>125989.0</td>
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<tr>
<td>Ambulance conveyances</td>
<td>M</td>
<td>3388</td>
<td>3344</td>
<td>38731</td>
<td>38447</td>
</tr>
<tr>
<td>Elective spells</td>
<td>M</td>
<td>656</td>
<td>685</td>
<td>7246</td>
<td>6605</td>
</tr>
<tr>
<td>Day Cases</td>
<td>M</td>
<td>3608</td>
<td>4194</td>
<td>40941</td>
<td>47557</td>
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<tr>
<td>Elective Beddays</td>
<td>M</td>
<td>2081</td>
<td>1714</td>
<td>19581</td>
<td>20203</td>
</tr>
<tr>
<td>Total Non-Elective Spells</td>
<td>M</td>
<td>4909</td>
<td>5076</td>
<td>51075</td>
<td>56567</td>
</tr>
<tr>
<td>Number of Emergency spells</td>
<td>M</td>
<td>4270</td>
<td>4490</td>
<td>43709</td>
<td>48867</td>
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<tr>
<td>Number of Maternity spells (ante and post partum)</td>
<td>M</td>
<td>344</td>
<td>318</td>
<td>-8.1%</td>
<td>3973</td>
</tr>
<tr>
<td>Number of other non-elective spells (Births/Transfers from other hospitals)</td>
<td>M</td>
<td>295</td>
<td>276</td>
<td>-6.5%</td>
<td>3203</td>
</tr>
<tr>
<td>Non-Elective beddays</td>
<td>M</td>
<td>23433</td>
<td>28464</td>
<td>265310</td>
<td>243715</td>
</tr>
</tbody>
</table>

**LO5**

- Elective Average Length of Stay: M 3.2 2.9 -0.2 2.7 3.0 0.3 3.0
- Non-Elective Average Length of Stay: M 4.9 4.1 -0.8 5.2 4.4 -0.6 4.4
- Inpatient Average Length of Stay at intermediate care units: M 31.0 25.3 -6.3 28.4 25.3 -3.1 25.3

### Leadership and Culture

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>TRUST</th>
<th>Trend line</th>
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</thead>
<tbody>
<tr>
<td>WORKFORCE CAPACITY</td>
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</tr>
<tr>
<td>Mar-16</td>
<td>Apr-16</td>
<td>May-16</td>
</tr>
<tr>
<td>Budgeted full time</td>
<td>0.85%</td>
<td>0.85%</td>
</tr>
<tr>
<td>Total full time usage</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Substantive vacancies</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Fill rate</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Bank file usage (as % total file usage)</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Agency file usage (as % total file usage)</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Turnover rate</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Stability rate</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>SICKNESS ABSENCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual sickness rate</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Monthly sickness rate (%)</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Short term sickness (&lt;28 days)</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Monthly long term sickness (&lt;28 days)</td>
<td>0.80%</td>
<td>0.86%</td>
</tr>
</tbody>
</table>

| MANDATORY TRAINING & APPRAISEMENTS |       |            |
| Appraisal rate           | 0.80% | 0.86%      |
| Moving & Handling        | 0.80% | 0.86%      |
| Induction                | 0.80% | 0.86%      |
| Inspec Control           | 0.80% | 0.86%      |
| Info Gov                 | 0.80% | 0.86%      |
| Health & Safety          | 0.80% | 0.86%      |
| MCA                     | 0.80% | 0.86%      |
| DoLS                    | 0.80% | 0.86%      |
| Safeguarding Vulnerable Adults | 0.80% | 0.86% | 0.80% | 0.86% | 0.80% | 0.86% | 0.80% | 0.86% |
| Safeguarding Children Level 2 | 0.80% | 0.86% | 0.80% | 0.86% | 0.80% | 0.86% | 0.80% | 0.86% |
Appendix 2 – National Clinical Audit and National Confidential Enquiries Programme

National clinical audits and national confidential enquiries we were eligible to participate in during 2018-2019.

<table>
<thead>
<tr>
<th>National Confidential Enquiries</th>
<th>ESHT Eligible</th>
<th>ESHT Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal, newborn and infant and perinatal mortality (MBRRACE-UK)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Child Health Clinical Outcome Review Programme</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Pulmonary Embolism</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>NCEPOD - Perioperative Management of Diabetes</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>NCEPOD - Acute Bowel Obstruction</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>ESHT Eligible</th>
<th>ESHT Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Community Acquired Pneumonia</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mandatory Surveillance of Bloodstream Infections and C. Diff infection</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Audit of Seizures and Epilepsies in Children &amp; Young People (Epilepsy 12)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Maternity and Perinatal Audit (NMPA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Adult Critical Care Audit (Case mix programme - ICNARC)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>FFFAP – Inpatient Falls</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>FFFAP – National Hip Fracture Database</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Gastrointestinal Cancer Audit Programme</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older Patients (NABCOP)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Surgical Site Infection Surveillance Service</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Major Trauma (TARN)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Audit of Coronary Angioplasty / PCI</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Acute Coronary Syndrome / Acute MI Audit (MINAP)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Inflammatory Bowel Disease Programme</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Elective Surgery (National PROMs Programme)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes (NPID) Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Adult Diabetes Inpatient Audit (NADIA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>NADIA Harms Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Diabetes Foot Care Audit (NDFA)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National Diabetes Adult Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Programme</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
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</tr>
<tr>
<td>National Diabetes Transition Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke National Audit (SSNAP)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LEDER)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Seven Day Services self-assessment survey</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National COPD Audit Programme - Pulmonary Rehabilitation</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National COPD Audit Programme - Secondary Care</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>National COPD Audit Programme – Adult Asthma</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Non-Invasive Ventilation – Adults</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Management of Massive Haemorrhage (Blood Transfusion</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Programme)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious Hazards of Transfusion (SHOT)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Feverish Children - Emergency Departments</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Vital Signs in Adults - Emergency Departments</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>VTE Risk in lower limb immobilisation – Emergency</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Departments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>British Society of Urological Surgeons (BAUS) – Cystectomy Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>BAUS – Nephrectomy Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>BAUS – Radical Prostatectomy Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>BAUS – PCNL Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>BAUS – Stress Urinary Incontinence Audit</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Reducing the Impact of serious infections – Antibiotic</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Consumption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing the Impact of serious infections – Antibiotic</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Stewardship</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3 – 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 2018/19, 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.

<table>
<thead>
<tr>
<th>Title</th>
<th>Number of Cases submitted</th>
<th>% submitted of those required</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Audit of Intermediate Care (NAIC)</td>
<td>Trust – 77 cases submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>Management of major haemorrhage</td>
<td>Trust – 7 cases submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>CONQ – 63 cases EDGH – 71 cases 2x Organisational site questionnaires submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>National Adult Diabetes Audit</td>
<td>Trust – 3540 cases submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>National Adult Diabetes Inpatient Audit</td>
<td>CONQ – Organisational questionnaire submitted EDGH – Organisational questionnaire submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit</td>
<td>Trust – 125 cases submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes Audit</td>
<td>CONQ – 8 cases EDGH – 8 cases</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life</td>
<td>Trust - 80 cases and an Organisational questionnaire submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>Seven Day Services Audit</td>
<td>Trust - 158 cases submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>National Maternity and Perinatal Audit (NMPA)</td>
<td>Trust – Organisational questionnaire submitted</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>Vital signs in Adults (RCEM)</td>
<td>CONQ - 121 cases EDGH - 102 cases</td>
<td>CONQ - 100% EDGH - 85%</td>
</tr>
<tr>
<td>VTE Risk in lower limb immobilisation (RCEM)</td>
<td>CONQ - 239 cases EDGH - 134 cases</td>
<td>CONQ - 100% EDGH - 100%</td>
</tr>
<tr>
<td>Feverish Children (RCEM)</td>
<td>CONQ - 133 cases EDGH - 115 cases</td>
<td>CONQ - 100% EDGH – 96%</td>
</tr>
<tr>
<td>Pulmonary Embolism (NCEPOD)</td>
<td>12 x Clinical Questionnaires 11 x Case notes 2 x Organisational Questionnaires</td>
<td>100% (all required data submitted)</td>
</tr>
<tr>
<td>Perioperative Management of Diabetes (NCEPOD)</td>
<td>25 x Clinical Questionnaires 14 x Case notes 2 x Organisational Questionnaires</td>
<td>96% Clinical Questionnaires 100% Case notes 100% Organisational Questionnaires</td>
</tr>
</tbody>
</table>
Appendix 4 – Other Non-Mandated National Clinical Audits

The Trust participated in twelve non-mandated national audits in 2018/19 as follows:

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the services for people with mental health needs who present to AE</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>(NASH 3) National Audit of Seizure Management in Hospitals</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>SAMBA 2018 (Society of Acute Medicine Benchmark audit 2018)</td>
<td>Acute Medicine</td>
</tr>
<tr>
<td>The Second UK Sprint National Anaesthesia Project: Epidemiology of Critical Care provision after Surgery (SNAP-2: EpiCCS)</td>
<td>Anaesthetics</td>
</tr>
<tr>
<td>National Head and Neck Cancer Audit (HANA)</td>
<td>Cancer Services / ENT</td>
</tr>
<tr>
<td>National Potential Donor Audit (PDA)</td>
<td>Critical Care</td>
</tr>
<tr>
<td>British Association of Dermatologists national clinical audit on the management of bullous pemphigoid</td>
<td>Dermatology</td>
</tr>
<tr>
<td>ABCD nationwide Libre Audit</td>
<td>Diabetes</td>
</tr>
<tr>
<td>BHIVA National clinical audit 2018: monitoring of adults with HIV aged 50 or over</td>
<td>Sexual Health</td>
</tr>
<tr>
<td>Smoking Cessation Organisational Audit</td>
<td>Trustwide</td>
</tr>
<tr>
<td>AcUte manaGeMEnt of aNkle fracTures (AUGMENT)</td>
<td>Trauma &amp; Orthopaedics</td>
</tr>
<tr>
<td>BAUS Urethroplasty Audit</td>
<td>Urology</td>
</tr>
</tbody>
</table>
## Appendix 5 – Equality Impact Assessment

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Answer</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the Quality Account affect a group with a protected characteristic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>less or more favourably than another on the basis of age, disability,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>gender reassignment, marriage and civil partnership, pregnancy and</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>maternity, race, religion of belief, sex or sexual orientation?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>No</td>
<td>All priorities are underpinned by a commitment to improve the quality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>of services and outcomes for patients and carers of all protected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>characteristics.</td>
</tr>
<tr>
<td>2.</td>
<td>Has the Quality Account taken into consideration any privacy and dignity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>or same sex accommodation requirements that may be relevant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>We are committed to respecting privacy and dignity and this is</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>implicit in improving our patient experience. Our capital schemes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>support compliance with delivering same sex accommodation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>requirements.</td>
</tr>
<tr>
<td>3.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>There is no evidence that the quality improvement priorities will</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>affect some groups differently. We recognise the need to target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>objectives for those who have needs relating to protected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>characteristics and these are considered in respect of each priority</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e.g. in respect of access, use of interpreters, making</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>information available in different formats etc.</td>
</tr>
<tr>
<td>4.</td>
<td>If you have identified potential discrimination, are any exceptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>valid, legal and/or justifiable?</td>
<td>N/A</td>
<td>No discrimination identified</td>
</tr>
<tr>
<td>5.</td>
<td>Is the impact of the Quality Account likely to be negative and if so,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>can the impact be avoided?</td>
<td>No</td>
<td>No negative impact identified</td>
</tr>
</tbody>
</table>

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Appendix 6 – Glossary

A

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

**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.

**Anaerobic bloodstream infections**
An anaerobic bloodstream infection is caused by anaerobes, which are bacteria that cannot grow in the presence of oxygen.

C

**Care Pathway**
This is an anticipated care plan that a patient will follow, in an anticipated time frame, and is agreed by a multi-disciplinary team (a team made up of individuals responsible for different aspects of a patient’s care).

**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](http://www.cqc.org.uk)

**Chronic Obstructive Pulmonary Disease (COPD)**
Chronic Obstructive Pulmonary Disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. It includes emphysema (damage to the air sacs in the lungs) and chronic bronchitis (long-term inflammation of the airways).

**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.

**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. Visit: [www.dh.gov.uk/en/](http://www.dh.gov.uk/en/)

**Culture**

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

**Data Quality**

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

**Data Security and Protection Toolkit (DSPT)**

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

**Datix/DatixWeb**

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

**Department of Health (DOH)**

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

**Deteriorating patient**

A patient whose observations indicate that their condition is getting worse

**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 specialities 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

**End of Life Care (EOLC)**
End of Life Care (EOLC) is healthcare for patients in the final hours or days of their lives, or for those with a terminal illness or terminal condition that has become advanced, progressive and incurable.

**Excellence in Care Programme**
The Excellence in Care Programme will provide a framework and ongoing review for quality care and leadership at departmental level. It is identified as a priority in the Patient Safety and Quality Strategy and will empower wards/departments to deliver high quality care through effective leadership and improvement culture.

**Friends and Family Test (FFT)**
The NHS Friends and Family Test (FFT) was 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.

**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

Health Research Authority (HRA)
The Health Research Authority (HRA) is an executive non-departmental public body of the Department of Health. The HRA exists to provide a unified national system for the governance of health research. Its core purpose is to protect and promote the interests of patients and the public in health and social care research by:

- ensuring research is ethically reviewed and approved
- promoting transparency in research
- overseeing a range of committees and services
- providing independent recommendations on the processing of identifiable patient information where it is not always practical to obtain consent, for research and non-research projects

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
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.

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.

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
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews clinical practice and identifies potentially remediable factors in the practice of anaesthesia and surgical and medical treatment. Its purpose is to assist in maintaining and improving standards
of medical and surgical care for the benefit of the public. It does this by reviewing the management of patients and undertaking confidential surveys and research, the results of which are published. Clinicians at ESHT participate in national enquiries and review the published reports to make sure any recommendations are put in place.

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

**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.

**Palliative care** Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

**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.

**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.
Privacy and dignity
To respect a person’s privacy is to recognise when they wish and need to be alone (or with family or friends), and protected from others looking at them or overhearing conversations that they might be having. It also means respecting their confidentiality and personal information. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual beliefs.

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.

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.

Research Ethics Committee (REC)
There are more than 80 NHS Research Ethics Committees across the UK. They exist to safeguard the rights, safety, dignity and well-being of research participants.

RECs review research proposals and give an opinion about whether the research is ethical. They also look at issues such as the participant involvement in the research. The committees are entirely independent of research sponsors (the organisations responsible for the management and conduct of the research), funders and the researchers themselves. This enables them to put participants at the centre of their review.

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.

**Royal College of Emergency Medicine (RCEM)**
The College is established to advance education and research in Emergency Medicine. The College is responsible for setting standards of training and administering examinations in Emergency Medicine for the award of Fellowship and Membership of the College as well as recommending trainees for CCT in Emergency Medicine. The College works to ensure high quality care by setting and monitoring standards of care and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

**Safety Huddles**
Short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical, the opportunity to understand what is going on with each patient and anticipate future risks to improve patient safety and care.

**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.

**Sign up to Safety**
Sign up to Safety is a campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result.

By signing up to the campaign, organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient safety, helping to ensure patients get harm free care every time, everywhere.

Chief Executives of NHS England, The Care Quality Commission, the NHS Trust Development Authority, Monitor, NHS Improving Quality and the NHS Litigation Authority have all signed up to align their work with this campaign.
**Speak Up Guardian**
A person who supports staff to raise concerns.

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

**Summary Hospital-level Mortality Indicator (SHMI)**
SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation is in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust (where 1.0 represents the national average). Depending on the SMHI value, Trusts are banded between 1 and 3 to indicate whether their SMI is low (3), average (2) or high (1) compared 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 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.

**Sussex MSK Partnership East (SMSKPE)**
Sussex MSK Partnership East are a local partnership bringing together primary care, specialist musculoskeletal (muscles, joints and bones) care, community, mental health and well-being experts to deliver the whole musculoskeletal service in East Sussex.

**Sustainability and Transformation Partnership (STP)**
This is an arrangement where NHS health organisations and local authority organisations, clinical commissioning groups and local councils who commission and provide health and care work together. The purpose is to produce a long-term plan outlining how local health and care services will evolve, improve and continue over the next five years.

**Trauma Audit and Research Network (TARN)**
The Trauma Audit and Research Network provides major trauma centre audits and information to help doctors, nurses and service managers to drive improvement.

**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.
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 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.